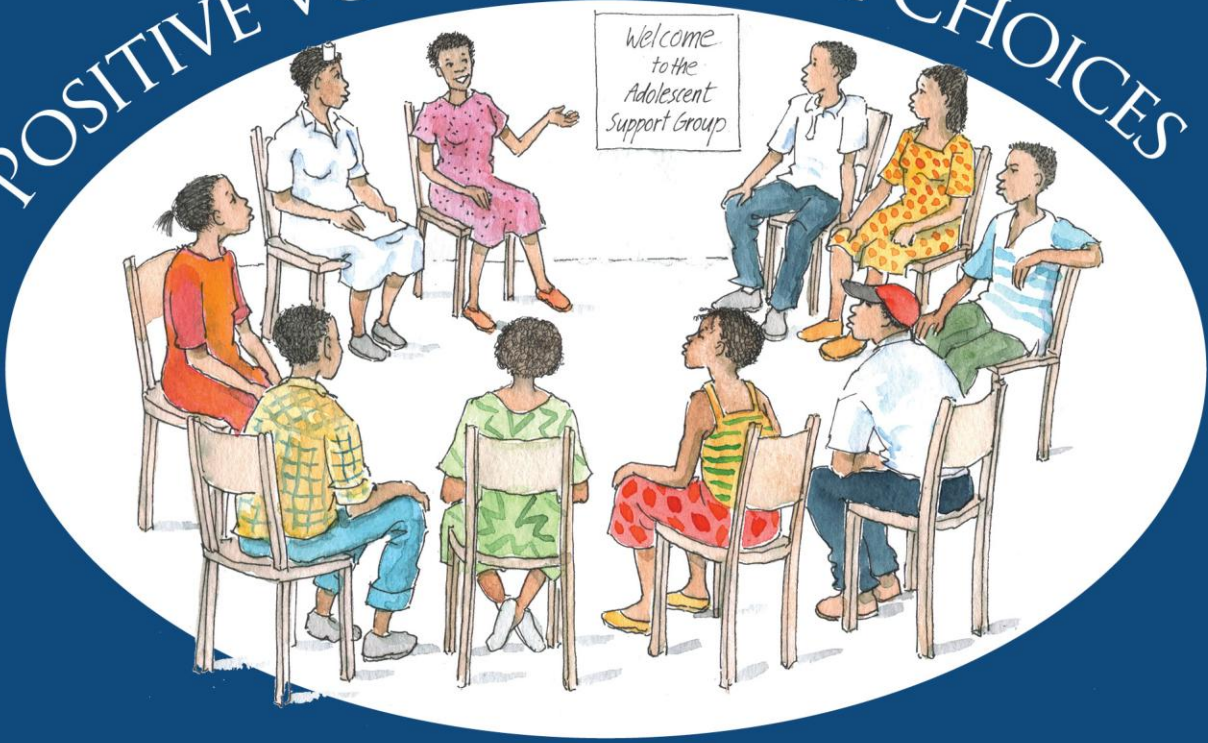


POSITIVE VOICES, POSITIVE CHOICES



A Comprehensive Training Curriculum for
Adolescent Peer Educators

TRAINER MANUAL



ICAP

Global. Health. Action.
COLUMBIA UNIVERSITY
Mailman School of Public Health

POSITIVE VOICES, POSITIVE CHOICES

A Comprehensive Training Curriculum for Adolescent Peer Educators Trainer Manual

2011

VERSION 1.0

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Foreword

Wisdom is like a baobab tree; no one individual can embrace it. ~Akan & Ewe Proverb

In a very short period of time the story of the HIV epidemic in sub-Saharan Africa and other high prevalence settings has changed dramatically. It was less than ten years ago that hospital wards and clinics were filled with infants, children, and adults severely ill and dying, suffering from untreated HIV infection. With the rapid scale up of HIV care services and increased availability of life-saving antiretroviral medications, HIV has been transformed from a universally fatal infection to a chronic disease. This transformation has been most noticeable among pediatric populations where efforts to prevent mother-to-child transmission have been successfully coupled with effective treatment of children with established HIV disease. Pediatric HIV clinics are seeing fewer babies with new HIV infections and are shifting their energy to support good health in children living with HIV infection, helping them to traverse childhood and adolescence and to successfully enter adulthood.

In the context of these noteworthy successes, new challenges have emerged. Clinics, health workers, families, and communities accustomed to addressing the needs of very sick babies and young children are now facing an aging population. In many settings there are growing numbers of adolescents living with HIV infection. Many acquired HIV infection through mother-to-child transmission and have survived the first decade of life, entering adolescence accustomed to taking daily medications, to making frequent clinic visits, and to dealing with fluctuating periods of wellness and illness. At the same time, increasing numbers of young people living with HIV only recently acquired the infection, most commonly within sexual partnerships, and are grappling with the reality of their diagnosis. It is now estimated that more than 40% of new HIV infections in people 15 years or older occur among youth. Generally referred to as adult care services, retention rates are particularly poor among newly infected youth.

With more adolescents in care, stories are emerging describing the various challenges facing health workers. Every nurse, counselor, and physician is anxious to talk about that previously adherent adolescent who is no longer taking his or her medications and is hanging out with friends, missing clinic visits, having sex, drinking alcohol, etc. Most of these stories can be interpreted as normal behaviors of adolescence, but when coupled with HIV infection, they can have deadly consequences. Health workers, public health officials, families, and communities are seeking ways to meet the needs of adolescents living with HIV and to successfully engage them in care and treatment services.

Adolescents often have a great deal to say, hold strong opinions, and engage with passion and enthusiasm. They are a fabulous resource for the health care system and should not be overlooked. Adolescents living with HIV are well poised to let us know what they need and how best to serve them. Who better to represent their needs and inform the delivery of services than those in care? They can be invaluable as peer counselors to provide information, share their experiences, and listen carefully to others like them. And adolescents who disclose their status within clinics and communities serve as role models for others while joining collective efforts to decrease discrimination and stigma.

For all of these reasons we have designed this adolescent Peer Education curriculum, *Positive Voices, Positive Choices: A Comprehensive Training Curriculum for Adolescent Peer Educators*. This

curriculum is intended to develop program capacity to involve adolescents living with HIV in providing peer support to other adolescents. It also provides guidance to enable clinics to develop youth-friendly HIV programs and to better support adolescents living with HIV. Finally, this curriculum also provides adolescents willing to become peer educators with a sound foundation of information about HIV infection, prevention, care, and treatment services, as well as other related health conditions. Guidance on communication skills, counseling, support groups, and working within multidisciplinary teams are also provided. The materials are highly interactive and engaging and draw on the knowledge and experiences of the participants. Adolescents completing the training should be well equipped to join the multidisciplinary team and, with close supervision and guidance, begin working with peers, families, and other staff.

The work on this project forced us to carefully consider our expectations for adolescent peer educators. We deeply value their insights and believe that their inputs as members of the multidisciplinary team are invaluable. Furthermore, peer counseling is a highly effective way to communicate information and influence behavior. In these tasks and with these expectations, adolescent peer educators should be considered equal members of the multidisciplinary team, where their voices should be heard and their work respected. At the same time, it is critical to remember that they are young people and subject to the same developmental challenges as their peers. They are often not ready to enter the adult world and embrace adult responsibilities. For these reasons, even the most accomplished adolescent peer educators require guidance, supervision, and positive reinforcement. Expectations of what they can accomplish need to be developmentally sound and need to acknowledge the limitations as well as the strengths associated with this complex developmental stage. They are neither adults nor children, but oftentimes a little of both. We anticipate that they will accomplish great things.

A youth without a link to the elders is like a tree without a root. (Africa)

I would like to express my appreciation and gratitude to all of the individuals who contributed to the development of these materials. Special thanks go to Tayla Colton, independent consultant, for her technical support, expertise, openness, and inspired and informed approach to material development; Anne Schley, independent consultant, for her creative, sensitive, and intelligent approach to the special issues of adolescents and for her tireless work on these materials; Anne Schoeneborn for her superb writing and editing skills; Beatriz Thome and Ruby Fayorsey, ICAP Clinical Officers, for their thoughtful contributions throughout the development process; Cristiane Costa, Regional Program Director, and Leah Westra, Project Officer, for their continued support throughout the development process; Petra Röhr-Rouendaal, artist, for her beautiful illustrations; Laurian Miles from Mantaray Design for designing many of the tools used in the curriculum; and Virginia Allread and her colleagues at François-Xavier Bagnoud Center (FXB), School of Nursing, University of Medicine and Dentistry of New Jersey, for producing a product that we can all be proud to share.

This work would not have been possible without the support of the MTCT-Plus Initiative. The MTCT-Plus Initiative was the first multi-country, family-centered HIV care and treatment program and it supported services in 14 centers in 9 countries in Sub-Saharan Africa and Thailand. The Initiative is recognized as a leader in family-focused HIV care and in addressing the special needs of pregnant and postpartum women and their children. Funding for the MTCT-Plus Initiative was provided by the Bill & Melinda Gates Foundation, the William and Flora Hewlett Foundation, the Robert Wood Johnson Foundation, the Henry J. Kaiser Family Foundation, the John D. and Catherine T. MacArthur Foundation, the David and Lucile Packard Foundation, the Rockefeller Foundation, the Starr Foundation, and the U.S. Agency for International Development.

The MTCT-Plus Initiative was the first program providing the foundation for the formation of ICAP, an important partner in the global effort to expand access to quality HIV prevention, care, and treatment services. ICAP, in collaboration with national and local governments and Ministries of Health, supports the design, development, and implementation of a diverse range of initiatives providing HIV prevention, care, and treatment services in resource-limited settings. ICAP endeavors to build sustainable programs that address the ongoing clinical and psychosocial concerns and needs of PLHIV, as well as their partners, families, and caregivers. ICAP programs are funded by a variety of U.S. government and private sources, including the U.S. Centers for Disease Control and Prevention (CDC) under the President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. Agency for International Development (USAID), the Department of Defense, and the National Institutes of Health.

I am hopeful that this guide will help individuals, agencies, governments, and organizations in their efforts to provide high quality health services to adolescents living with HIV and that these materials will help all of us engage, listen to, learn from, and support adolescents along as they travel the path from childhood to adulthood.

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Acronyms

3TC	lamivudine
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescent(s) living with HIV
ART	Antiretroviral therapy
ARV	Antiretroviral
AZT	zidovudine
CTX	cotrimoxazole
d4T	stavudine
EFV	efavirenz
FTC	emtricitabine
HIV	Human Immunodeficiency Virus
IUD	Intra-uterine device
MTCT	Mother-to-child transmission (of HIV)
NGO	Non-governmental organization
NVP	nevirapine
OI	Opportunistic infection
PCP	<i>Pneumocystis jiroveci</i> pneumonia
PLHIV	Person (or people) living with HIV
PMTCT	Prevention of mother-to-child transmission (of HIV)
TB	Tuberculosis
TDF	tenofovir
STI	Sexually transmitted infection
VCT	Voluntary counseling and testing
UNAIDS	Joint United Nations Program on HIV/AIDS
WHO	World Health Organization
YLHIV	Youth living with HIV
ZDV	zidovudine

Notes to the Trainer

Introduction

The HIV epidemic continues to take a devastating toll on young people. Approximately 5 million youth, aged 15-24, are currently living with HIV globally—76% of whom reside in sub-Saharan Africa. In 2009, 41% of new HIV infections in people age 15 and over were among youth and each day of the year almost 2,500 youth were infected with HIV.¹ In addition to the alarming numbers of new HIV infections among youth, many infants, particularly in sub-Saharan Africa, also acquire HIV perinatally (through mother-to-child transmission of HIV [MTCT]). In 2009, an estimated 370,000 children contracted HIV during the perinatal and breastfeeding period and approximately 2.5 million children 0-14 were living with HIV.² However, improved access to pediatric HIV testing, care, and antiretroviral therapy (ART) over the last decade has made it possible for increasing numbers of children infected with HIV to reach adolescence and for adolescents³ living with HIV (ALHIV) to reach adulthood.

Whether behaviorally or perinatally infected with HIV, most young people face unique developmental and health-related challenges. As a result, they require innovative and responsive public health strategies that address these unique needs. Adolescents and their caregivers often do not access the health and social services they urgently need due to lack of information, fear of stigma or judgment, and various health systems barriers, including the lack of youth-friendly, accessible HIV services. In addition to clinical care, ALHIV require comprehensive services to support their healthy development, psychosocial wellbeing, retention in care, adherence to treatment, and their emerging sexuality and reproductive health. Therefore, a concerted, multi-faceted effort is required to minimize barriers and challenges and to empower ALHIV to become active partners in their own health and in the larger response to HIV at the clinic, community, national, and global level.

About ICAP

As an important partner in the global effort to expand access to quality HIV prevention, care, and treatment services to all people living with HIV (PLHIV) and their families, ICAP at Columbia University supports the design, development, and implementation of a diverse range of HIV-related clinical and systems strengthening activities in 13 countries. As part of its multidisciplinary approach and commitment to the meaningful involvement of PLHIV, ICAP has successfully supported the development and scale-up of adult Peer Education programs in a number of sub-Saharan African countries and has developed materials to share these experiences more widely: *Greater Involvement of People Living with HIV in PMTCT and Care and Treatment Programs: Comprehensive Peer Educator Training Curriculum* and *Planning, Managing and Monitoring Peer Educator Programs: An Implementation Manual*. Please refer to ICAP's website for more information and to access these materials.⁴

In many ICAP-supported programs, there are increasing numbers of ALHIV in need of or already receiving HIV care and treatment services at either pediatric or adult HIV clinics. In response, ICAP is

¹ United Nations Children's Fund (UNICEF). (2011). *Opportunity in crisis: Preventing HIV from early adolescence to young adulthood*. New York: UNICEF.

² Joint United Nations Programme On HIV/AIDS (UNAIDS). (2010). *UNAIDS Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

³ Please note that "youth" are usually defined as people between the ages of 10-24 years. For the purposes of this curriculum, "adolescents" are defined as people between the ages of 10-19 years.

⁴ <http://www.columbia-icap.org/resources/peresources/PE.html>

developing and sharing strategic approaches to HIV care and treatment for young people to build the capacity of health facilities and health care workers to provide them with quality services. ICAP's strategies, program approaches, and materials build on the growing body of literature on adolescent health and HIV, the lessons learned from both adult and pediatric HIV programs, and the experiences of existing youth programs. ICAP developed a comprehensive training curriculum on adolescent HIV care and treatment for multidisciplinary health care workers and teams entitled, *Adolescent HIV Care and Treatment: A Training Curriculum for Health Workers*, as well as this adolescent Peer Education curriculum, *Positive Voices, Positive Choices: A Comprehensive Training Curriculum for Adolescent Peer Educators*.⁵ This curriculum aims to support program capacity to systematically involve ALHIV in providing peer support to other adolescents, to improve the quality and youth-friendliness of HIV programs for young people, and to better support ALHIV and their families. Both this adolescent Peer Educator curriculum as well as the training curriculum for health care workers are generic in form and can be adapted to a range of country- and program-specific settings.

Adolescent Peer Education in HIV Care and Treatment Programs

Peer Education provides an important link to care and treatment services for ALHIV. Peer Education can help adolescents live long, healthy lives; can improve the health and well being of their caregivers, families, and partners; can help decrease stigma and discrimination; and can slow the HIV epidemic by preventing new infections.

When properly implemented, Peer Education is also an excellent example of a youth-adult partnership. Youth-adult partnerships arise from the conviction that young people have a right to participate in developing the programs that serve them and a right to have a voice in shaping the policies that will affect them. In addition, youth participation can help achieve stronger program outcomes for HIV care and treatment programs. A review conducted for the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) found that Peer Education programs for youth in developing countries are effective in improving knowledge among youth and, to some extent, changing attitudes and sexual behaviors.⁶

The meaningful engagement of ALHIV as Peer Educators can also complement the work of health care providers and play an important role in ensuring access to effective and sustained HIV care and treatment for youth. Some of the advantages of Adolescent Peer Educator programs include:

- **People trust others in a similar situation:** Adolescents relate well, and perhaps best, to people similar to them in age, background, and interests (i.e. their peers). Adolescent Peer Educators provide ALHIV with the opportunity to discuss their personal circumstances in a safe environment with someone who relates to their situation. They can also help set up and facilitate support groups for young people to come together, support one another, and share their challenges and solutions.
- **Improved service quality for ALHIV:** Adolescent Peer Educators can help improve the overall quality and effectiveness of health care programs by giving feedback to the clinic regarding the needs of ALHIV and ways to make services more youth-friendly. Adolescent Peer Educators can also help clinics form linkages with schools, youth clubs, and other youth-friendly programs and services.

⁵ <http://www.columbia-icap.org/resources/supporttools/index.html>

⁶ Adamchak, S. (2006). *Youth peer education in reproductive health and HIV/AIDS : Progress, process, and programming for the future. Youth Issues Paper 7*. YouthNet. Family Health International.

- **Empowerment of ALHIV:** Adolescent Peer Educators can increase adolescents' confidence that they can make good decisions and take action. Adolescent Peer Education programs can help both Peer Educators and their clients adopt healthy behaviors.
 - **Improved adherence:** Adolescent Peer Educators can support retention and adherence to care and treatment of ALHIV because they are likely to have a deep understanding of what adolescent clients are going through.
 - **Increased access for ALHIV:** Adolescent Peer Educators can gain access to groups that are otherwise often difficult to reach. This includes accessing adolescents in general as well as most-at-risk adolescents and encouraging them to seek care and treatment services.
- Job opportunities:** Training and voluntary work experience may better equip Adolescent Peer Educators for future job opportunities in the formal economic sector.
- **Community mobilization and linkages:** Adolescent Peer Educators can play a role in community advocacy and mobilization, decreasing stigma and increasing support for ALHIV.

Suggested Job Responsibilities for an Adolescent Peer Educator

Once trained, a Peer Educator might perform any of the following activities, depending on the overall plan of the program:

- Help conduct/co-facilitate support groups and other psychosocial support activities for ALHIV of different ages and stages
- Conduct Peer Education sessions (one-on-one, with members of the multidisciplinary care team, and in groups) with ALHIV
- Provide support to ALHIV on HIV care and treatment, adherence, disclosure, and other topics
- Help ALHIV with referrals within the health facility
- Help link ALHIV with needed community support services
- Be positive living role models to other ALHIV
- Act as a link between clients and the multidisciplinary care team
- Provide input to the multidisciplinary care team, representing the needs of ALHIV

How to Use this Curriculum

This comprehensive training course was designed to train Adolescent Peer Educators to become active members of multidisciplinary HIV care teams and to support their peers with adherence, disclosure, and psychosocial support issues. The purpose of this training course is to empower and ensure greater involvement of ALHIV as active providers and recipients of HIV services.

In order for training to be effective, it is recommended that training groups not exceed 20 participants. The basic training course contains 15 Modules, which can be conducted over nine half-days, with 5 half-days of additional practicum. Whenever possible, the training should be broken down into half-days rather than full days in order to maximize young people's learning and attention span and to accommodate their other obligations. Training organizers should also take into consideration adolescents' school, work, and family schedules when planning the agenda. Adaptations to the training schedule should be made as needed, based on the availability of trainers and participants, the training location, the availability of time for practicum sessions, and other factors. As Peer Educators gain skills, confidence, and experience, and as the program matures and changes, refresher and advanced training should be provided at regular intervals. Daily supervision and regular mentoring are also critical for adolescents' skill development and program success (see below).

The training curriculum is designed to acknowledge and build upon the wealth of knowledge and personal experience that Peer Educators already have as ALHIV and clients in HIV care and treatment programs themselves. By using the suggested participatory training methodologies, participants will be able to share their thoughts and experiences openly and learn from one another as much as they learn from the trainers. The key information covered in the training is intended to be practical and interesting to youth participants. The experiences, baseline knowledge, and literacy levels of participants will vary, so trainers should make adaptations as needed.

Curriculum Design

There are two parts to the curriculum: a Trainer Manual and a Participant Manual. Each Module of the Trainer Manual begins with the following information, followed by step-by-step trainer instructions and key content information for each Session:



Duration: The approximate time it will take to facilitate the training Module



Learning Objectives: The expected knowledge and skills participants will gain by the end of the Module



Key Content Areas: A list of the Sessions within the Module



Methodologies: An overview of the training methods used in the Module



Materials Needed: A list of materials the trainer should collect and prepare before the training sessions, such as flip chart, markers, tape, or Bostik, etc.



Work for the Trainer to Do in Advance: Key preparatory activities for the trainers to do before facilitating the Module



Key Points: A summary of key points at the end of each Module

Step-by-Step Trainer Instructions: The training is designed to be participant-focused and youth-friendly. Adolescents have a lot of energy, and they learn and retain more information when they participate fully, actively, and equally in the learning process. The trainer's main task is to facilitate the learning process and to encourage active interaction and learning between participants, recognizing the enormous amount of knowledge young people have as clients in HIV programs. The trainer's role is to draw out these experiences and to encourage skills building, exchange of information, and confidence building among participants. The training methods used should serve as a model for how Adolescent Peer Educators should communicate with clients in their work. Lectures and trainer-led activities should be minimized as much as possible, emphasizing instead creative, hands-on, participatory activities during which the trainer supplements information when needed. It is important that trainers have substantial knowledge of HIV care and treatment as well as the other topic areas discussed in the training so that they can communicate facts correctly and ensure that participants acquire accurate information during the training.

The participatory, youth-friendly training methodologies used in the curriculum include:

- Interactive trainer presentation
- Large group discussion
- Large group work

- Small group discussion
- Small group work
- Brainstorming
- Guest speakers
- Case studies
- Role play
- Demonstration and return demonstration
- Reflection
- Observation
- Games
- Facility-based practicum

Each Session begins with a shaded box listing the training methodologies used in that Session, followed by suggested step-by-step guidance for trainers.

Module 14 includes detailed information about preparing for and implementing facility-based practicum sessions.

Key Information: The key content information for each Session follows the step-by-step trainer instructions. Trainers should adapt the key information as needed for their particular setting and on the baseline knowledge of participants (for example, sometimes it will be useful to cover all of the key information, but in other cases when participants already know a good deal about the topic, trainers may just want to review some parts of the key information). Notes are included in cases where trainers should adapt the key information to their country context, for example, when discussing specific ART or PMTCT regimens. Some of the Modules also contain Appendices that will be useful for trainers and participants.

The Participant Manual contains a simplified version of the Key Information in the Trainer Manual. Trainers should encourage participants to refer to their Manual during the training, to read through specific Participant Manual Modules in advance of each training day, and to take their own notes as needed. The Participant Manual also serves as a useful reference for Peer Educators after the training.

How to be an Effective Training Facilitator

Trainers should always keep the following “dos and don’ts” in mind.

DOs

- Do maintain good eye contact.
- Do prepare in advance.
- Do involve participants.
- Do use visual aids.
- Do speak clearly.
- Do speak loud enough.
- Do encourage questions.
- Do recap at the end of each Session.
- Do bridge one topic to the next.
- Do encourage participation.
- Do write clearly and boldly.
- Do summarize.
- Do use logical sequencing of topics.
- Do use good time management.

- Do K.I.S. (Keep It Simple).
- Do give feedback.
- Do position visuals so everyone can see them.
- Do avoid distracting mannerisms and distractions in the room.
- Do be aware of the participants' body language.
- Do keep the group focused on the task.
- Do provide clear instructions.
- Do check to see if your instructions are understood.
- Do evaluate as you go.
- Do be patient.

DON'Ts

- Don't talk to the flip chart.
- Don't block the visual aids.
- Don't stand in one spot—move around the room.
- Don't ignore the participants' comments and feedback (verbal and non-verbal).
- Don't read from the curriculum.
- Don't shout at the participants.
- Don't assume everyone has the same level of baseline knowledge.
- Don't assume everyone can read and write at the same level.

Note: The dos and don'ts of training were adapted from: Colton, T., Dillow, A., Hainsworth, G., Israel, E. & Kane, M. (2006). *Community home-based care for people and communities affected by HIV/AIDS: A comprehensive training course for community health workers*. Watertown, MA: Pathfinder International.

Other Important Considerations for Peer Educator Trainers and Supervisors

There are some significant differences between Adult and Adolescent Peer Educators, ranging from their availability to their attention span, brain function, and decision-making. Thus, expectations of Adolescent Peer Educators and their supervisory structures must also be different from those of Adult Peer Educators. Adolescents, usually self-conscious because of their age, inexperience, and outsider status, try hard to fit into adult environments. When they are successful, it can be easy to forget that they are not adults. However, when they are under stress, the mask of adulthood may slip, revealing their youth along with their need for close supervision and guidance.

It is also important to note that adolescents are a very diverse group of people. Participants will not all be leading easy lives. Some will be juggling school, work, and family responsibilities. Many are likely coming from school settings where young people are in the majority, and will need to adjust to a clinic setting where they may be in the minority. For most, it will be the first time they are immersing themselves in this type of training and working in a clinical setting. Undoubtedly there will be people at the clinic whose values and personal styles are quite different from those they are familiar with. While this transition is very exciting, it can also be intimidating. Adolescents are resilient, ambitious, determined, and curious, but they will look to their program supervisors and their multidisciplinary care team “family” for support and guidance.

The following tips can help trainers and program supervisors work more effectively with Adolescent Peer Educators:

- Ensure close, daily supervision and continuous feedback about performance throughout the training and on the job.

- Supervisors should set up regular, individual supervision meetings with each Peer Educator (it is also good to meet regularly as a group). Supervision meetings allow supervisors the opportunity to discuss current performance and progress toward meeting goals. During meetings, supervisors can also help Adolescent Peer Educators work through challenges. Regularly scheduled meetings provide consistency and feedback so Peer Educators know what is expected of them. In turn, this will give them a sense of stability and allow them to feel safe and supported in their work.
- Ensure there is a back-up supervisor or mentor from the multidisciplinary care team who can support Peer Educators when the assigned supervisor is away or unavailable. It may also be useful to select a Peer Educator who is slightly older to act as a “buddy” to newly trained volunteers and who can help the supervisor as needed.
- Provide opportunities for refresher and advanced training. Peer Educators who are not well trained might conduct themselves unprofessionally or misinform clients, thus having a harmful rather than a positive effect. It is not enough to simply make training available, supervisors should make sure that Peer Educators actually attend the training and then check that key messages were understood.
- Treat all adolescents as individuals and always be respectful of their opinions and input.
- Keep expectations realistic but do not patronize youth by lowering expectations. Make clear what you will and will not do for them, how you interpret the rules and intend to apply the consequences when rules are broken, and when and how you want to be approached for help or advice.
- Keep goals for Adolescent Peer Educators reasonable and measureable but also encourage them to stretch themselves and achieve. Adolescents should be encouraged to take responsibility for themselves, but also to realize that asking for help is not a sign of weakness.
- Be patient and supportive. Many youth feel intimidated by adults and are not used to participating in discussions with them. Some may feel they have nothing to contribute or that they will be judged negatively by adults.
- Prioritize participation throughout the training. Interaction and participation improve learning outcomes, especially with young people.
- Regularly enforce compliance with the code of ethics (e.g. confidentiality) and outline a standard set of ground rules for all Peer Education staff to sustain the best possible professional environment. As a supervisor, you may encounter some behavioral problems—Peer Educators may come in late, not listen when you are talking, “forget” what you asked them to do, refuse an assignment, use “unprofessional” language, have inappropriate relationships with each other or with clients, or ignore a repeated request to change their behavior. Sometimes, it is merely their adolescent need for self-expression that interferes with their effectiveness as Peer Educators and team members. Other times, they want to create situations to get attention or power, or to avoid being tested on their performance. It is very important to let them know that problems of attitude or behavior will not be ignored. Develop a strategy that you think will be an appropriate and effective remedy to these problems.
- Always manage the group dynamic, encourage team building, and stay aware of personal relationships.
- Integrate young people into the multidisciplinary care team’s program planning and monitoring efforts. Schedule meetings when adolescents can attend and in a location accessible to them.
- Remember that all peer education programs require careful planning, the identification and training of peer educators, and follow-up evaluations. Simply getting a group of adolescents together to discuss a serious topic is not an application of peer education.

- Effectively training and working with adolescents requires a gradual breakdown of stereotypes that both adults and young people have about each other. The building of trust and breakdown of stereotypes can occur through positive interactions and open, consistent, honest communication as adults and young people work together as a team.

Note: Some of the points above were adapted from Advocates for Youth. (2001). *Transitions: The Rights, Respect, Responsibility Campaign, Volume 14, No. 1* and Massachusetts Office for School to Career Transition Department of Education (2002). *Mentoring and supervising teenagers: The work-based learning toolkit*.

A Note on Confidentiality

The success of Peer Educator training depends on the active participation and engagement of each participant. Participants should be encouraged to share their own personal experiences—including the challenges they have faced at the hospital, in their community, and at home—and should feel “safe” doing so. Trainers should remind participants that what is said in the training sessions is confidential (trainers should respect this rule themselves) and that no one will be judged or stigmatized for their comments or questions.

Evaluation

Training evaluation methods include:

- A learning needs assessment (pre-test BINGO game) in Module 1 and a post-test in Module 15
- Observation and assessment during the practicum session, using a skills checklist
- Participant feedback on a daily basis (see below), as well as a participant training evaluation at the end of the course

How Did it Go?: Informal evaluations should be conducted at the end of each training day through “How did it go” exercises to ensure that participants understand course content and so that trainers can adjust content or methodology if needed. To encourage honest evaluation, trainers can ask participants to write down what they liked and did not like about the day on pieces of paper (one piece with a happy face to record things they liked about the day and another piece with a sad face to note things that did not go well) or on pieces of flip chart. Alternatively, one of the participants can volunteer to lead the “How did it go” exercise, which can be conducted with the trainers out of the room. The participant should then report back to the trainers on how participants felt about that training day. This feedback should be reviewed by trainers and modifications should be made as needed for subsequent training days.

MODULE 1: Course Overview and Introduction to the Training



DURATION: 60 minutes (1 hour)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Know more about the trainers and other training participants
- Understand the training agenda, objectives, and “ground rules”
- Assess their own baseline knowledge about content and skills to be covered during the training



CONTENT:

Session 1.1: Welcome, Introductions, Agenda, and Ground Rules

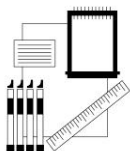
Session 1.2: Why We Are Here: Review of Training Objectives

Session 1.3: Learning Needs Assessment



METHODOLOGIES:

- Guest speaker (optional)
- Interactive trainer presentation
- Small group work
- Large group discussion
- Needs assessment



MATERIALS NEEDED:

- Flip chart
- Markers
- Tape or Bostik
- Name tags
- Pens and notebooks (for each participant)
- Copies of the Participant Manual (for each participant)
- Small sticky notes or small pieces of paper
- Box with slit cut out of it, labeled “QUESTIONS”
- Copies of *Appendix 1A* and *Appendix 1C* (note that *Appendix 1B* is included in the Participant Manual)



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- Finalize the training agenda, using *Appendix 1B: Sample Training Agenda* as a guide.
- Finalize all training logistics, including for the practical session(s), and ensure that the training room is set up, all materials for the training are available, meals are arranged for participants, etc.
- Make 1-2 copies (depending on the number of participants) of *Appendix 1A: Sample Training Registration Form*.
- Write the training objectives on flip chart or prepare an overhead.
- Make a “Question Box” for participants to anonymously submit questions throughout the training.
- Make enough copies of *Appendix 1C: Peer Educator Bingo* so that there are enough for each participant.

SESSION 1.1: Welcome, Introductions, Agenda, and Ground Rules (25 minutes)



TRAINER INSTRUCTIONS

Methodologies: Guest Speaker (optional), Interactive Trainer Presentation, Small Group Work, Large Group Discussion

- Step 1:** Introduce yourself and the other trainers and welcome participants to the training. Ask a guest speaker (optional) to officially open the training.
- Step 2:** Pass around a registration sheet (see *Appendix 1A* for a sample) and ask participants to record their name, age, sex, and contact information. Give all participants a name tag and ask them to be creative in designing it.
- Note:** Remember to ask participants to sign in for each day of the training (a second sign-in sheet may be required depending on the number of participants).
- Step 3:** Give each participant a copy of the Participant Manual, a notebook, and a pen. Explain that the Participant Manual contains the key points for each Module and that it can be used during the training and also as a reference after the training. Encourage participants to take their own notes during the training—a notebook and pen are being provided to each participant for this purpose.
- Step 4:** Introduce the 2 recurring themes that participants will see in their Participant Manuals. First, talk about how the image of the African Baobab tree will be used as an education and adherence support tool for Peer Educators throughout this training. Explain that this tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows under harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Because of its importance and relevance in our lives, the tree was chosen to represent counseling and support.
- Step 5:** Next, explain that in order to help participants remember and learn key points throughout the training, *Louisa the Parrot* will appear frequently throughout their Participant Manuals. Encourage participants to pay careful attention whenever they see Louisa opening her beak and speaking because she will be explaining important information and giving helpful tips. Tell participants that, “*Louisa is like a ‘parrot on your shoulder,’ who reminds you of important things to do when working as a Peer Educator.*”
- Step 6:** Lead an introductory activity so people can introduce themselves and get to know more about one another and the trainers. Adjust the activity depending on the size of the group.
- Here is one example of an introductory activity: Tell everyone to move into a circle. Go over the instructions for the activity: one at a time, each person should step forward, say his or her name, age, where he or she is from, and act out or mime his or her favorite hobby without speaking (e.g. playing football). The first participant who guesses what the person is miming gets to go next. The trainer should give encouragement and positive feedback throughout the activity.

Step 7: Go over the training agenda that participants have in the beginning of their Participant Manuals (see *Appendix 1B*). Do not forget to mention logistics, such as breaks or lunch, start and end times, and transport arrangements. Ask if there are questions about the agenda before moving on.

Step 8: Lead participants to set “ground rules” for the training. Record these rules on flip chart and encourage participation from the whole group.

Examples include:

- Turn off mobile phones.
- What we share in the group will remain in the group (confidentiality).
- Everyone should be an active participant.
- No judgmental attitudes—it is okay to disagree but not to put down another person.
- There are no "dumb" questions.
- Help one another.
- Everyone should be respected when they have the floor.
- Come back from breaks on time.

Keep these “ground rules” posted throughout the training. Remind the group that these rules act as reminders to keep everyone focused. Ask everyone to agree to abide by the rules.

Step 9: Introduce the Question Box to participants, reminding them that they can write down any question that they think of during the training and put it in the box anonymously. The trainers will go through and try to address all of the questions each day.

Step 10: Tell participants that if they would like to talk privately to you—about the training or about any personal issues—they should come tell you during a break or at the end of the day.

KEY INFORMATION

Remember, it’s very important to be a respectful and active participant—be open to one another’s opinions, be on time, and keep any personal information shared during the training private!



SESSION 1.2: Why We Are Here: Review of Training Objectives (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

Step 1: Ask participants to write an answer to the following question on colored post-it notes or small slips of paper.

- *What skills and information do you hope to learn at this Peer Educator training?*

Then collect and stick all of the small papers on a wall where they are visible to all participants. Periodically go back and review these goals and take them down as they are achieved.

Step 2: Review each of the training objectives below, referring to the pre-prepared flip chart where the training objectives have been written.

Step 3: Allow participants time to ask questions about the training objectives and remind them that, in addition to this basic training, Peer Educators will get on-the-job support from their supervisor and members of the multidisciplinary care team as well as refresher trainings.

KEY INFORMATION

Training objectives

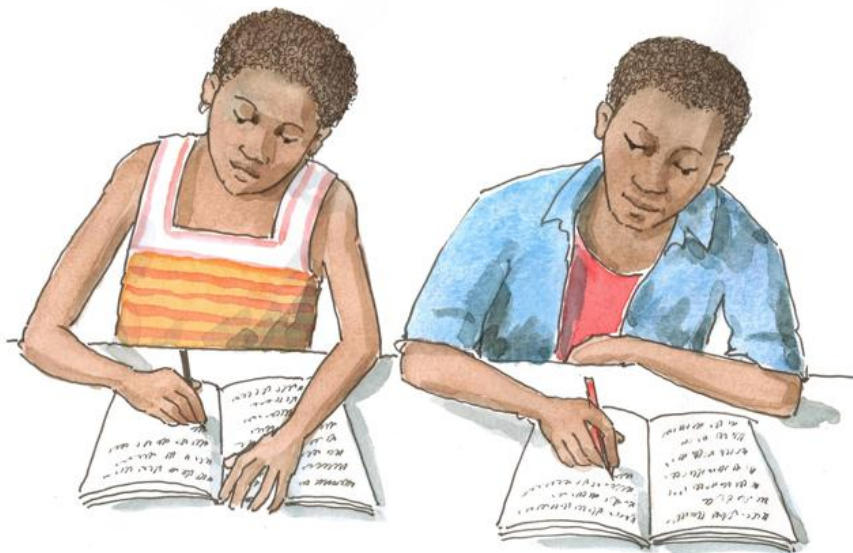
By the end of this basic training course, participants will be able to:

1. Work as an integral part of a clinic's multidisciplinary care team
2. Understand needs and challenges of adolescents living with HIV (ALHIV) and how to help make clinic services more youth-friendly
3. Give one-on-one peer education and assist with facilitation of group education to ALHIV so they better understand, use, and adhere to HIV prevention, care, and treatment services
4. Demonstrate knowledge about issues related to sexual and reproductive health and show that they are comfortable talking about them
5. Help address the psychosocial needs of ALHIV and caregivers
6. Disclose their own HIV-status to clients, support ALHIV through the disclosure process, and help members of the multidisciplinary care team support caregivers who disclose their perinatally-infected child's status
7. Be role models of positive living, disclosure, and adherence to care and treatment
8. Help ALHIV and family members live positively with HIV
9. Link ALHIV to required health services or support services within the community and clinic settings
10. Keep basic records of daily and monthly activities

There is also a supervised practicum (Module 15) included in this training. By the end of the practical sessions, which will take place in the clinic setting, participants will be able to:

1. Practice skills learned during the training in a health facility offering HIV prevention, care, and treatment services to young people
2. Show competency in the major skills taught during the training, with supportive supervision and mentoring
3. Identify skill areas where further on-the-job practice and mentoring are needed

Please note: For the purposes of this curriculum, we define “adolescents” as people between the ages of 10 and 19 years.



SESSION 1.3: Learning Needs Assessment (20 minutes)



TRAINER INSTRUCTIONS

Methodologies: Needs Assessment

- Step 1:** Tell participants that in order to guide the training and make it useful to them, trainers need to have an idea of what people already know and what they still need to learn.
- Step 2:** Pass out copies of *Appendix 1C: Peer Educator Bingo* to each participant. Give participants about 10 minutes to respond to the questions—they should circle the T (for true) or the F (for false) under each question. Tell participants that they probably will not know the answer to every question right now, but that they will have another opportunity to play Peer Educator Bingo after they finish the training. Ask participants to hand their papers to a trainer when they have finished. The trainers should score each Bingo game by referring to *Appendix 1D: Answers to Peer Educator Bingo* as a guide.
- Step 3:** After the needs assessment, debrief by asking participants how they felt about the questions:
- *Were the questions easy or difficult?*

Again, remind participants that we are all here to learn and that at the end of the training they will be able to answer all of these questions and many more with confidence.

KEY INFORMATION

See *Appendix 1C: Peer Educator Bingo*

As you continue with this training, you will develop the confidence, knowledge, and skills needed to be an Adolescent Peer Educator!



APPENDIX 1A: Sample Training Registration Form

Name	Organization, if applicable	Sex	Age	Address	Phone # (or contact #)	School Attended and Address	Grade Level

APPENDIX 1B: Sample Training Agenda

This suggested Peer Educator basic training agenda should be used as a guide. The exact agenda will depend on the days and times of the training and the availability of trainers, preceptors, and participants; the training and practicum venue; as well as the expected role of adolescent PE and participants' knowledge and skills.

Week 1:

Time	Day 1	Day 2	Day 3	Day 4	Day 5
12:00-12:30	Lunch Official Opening	Lunch Review and recap of Day 1	Lunch Review and recap of Day 2	Lunch Review and recap of Day 3	Lunch Review and recap of Day 4
12:30-14:30	Module 1: Course Overview and Introduction Module 2: The Needs of Adolescents Living with HIV (ALHIV) and the Role of Adolescent Peer Educators in Meeting Them	Module 3: Review of HIV Basics	Module 4, continued	Module 5: Comprehensive HIV Care and ART	Module 6: Supporting Adherence to HIV Care and Treatment
14:30-14:45	TEA BREAK	TEA BREAK	TEA BREAK	TEA BREAK	TEA BREAK
14:45-16:45	Module 2, continued	Module 4: Communicating with your Peers	Module 4, continued	Module 5, continued	Module 6, continued
16:45 -17:00	Daily Summary and Closing	Daily Summary and Closing	Daily Summary and Closing	Daily Summary and Closing	Daily Summary and Closing

Week 2:

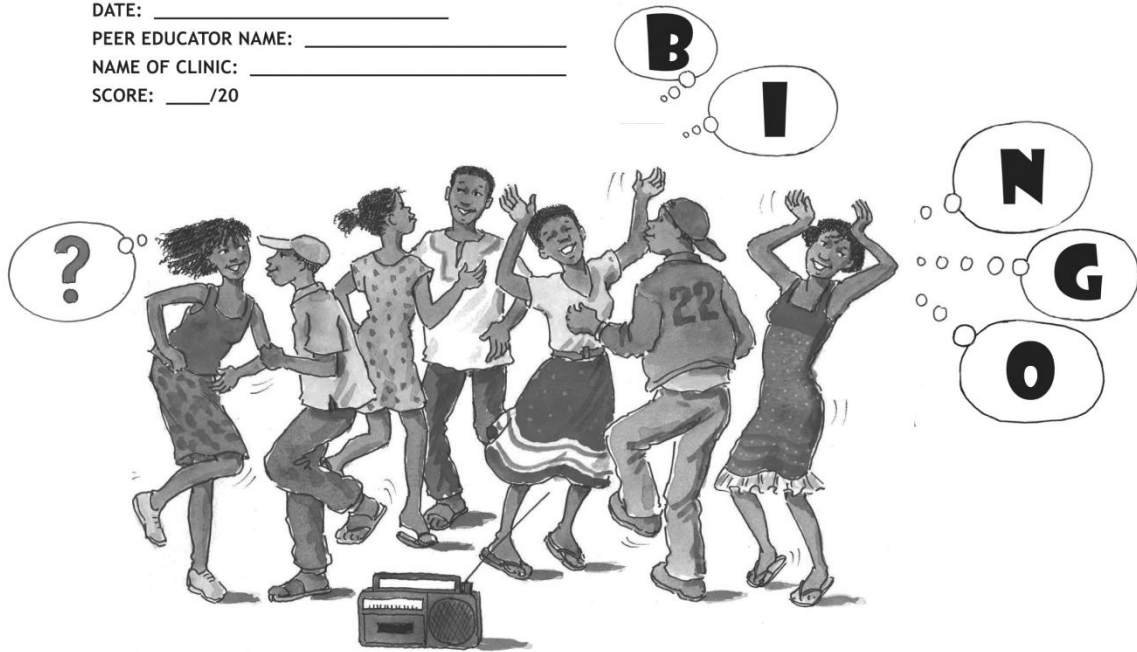
Time	Day 6	Day 7	Day 8	Day 9	Day 10
12:00-12:30	Lunch Review and recap of Day 5	Lunch Review and recap of Day 6	Lunch Review and recap of Day 7	Lunch Review and recap of Day 8	Lunch Review and recap of Day 9
12:30-14:30	Module 7: Providing Psychosocial Support	Module 8: Planning and Co-Facilitating Support Groups for ALHIV	Module 9: Understanding and Supporting the Disclosure Process	Module 10: Sexual and Reproductive Health	Module 11: Positive Living
14:30-14:45	TEA BREAK	TEA BREAK	TEA BREAK	TEA BREAK	TEA BREAK
14:45-16:45	Module 7, continued	Module 8, continued	Module 9, continued	Module 10, continued	Module 11, continued Module 12: Community Outreach, Education, and Linkages
16:45-17:00	Daily Summary and Closing	Daily Summary and Closing	Daily Summary and Closing	Daily Summary and Closing	Daily Summary and Closing

Week 3:

Time	Day 11	Day 12	Day 13	Day 14	Day 15
12:00-12:30	Lunch Review and recap of Day 10	SUPERVISED PRACTICUM – DAY 1 Note: the suggested time for the supervised practicum is 3-5 days, but can be adjusted according to the program’s needs and training requirements	SUPERVISED PRACTICUM – DAY 2	SUPERVISED PRACTICUM – DAY 3	Module 15: Next Steps, Course Evaluation, and Graduation/Celebration
12:30-14:30	Module 12, continued Module 13: Record-keeping and Reporting				
14:30-14:45	TEA BREAK				
14:45-16:45	Module 14: Supervised Practicum (classroom preparation 60 minutes)				
16:45-17:00	Daily Summary and Closing				

APPENDIX 1C: Peer Educator Bingo

DATE: _____
 PEER EDUCATOR NAME: _____
 NAME OF CLINIC: _____
 SCORE: ____/20



Peer Educators are volunteers, so they are not members of the multidisciplinary HIV care team. T? F?	CD4 cells help protect us from infections. T? F?	Dual protection means wearing 2 condoms at a time. T? F?	If a man is circumcised, he still has to use a condom. T? F?
HIV is most commonly spread through having a blood transfusion. T? F?	Counseling includes telling people what you think is best and making sure they follow your advice. T? F?	Shared confidentiality means you should tell a person's family, but not community members, the person has HIV. T? F?	Only people on antiretroviral therapy (ART) need HIV care services. T? F?
If you feel healthy, you probably don't need ART. T? F?	A person on ART can not spread HIV to another person. T? F?	It is safe for pregnant women to take ARVs. T? F?	Adolescents are basically "big children." T? F?
Peer Educators can help clients create an ART adherence plan. T? F?	AZT is a common type of ARV for adolescents. T? F?	Most adolescents miss their ARV doses because they are lazy. T? F?	Missing one ARV dose per week is okay. T? F?
Positive living means telling people you are living with HIV. T? F?	People with STIs are less likely to contract HIV during unsafe sex. T? F?	Disclosure is an ongoing process. T? F?	Peer Educators are also community educators and advocates. T? F?

APPENDIX 1D: Answers to Peer Educator Bingo

#	Questions (tick True, False or Don't Know for each question)	True	False	Don't Know
1	Peer Educators are volunteers so they are not members of the multidisciplinary HIV care team.		X	
2	CD4 cells help protect us from infections.	X		
3	Dual protection means wearing 2 condoms at a time.		X	
4	If a man is circumcised, he still has to use a condom.	X		
5	HIV is most commonly spread through blood transfusions.		X	
6	Counseling includes telling people what you think is best and making sure they follow your advice.		X	
7	Shared confidentiality means you should tell a person's family, but not community members, that the person has HIV.		X	
8	Only people on antiretroviral therapy (ART) need HIV care services.		X	
9	If you feel healthy, you probably don't need ART.		X	
10	A person on ART cannot pass HIV to another person.		X	
11	It is safe for pregnant women to take ARVs.	X		
12	Adolescents are basically "big children."		X	
13	Peer Educators can help clients create an ART adherence plan.	X		
14	AZT is a common type of ARV for adolescents.	X		
15	Most adolescents miss their ARV doses because they are lazy.		X	
16	Missing one ARV dose per week is okay.		X	
17	Positive living means telling people you are living with HIV.		X	
18	People with STIs are less likely to contract HIV during unsafe sex.		X	
19	Disclosure is an ongoing process.	X		
20	Peer Educators are also community educators and advocates.	X		

MODULE 2: The Needs of Adolescents Living with HIV (ALHIV) and the Roles of Adolescent Peer Educators in Meeting Them



DURATION: 135 minutes (2 hours, 15 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Define adolescence
- Describe the developmental stages of adolescence
- Describe common barriers and challenges that ALHIV face, especially with HIV care and treatment
- Discuss the goals and objectives of the Adolescent Peer Education program
- Discuss the many roles Peer Educators can play in improving access and adherence to comprehensive HIV prevention, care, and treatment services for ALHIV
- Describe how Peer Educators work as part of the clinic's multidisciplinary care team to improve services and make them more youth-friendly



CONTENT:

Session 2.1: Introduction: The Needs of ALHIV and the Challenges They Face

Session 2.2: Overview of the Adolescent Peer Educator Program

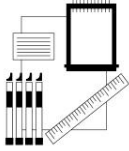
Session 2.3: Roles and Responsibilities of Adolescent Peer Educators

Session 2.4: Module Summary



METHODOLOGIES:

- Interactive trainer presentation
- Large group discussion
- Small group work
- Brainstorming
- Guest speaker (optional)



MATERIALS NEEDED:

- Flip chart and stand
- Markers
- Tape or Bostik
- Adolescent Peer Education program description, if available
- Adolescent Peer Educator job description (see *Appendix 2A*)



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- Invite program partners to this part of the training to explain more about the program.
- Complete background information on the program to be discussed in *Session 2.2*.
- Work with program partners, including multidisciplinary care team members, to develop and adapt the sample job description for Adolescent Peer Educators (see *Appendix 2A*).



SESSION 2.1: Introduction: The Needs of ALHIV and the Challenges They Face (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Small Group Work, Brainstorming

- Step 1:** Review the Module learning objectives.
- Step 2:** Thank everyone for choosing to be a Peer Educator! Remind them that they have a unique opportunity to help adolescents living with HIV achieve success, find relief, and gain new understanding in their lives by offering them support, guidance, and education. Peer Education is one of the best ways that an adolescent can make a difference in his or her community!
- Step 3:** Ask participants to define the term “adolescence” and write responses on a flip chart. Introduce the idea that adolescents are not all the same. Explain that there are different stages of adolescence and that each adolescent has different needs—some are in school/out of school, married/unmarried, some are living in rural or urban environments, with families or without. Some adolescents live in very difficult conditions and some are even homeless, with very few people to support them. Some adolescents were infected with HIV when they were babies (perinatally infected) and others were infected later in life.
- Step 4:** Ask participants to brainstorm some of the physical and sexual changes that happen during adolescence. Ask participants to draw on their own experiences as well as those of their peers. Write responses on flip chart and fill in content as needed. Then discuss the different stages of adolescence—early, middle, and late—and the common aspects of each stage.
- Step 5:** Break participants into small groups and give each group a piece of flip chart paper. Ask groups to brainstorm about the following questions:
- *What are the things people say about adolescents?*
 - *Which of these have a negative effect?*
 - *Are there any that are positive (e.g. adolescents are our future, adolescents have energy and ambition, etc.)?*
- Ask each group to tape their piece of flip chart on the wall, creating a "graffiti wall" of responses. Facilitate a general discussion about the responses after bringing the larger group back together.
- Step 6:** Next, draw an outline of a young person on flip chart paper. Explain that adolescents are not "big kids" or "little adults." Brainstorm ways that adolescent clients are different from adults and children when we are referring to HIV care and treatment. Write responses in thought bubbles around the outline of the person. Fill in using the content below.

Step 7: Ask participants to brainstorm responses to the following questions, drawing on their own experiences:

- *What do we mean when we say adolescents are vulnerable? Vulnerable to what?*
- *What makes adolescents vulnerable to poor health?*
- *What specifically makes adolescent girls vulnerable? Adolescent boys?*

Write responses on flip chart and fill in using the content below, dividing responses into 3 categories: physical, emotional, and social vulnerabilities.

Step 8: Continue the discussion by explaining that a major challenge for ALHIV is the difficulty they have accessing health care. Ask the participants to think about whether this has been true in their own lives and to think about possible reasons for this. Read the following case study out loud:

B___ is 16 years old and living with HIV. She just started having sex with her boyfriend. B___ is curious about condoms, although she has never used them with her boyfriend before. She would like some free condoms, but she is afraid to ask for them at the clinic because she thinks the providers will tell the other adults about her sexual activity. Also, the clinic is only open during the week and is closed on Saturdays. Last time B___ went to the clinic, the nurse told her she should be in school. She is too shy to go back.

Ask participants the following questions to facilitate discussion and discuss how Peer Educators can play an important role in making the clinic more youth-friendly for adolescents.

- *What are some of the barriers that made it difficult for B___ to access services at the clinic?*
- *What can Peer Educators do to help the clinic and multidisciplinary care team be more youth-friendly?*

Step 9: End by telling participants that we are all motivated to be Peer Educators for different reasons, but usually we are motivated because of our own experiences—both the good and bad things that have happened to us—as ALHIV and clients in HIV programs. Emphasize that ALHIV have some unique needs, as compared to adults, and also have some special challenges. Peer Educators can help adolescents overcome these challenges because they have very important knowledge—wisdom from their own experiences.

KEY INFORMATION

How do we define adolescence?

- The meaning of "adolescence" is understood in different ways in different cultures. It is seen almost everywhere, however, as a time of transition between childhood and adulthood. It is a period characterized by lots of physical and mental changes associated with puberty and a period of preparation for adulthood.

- Many organizations define “youth” as people between the ages of 10 and 24 years. For the purposes of this curriculum, we define “adolescents” as individuals between the ages of 10 and 19 years.
- Adolescence is a unique phase and stage of development. Adolescents are not “big kids” and they are not “little adults.”

The Changes of Adolescence

There are a number of physical and sexual changes that occur during adolescence:

In females:

- Menarche (getting your period)
- Breasts develop
- Hips widen
- Pubic and underarm hair grows
- The vulva and pelvis develop

In males:

- The penis, scrotum, and testicles grow
- Night-time ejaculation (wet dreams)
- Morning erections
- Back muscles develop
- Pubic and underarm, chest, and leg hair grows

In both females and males:

- Quicker growth
- Increased perspiration
- Acne (pimples)
- Face has characteristics of young adult
- Tone of voice changes
- Sexual desire is activated
- Initiation of sexual activities

The Stages of Adolescent Development

Adolescence can be categorized into 3 overlapping developmental stages: ages 10-15, 14-17, and 16-19 years. The overlap of ages is important because the changes are not fixed and happen at different ages and times for each adolescent.

<p>In “Early Adolescence” (10-15 years old), an adolescent:</p> <ul style="list-style-type: none"> • Begins puberty (this is a time of rapid physical growth) • Begins to experiment • Begins to think differently and more broadly • Is influenced by people beyond his or her own family, especially peers • Is very concerned with image and acceptance by peers
<p>In “Middle Adolescence” (14-17 years old), an adolescent:</p> <ul style="list-style-type: none"> • Continues growing and developing physically • Starts to challenge rules and test limits • Develops more “thinking” or analytical skills • Develops more understanding or awareness of the consequences of his or her behavior • Is strongly influenced by peers, especially in terms of image and social behavior • Has an increasing interest in sex; starts having romantic, intimate, or sexual relationships
<p>In “Late Adolescence” (16-19 years old), an adolescent:</p> <ul style="list-style-type: none"> • Reaches physical and sexual maturity

- Develops a sexual identity
- Has a greater ability to express thoughts, feelings, and ideas
- Can increasingly make independent decisions
- Is concerned about and plans for the future, including career, family, marriage, etc.
- May become more comfortable with own body image
- May be less influenced by peers as opposed to individual friendships

Adolescents: Not Big Kids or Little Adults

Adolescence is a unique stage in life. Adolescents are very different from adults and children, and these differences have implications for HIV care and treatment. ALHIV are different from adults and children living with HIV because of the rapid physical and emotional changes that happen throughout this stage of development.

How are ALHIV different from children living with HIV?

- Often, blame is placed on adolescents living with HIV (especially those who acquire HIV behaviorally) because of their “risky behavior.” This results in stigma and discrimination, whereas small children living with HIV are usually treated as “innocents” or “victims.”
- Adolescents need to take an active role in their own adherence to both clinical care and medicines.
- Adolescents are often dealing with their physical, psychosocial, emotional, and sexual development, which can cause confusion.
- Adolescents are more vulnerable to unintended pregnancy and sexually transmitted infections (STIs).
- It can be more difficult to find and bring young people into care because of the need for parental consent and/or involvement (however, this parental involvement may be a very positive factor in providing care and treatment to small children).
- Outreach is more difficult for adolescents because they are scattered and it is harder to bring them into care (while children are accessible through their parents and caregivers).
- Adolescents will eventually have to transition to adult care and treatment and, without adequate planning, support, and follow-up, they can be lost in the system during this transition.
- Adolescents can demand their rights while young children cannot.

How are ALHIV different from adults living with HIV?

- Some people think that adolescents living with HIV are “not supposed” to be having sex. As a result, adolescents may hide their sexuality.
- Adolescent clients are more likely to lack the skills to understand medicine side effects, treatment options, and regimen requirements.
- Adolescents have different ways of thinking that require different communication approaches.
- Younger adolescents often have to rely on a parent or caregiver to take medicines and adhere to both care and treatment.
- Adolescent clients often depend on their parents or caregivers (for money and housing, etc.) and can therefore not always make independent decisions.
- Adolescents may just be starting to think about their future careers, getting married, and having a family, whereas some adults may have made these decisions already and may have their own families and children.
- Condom and contraceptive use may be more difficult for adolescents.
- Adolescents usually have less stable relationships than adults.
- Adolescent clients face peer pressure and often want to be the same as their peers, even though this may be difficult.

- Not all adolescent clients know or understand their legal rights to access health services that ensure privacy and confidentiality.



Adolescents are not big kids or little adults. They have their own special needs!

Adolescent Vulnerabilities

How are adolescents physically vulnerable?

- Adolescents, in particular young women, are more susceptible to STIs (including HIV). This is because their cervixes are still forming and growing, and are more susceptible to infection.
- Young adolescent males may be more vulnerable to STIs, including HIV, if they are not circumcised.
- Adolescents are growing quickly and need a nutritious diet. Because of their increased energy needs, adolescents are susceptible to nutritional deficiencies.
- An adolescent's physical and mental development can be affected by HIV and other infections and diseases.

How are adolescents emotionally vulnerable?

- Adolescence is a time mental illnesses can emerge.
- Adolescents living with HIV may be especially susceptible to mental health problems.
- Adolescents often lack assertiveness and good communication skills, making it difficult for them to express their needs to adults and also to deal with peer pressure.
- Adolescents may feel pressure to “fit in” with their peers and to adopt the same behaviors as their peers.
- Adolescents are more vulnerable than adults to sexual, physical, and verbal abuse because they are less able to prevent these shows of power.
- Sometimes communication and relationships between adolescents and adults are challenging because adults may still see adolescents as children.
- Adolescents may not have the maturity to make good, rational decisions.

How are adolescents socially vulnerable?

- During adolescence, young people's need for money often increases, yet they typically have little access to money or employment. This may lead adolescents to feel that their only option is to work in dangerous situations. For example, young women may have transactional or commercial sex to earn money (for food, school fees, etc.) or in exchange for goods.
- Poverty and economic hardships can increase health risks because of poor sanitation, lack of clean water, and the inability to afford/access health care and medicines.
- Disadvantaged adolescents are at greater risk for substance abuse.
- Young women often face gender discrimination that affects food how food is shared, access to health care, adherence to care, the ability to negotiate safer sex, and education and employment opportunities.

- In many societies, a girl's status is only recognized when she marries and has a child. Some young women marry very young to escape poverty but, as a result, they may find themselves in another difficult situation.
- Some young people are particularly vulnerable, such as street children, sex workers, child laborers, refugees, young criminals, those orphaned because of AIDS and other circumstances, and other neglected and/or abandoned youth.

Youth-Friendly Services

ALHIV have a difficult time accessing health care because they may lack of financial resources, they may not trust health care professionals, and there may not be enough providers with expertise in both HIV and adolescents. Young people may also be scared because they are worried about the level of confidentiality.

Peer Educators can help make clinics and health facilities more “youth friendly” and can help link ALHIV to HIV care and treatment services by doing the following:

- Getting involved in how the program is designed
- Giving inputs and feedback from the adolescent clients' perspective
- Making sure all clients are welcomed and treated equally (boys, girls, married, unmarried, street youth, etc.)
- Working with the multidisciplinary care team to ensure that peer support groups and group education sessions/discussions are available to adolescent clients
- Making sure adolescents know about the services offered at the clinic
- Assisting with referrals by walking with the client to the referral point and making sure he or she does not have to wait a long time
- Explaining educational materials or health-related information in easy-to-understand language that young people can “hear”
- Helping the clinic to form linkages with schools, youth clubs, and other youth-friendly institutions

Peer Educators can help make clinic services youth friendly for ALHIV!



SESSION 2.2: Overview of the Adolescent Peer Education Program (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Small Group Work, Large Group Discussion, Interactive Trainer Presentation, Guest Speaker (Optional)

Step 1: Divide participants into 2 groups. Pass out a piece of flip chart paper, colored markers, and tape or Bostik to each group. Ask participants to close their eyes and to think of situations when they have been influenced by their peers to do or not do something. Ask one group to use their paper to write some phrases or to draw some images about positive things they have learned from their peers or times when they were positively influenced by their peers (e.g. getting help with homework). The other group should use their paper to write about or draw some examples of when they were negatively influenced (e.g. staying out late). Ask the participants to put their papers up on a wall and facilitate a brief discussion about the power of peer influence and why peer education is potentially effective in changing behavior. Emphasize the following points:

- *We all influence and are influenced by people, in both positive and negative ways.*
- *We learn a lot from our peers, sometimes without realizing it.*
- *Since a peer is from the same group, he or she can speak the same language and understand, empathize, and relate better than a non-peer.*
- *Peer Educators can be powerful role models who help ALHIV live positively and who help them have better access to HIV care and treatment.*

Step 2: Ask the group how they would define the following terms, based on the prior discussion: peer, education, peer education, and Adolescent Peer Educators. Write down responses on a flip chart and fill in content as needed.

Step 3: Present an overview of the Peer Education program to participants. Use the major discussion points below to guide the presentation. Be sure to review the overall scope and goals of the program, the roles of all participants and partners, as well as the advantages of the program.

Note: If the training facilitators are not part of the organization that is managing or implementing the Peer Education program, it is recommended that someone from this organization (for example a local NGO, the national PLHIV Association, or the Ministry of Health) be invited to the training to give an overview of the program.

Step 4: Allow time for participants to ask questions about the program.

KEY INFORMATION

Key terms:

- The English term **“peer”** refers to *“one that is of equal standing with another; one belonging to the same group especially based on age or status.”* In modern times, the term has come to mean, more generally, an equal or a match.
- **Education** refers to the development of a person’s knowledge, attitudes, beliefs, or behavior that results from the learning process.
- **Peer education** is the transfer of knowledge and skills to members of a social group by others within the same group.
- **Adolescent Peer Educators** are people who are themselves enrolled in HIV prevention, care, and/or treatment services; have a good understanding of HIV, care, treatment, and adherence; and have the skills to help other adolescents with their care and treatment. Usually, Peer Educators are volunteers.

Note: The training facilitators and Peer Educator program partners should fill in the following key information according to the local program design and implementation plan.

Background of the Peer Education program:

- The program was started in _____ (month, year).
- The program was started by _____ (organization/s).

The Peer Education program goal is to:

_____ (fill in)

Partners in the Peer Education program include:

_____ (fill in)

Note: Fill in and give a brief summary of each partner’s role in the program. Examples of partners may include: the Ministry of Health, provincial or district health teams, hospitals, health centers, clinics, health care workers, Peer Educator supervisors, ALHIV associations, community-based and faith-based organizations, community health workers, donors, etc.

SESSION 2.3: Roles and Responsibilities of Adolescent Peer Educators (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Brainstorming, Interactive Trainer Presentation, Large Group Discussion

Note: It is recommended that the Peer Educator Supervisor be invited to this Session to give an overview of supervision, communication, and monitoring procedures.

- Step 1:** Ask participants to think for 1 minute about a person who they trust and who they can "really talk to." Ask about this person's qualities and write responses on a flip chart. Facilitate a brief discussion about the necessary qualities of a Peer Educator (e.g. good listener, good communicator, trustworthy, open-minded, sensitive, caring, able to consider different perspectives). Also, mention the importance of Peer Educators disclosing their HIV-status to peers/clients at the clinic so that they are seen as role models and can gain the trust of clients.
- Step 2:** Refer to the Peer Educator job description in *Appendix 2A* and review the general responsibilities of a Peer Educator. Emphasize that Peer Educators should never work alone—the clinical team should always support and supervise them.
- Step 3:** Review how Peer Educators will be supported and supervised by program partners, for example, by health care workers, NGOs, or district health teams. Ask the Peer Educator Supervisor to describe to participants in detail who the Peer Educators will report to every day and how and when Peer Educators will communicate with this person. You may also want to discuss any Peer Educator incentives (stipend, transport allowance, uniform, etc.) that are available.
- Step 4:** Remind participants that they are going to be an important part of the multidisciplinary care team. Ask participants to list all the people they have come in contact with at the facility when accessing HIV care and treatment services. List these on flip chart, and fill in using the content below if needed.
- Step 5:** Ask participants to discuss why each of the people listed on the flip chart is important to providing quality HIV services to clients and family members. Remind them to draw on their own experiences. Ask participants what they think would happen if one member of the multidisciplinary care team left. How would this affect a client's care?
- Step 6:** Explain that multidisciplinary care teams need to work together, communicate with one another, and respect each individual's contribution to improving the health and well-being of clients. If one "link in the chain" is missing, clients will not get the quality care they need in the hospital, community, or home. It is important that multidisciplinary care teams plan specific ways to work together, such as by meeting regularly to talk about the program and particular clients' care.

KEY INFORMATION

Example of a Peer Educator job description (adapt to the local context, see *Appendix 2A*):

Peer Educators are expected to:

- Spend at least 2-3 days per week at the clinic
- Participate as an active member of the multidisciplinary care team in the clinic, including attending meetings and trainings if required
- Openly disclose their HIV-status to clients
- Help conduct/co-facilitate support groups and other psychosocial support activities for ALHIV of different ages and stages
- Conduct Peer Education sessions (one-on-one, with members of the multidisciplinary team, and in groups) with ALHIV and provide support on the following topics:
 - Basic information about HIV and HIV care and treatment
 - Adherence to HIV care and treatment
 - Disclosure
 - Positive living
 - Safer sex
 - Basic emotional and psychosocial support
 - Others, as decided by the program
- Help ALHIV with referrals within the health facility
- Help link ALHIV with needed community support services
- Be role models to other ALHIV
- Act as a link between clients and the multidisciplinary care team
- Keep basic records and compile monthly reports

Peer Educators never work alone:

- No one person, no matter how skilled, can provide all of the care and support that a client needs. We all have different training, skills, and personal strengths. Also, no one person has time to do everything.
- This is why it is important for HIV prevention, care, and treatment programs to have a multidisciplinary care team that looks after every client. Peer educators are important members of this team.

Depending on the specific site, other members of the multidisciplinary care team can include:

- Doctors
- Nurses
- Pharmacists
- Lab technicians
- Counselors or social workers
- Lay counselors
- Data clerks/information officers

“Multidisciplinary” means a mix of different professionals and volunteers—doctors, nurses, counselors, peer educators, administrative staff, and others—working as members of a team.

- Other clinic staff such as receptionists, cleaners, and security guards
- Site coordinators or advisors
- Community-based workers and organizations
- Faith-based organizations and spiritual leaders
- The clients themselves
- Family members and friends of clients



No one person, no matter how skilled, can provide all of the care and support that a client needs. Also, no one person has the time to do everything. That's why it is important for HIV prevention, care, and treatment programs to have a multidisciplinary care team that looks after every client. Peer Educators are important members of the team!

Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

Centers for Disease Control and Prevention. (2009). *Sexual risk behaviors*. Retrieved from <http://www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm>

Colton, T., Costa, C., Twyman, P., Westra, L., & Abrams E. (2009). *Comprehensive peer educator training curriculum, Trainer manual, Version 1.0*. New York: ICAP.

Pathfinder International. (2000). *Programmatic issues for youth friendly programs*. Retrieved from <http://www.pathfind.org/pf/pubs/focus/RPPS-Papers/OverviewKE.html>

Senderowitz, J., Solter, C., & Hainsworth, G. (2004). *Comprehensive reproductive health and family planning training curriculum. 16: Reproductive health services for adolescents*. Watertown, MA: Pathfinder International.

World Health Organization. (2010). *IMAI One-day orientation on adolescents living with HIV, Facilitator guide*. Geneva, Switzerland: WHO Press.

SESSION 2.4: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Start by holding the ball and saying one key point of the module out loud. Throw the ball to one of the participants, who should then state another key point. Continue on until all participants have listed a key point. Cover any key points not already mentioned.
- Step 2:** Ask if there are any questions or clarifications.
- Step 3:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 4:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- "Adolescence"—the period between 10 and 19 years of age—is seen as a time of transition between childhood and adulthood.
- Adolescents are a very “mixed” group that includes young people of different ages, needs, and stages of development.
- Adolescents are not “big kids” or “little adults.” They have their own set of needs and challenges.
- Adolescents may be more vulnerable to mental health problems and other medical problems, like sexually transmitted infections.
- Adolescents are dealing with many rapid physical, mental, emotional, and sexual changes, which can cause changes in their relationships, problem solving abilities, and general ways of thinking.
- ALHIV differ from adults and children living with HIV because of the rapid physical and emotional changes that occur during this stage of development.
- Peer Educators have important jobs. They are both providers and recipients of HIV prevention, care, and treatment services.
- Peer Educators have many important roles and responsibilities in supporting ALHIV, including providing adolescent clients with emotional support, sharing their own experiences with care and treatment, and acting as good role models.
- ALHIV can have difficulty accessing health care. Peer Educators can help make clinics and health facilities more “youth friendly” and they can help ALHIV by linking them to HIV care and treatment services.
- Peer Educators are important members of the multidisciplinary care team.

APPENDIX 2A: Sample Adolescent Peer Educator Job Description

Adolescent Peer Educator Volunteer Job Description

The purpose of the Adolescent Peer Educator position is to educate and support youth living with HIV in ____ (fill in name of clinic/district) ____ on the issues related to HIV care and treatment, in collaboration with the clinic's multidisciplinary care team.

Expectations of Peer Educators (fill in/adapt as needed):

Peer Educators are expected to:

- Participate as an active member of the multidisciplinary care team in the clinic, including attending meetings and trainings if required
- Openly disclose their HIV-status to clients
- Help conduct/co-facilitate support groups and other psychosocial support activities for ALHIV of different ages and stages
- Conduct Peer Education sessions (one-on-one, with members of the multidisciplinary care team, and in groups) with ALHIV and provide support on the following topics:
 - Basic information about HIV and HIV care and treatment
 - Adherence to HIV care and treatment
 - Disclosure
 - Positive living
 - Safer sex
 - Basic emotional and psychosocial support
 - Others, as decided by the program
- Help ALHIV with referrals within the health facility
- Help link ALHIV with needed community support services
- Be role models to other ALHIV
- Act as a link between clients and the multidisciplinary care team
- Keep basic records and compile monthly reports

Responsible to (fill in/adapt as needed):

- Peer Educator Supervisor
- Peer Education Program Coordinator
- Other?

Time Requirements (fill in/adapt as needed):

- The length of the year commitment begins in __ (fill in month) __ and continues through the end of the school year, and will likely include some summer activities.
- 10 days of Peer Education training (see attached dates).
- At least 2-3 days per week at the clinic
- Time, as needed, for Peer Education meetings



MODULE 3: Review of HIV Basics



DURATION: 125 minutes (2 hours, 5 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Discuss common myths and rumors about HIV, AIDS, and ALHIV
- Discuss the difference between HIV and AIDS
- Discuss how HIV affects the immune system
- Recall the ways HIV is transmitted and prevented
- Identify behaviors that increase risk of HIV transmission and discuss the challenges young people face in reducing risk



CONTENT:

Session 3.1: Introduction: Myths and Rumors about HIV, AIDS, and ALHIV

Session 3.2: From HIV to AIDS—What HIV Does to the Body

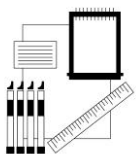
Session 3.3: HIV Transmission and Prevention

Session 3.4: Module Summary



METHODOLOGIES:

- Interactive trainer presentation
- Game
- Large group discussion
- Role play
- Brainstorming



MATERIALS NEEDED:

- Flip chart
- Markers
- Tape or Bostik
- Small sheets of paper or index cards
- Prizes for games
- Copy of the script for the participant activity in *Session 3.2*



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- For *Session 3.2*, write the definitions of HIV and AIDS on flip chart.
- Make 1 copy of the script for the participant activity in *Session 3.2*, adapting it as needed



SESSION 3.1: Introduction: Myths and Rumors about HIV, AIDS, and ALHIV (25 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Game, Large Group Discussion

- Step 1:** Review the Module learning objectives.
- Step 2:** Explain that rumors are unconfirmed stories or information that are told by one person to another. Rumors are common among adolescents because so much information is passed between and among them. Break participants into 2 groups. Ask one group to state a common rumor about HIV or ALHIV. Then ask the other group to state a fact about HIV. Then the first group should state a fact and the second group a rumor, etc. Each team receives a point for saying a fact/rumor and loses a point for being incorrect. The team with the most points after 15 minutes wins.
- Step 3:** Bring the participants back together. Discuss the rumors each group suggested, why these rumors exist, and the effect the rumor has. The trainer should also cover any rumors or facts not mentioned from the list below.
- Step 4:** Explain to the group that an important part of being a Peer Educator is knowing all the facts about HIV and AIDS and being able to explain the facts to people in the clinic and community.
- Remind participants that while everyone is allowed to have his or her own opinions, knowing the facts will help decrease stigma and discrimination against ALHIV and encourage people to seek prevention, care, and treatment services. It is important for Peer Educators to recognize rumors and use knowledge and facts to combat them!

KEY INFORMATION

Common rumors or myths about HIV, AIDS, and ALHIV (adapt to your local setting and include any common myths and rumors in your community):

- Having sex with a virgin can cure AIDS.
- ALHIV get infected because they are promiscuous (have sex with many partners).
- Anyone with TB or pneumonia has HIV.
- An HIV-positive girl must have been sleeping around.
- People over age 40 do not get HIV.
- Young people who get HIV from their mothers are victims.
- ALHIV should never have sex.
- ALHIV should be responsible and tell everyone they know about their HIV-status as soon as they know they are positive.
- Traditional healers can cure people with HIV.
- A faithful couple does not need to use condoms if both partners are living with HIV.
- Being diagnosed with HIV is a death sentence.

- You can tell if a person has HIV or AIDS by looking at him or her.
- ART is only for people who look very sick.
- ART makes you look better on the outside, but it makes you sick on the inside and may kill you in the end.
- Feeling better after starting ART means an HIV-positive person has been cured.
- ALHIV should never have children.
- All children born to women with HIV will get infected with HIV.
- ART is too strong for young people to take—it will hurt their growing bodies.
- Young people who get HIV from unsafe sex should be blamed for their illness.

Facts About HIV, AIDS and ALHIV

- The AIDS virus attacks the body's defense system and makes a person vulnerable or weak to other infections.
- A person who is HIV-infected might be very healthy and may not have any signs of illness for a long time, but they can still pass the virus to others.
- A woman can pass HIV to her unborn child.
- Using condoms reduces the risk of getting and giving HIV infection.
- You can only tell if you are HIV-infected by getting a blood test.
- Half of all new HIV infections occur in young people aged 15 to 24.
- HIV kills CD4 cells.
- ART stops the HIV virus from reproducing and prevents a body's CD4 cells from dying.
- People on ART (who take their medicines the right way, at the same time, every day) are less likely to pass on HIV to their sexual partner or unborn child.
- Peer Educators can help make HIV care and treatment services more youth-friendly.
- Health and medical services are basic rights of young people.
- HIV lives in semen, vaginal and birthing fluids, blood, and breast milk.
- Peer Educators need to talk openly about sexuality with people and help them practice safer sex.
- You cannot get HIV by sharing a latrine or toilet.
- You can become infected with HIV when you have unprotected sex one time with an HIV-infected person.

Peer Educators need to know the facts about HIV! It is important for Peer Educators to recognize rumors and to use their knowledge to make sure that everyone has the facts!



SESSION 3.2: From HIV to AIDS—What HIV Does to the Body (45 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Role Play, Large Group Discussion

- Step 1:** Tell participants that it is important for Peer Educators to know and be able to explain the difference between HIV and AIDS and to understand what effects HIV has on the body. Ask participants to think about how/where this information was explained to them. Ask participants to define what it means when someone is “HIV-infected.” What does it mean when someone has “AIDS?” What about “HIV-exposed?” Fill in using the content below.
- Step 2:** Tell the participants that everyone is going to perform a play on how HIV can attack the immune system. Ask for volunteers to act out the following roles: *Veronica, HIV, CD4 cells (group of people), and an infection (such as pneumonia)*. Give the script to the storyteller, who should stand at the side of the room and read Part 1 of the story aloud. Give instructions to the other actors in the play and use or adapt the script suggested below.
- Step 3:** Bring the group back together and read Part 2 of the story. Ask participants to narrate an ending. Each participant should take a turn making a statement that adds to the story. End the activity by asking the following questions:
- *How does HIV affect the immune system specifically in the case of youth?*
 - *How does HIV affect babies and children differently from the way it affects adolescents and adults?*
 - *What does it mean when a baby is HIV-exposed? How is this different from HIV-infected?*

KEY INFORMATION

HIV stands for **Human Immunodeficiency Virus:**

H Human (refers to us)

I Immunodeficiency (means the body cannot fight diseases and protect itself from getting sick)

V Virus (a type of germ in the body that cannot be cured and causes diseases)

AIDS stands for **Acquired Immune Deficiency Syndrome:**

A Acquire (to get something)

I Immune (the way the body fights disease)

D Deficiency (not enough of something—in this case a lack of protection from getting sick)

S Syndrome (a collection of signs and symptoms of disease)

Basic Definitions

- **HIV** is the virus that gets into the body.
- **AIDS** is a group of serious illnesses and opportunistic infections that develop after more and more HIV grows in the body and the body is too weak to fight back. Having a CD4 count below 200 also means a person has AIDS, even if he or she is not sick.
- **HIV-infected** is when HIV has entered a person's body. A person who is HIV-infected might be very healthy and may not have any signs of illness for a long time. The time it takes for HIV to develop into AIDS varies from person to person. This time can be as long as 10 years for some people or as short as 1-2 years for others. This is why the only way to tell if a person has HIV is with a blood test (and why you cannot tell just by looking at them).
- **HIV-exposed** usually refers to an infant born to a mother infected with HIV and exposed to HIV during pregnancy, childbirth, or breast-feeding.
- Babies and children with HIV infection develop AIDS much faster than adults.
- HIV kills important cells in the body that fight disease. These cells are called **CD4 cells**. Eventually, HIV attacks so many of the CD4 cells that the body cannot fight infections anymore and the person develops AIDS. If a person's CD4 count is below 200, he or she is diagnosed as having AIDS.
- The body of a person who is HIV-infected is more likely to be attacked by infections and diseases. These infections are called **opportunistic infections (OIs)** and can include pneumonia, tuberculosis, meningitis, as well as others. OIs can make people living with HIV—especially babies, children, and people not taking ART—sick because their body's immune or defense system is weakened. Participants will learn more about OIs in *Module 5*.
- HIV can result in other severe life-threatening infections, such as some forms of cancer, problems in the nervous system, and brain diseases. Encephalopathy is a term used to describe a number of different conditions, all of which affect the brain.

What does HIV do to the immune system?

- The immune system is the body's natural defense against diseases.
- The human body is made up of many tiny cells. Cells are the basic building blocks in our body. They give us energy and keep us healthy and alive.
- In a healthy person, the immune system fights off diseases that enter the body, keeping the person healthy. CD4 cells are one type of blood cell in the immune system that fight infection. We can say that CD4 cells are the "guardian angels" that protect us from disease.
- When a person is infected with HIV, HIV enters the blood stream and starts to attack CD4 cells.
- HIV makes more copies of itself in the CD4 cells. These are the same cells that the body uses to fight infection.
- For a while, the CD4 "guardian angel" cells keep the virus weak in the body.
- After some time, HIV becomes stronger than the CD4 cells and keeps making more of the virus and attacking more of the CD4 cells. HIV keeps reproducing and there is more and more of it in the body.
- This makes a person more likely to get infections and makes it harder for his or her body to fight these infections because it does not have as many CD4 cells, or "guardian angel cells."

- Eventually, the HIV attacks so many of the CD4 cells that there are not enough to fight back. The body is attacked by infections and germs that the person cannot fight off.
- These infections (called opportunistic infections, or OIs) are what eventually make people develop AIDS who, without treatment, will die.
- HIV affects babies/children very quickly—much quicker than it affects adults—because a baby’s immune system is still developing.
- Taking ART the right way, at the same time, every day will prevent the HIV from becoming stronger in the body and making the person sick. Taking ART will keep the person’s CD4 cells from dying (and keep their CD4 count up).

HIV Infection in Babies and Children

The way HIV affects the immune system in babies and children is similar to adults. But babies and children with HIV usually progress from HIV to AIDS very quickly if they are not on ART.

CD4 cells are our “guardian angels” and protect our bodies from infections that can make us sick. **The higher a person’s CD4 count, the better!**



Suggested script for participant activity (stage directions in brackets):

Part I: Veronica's Story

Storyteller: This is the story of how a healthy immune system works and what HIV does to the body. This is Veronica, who is 16-years-old, attends secondary school, and lives with her grandmother and younger sister. (Veronica comes forward and stands in the middle of the room. Veronica looks happy and shows that she is strong.)

Storyteller: Veronica is protected from infections by her immune system. Her immune system is made up of CD4 cells, which fight disease. They are Veronica's "guardian angels" and protect her from illness and keep her healthy. (The small group of people, holding hands in a circle, moves to surround Veronica.)

Storyteller: When Veronica gets an infection, her immune system fights it and she becomes well again. (The pneumonia infection comes forward and Veronica looks in pain. The infection tries to break through the immune system circle, but they do not let him and he goes away.)

Storyteller: Veronica had sex with her boyfriend. He did not use a condom and she felt too afraid to ask him if he would. Now Veronica has become infected with HIV because her boyfriend carries the virus and they have had unprotected sex. (HIV comes forward and starts to fight with Veronica's immune system. HIV manages to get inside the immune system circle. HIV pretends to hit one of the immune-system actors, who falls down).

Storyteller: A few months later, Veronica's life is continuing as normal. Veronica feels healthy and strong. She continues with her normal daily routine: she goes to school, hangs out with friends, and spends evenings helping her grandmother make food for her younger sister.

Storyteller: Because HIV has managed to get inside Veronica's immune system and kill a part of it, her system is weak and cannot fight HIV. Because the immune system is damaged, it cannot fight off other infections. Ask participants, "What do you think will happen to Veronica now that her body is having difficulty fighting disease?"

Storyteller: Veronica goes to the clinic and is enrolled in care and treatment services. She starts to take ART and, after several months, starts to feel better. (HIV comes forward and starts to fight with Veronica's immune system. HIV falls down. Veronica looks happy and shows that she is strong).

Part II: 10 months later

Storyteller: Veronica is pregnant. Veronica wants to stay healthy during her pregnancy. However, she is scared and anxious about taking ART during pregnancy because she thinks it will harm the baby.

Note: This activity and script were adapted from: International Federation of Red Cross and Red Crescent Societies. (2000). *Action with youth - HIV/AIDS and STD: A training manual for young people, Second edition.*

SESSION 3.3: HIV Transmission and Prevention (40 minutes)



TRAINER INSTRUCTIONS

Methodologies: Brainstorming, Large Group Discussion, Game, Interactive Trainer Presentation

Step 1: Prepare 4 sheets of flip chart with the following titles: BODY FLUIDS THAT CARRY HIV; BODY FLUIDS THAT DO NOT CARRY HIV; ACTIONS THAT MAY TRANSMIT HIV; and ACTIONS THAT DO NOT TRANSMIT HIV. Give participants markers and ask them to stand up and write responses on the appropriate flip charts. You may need to give some examples to get participants started. Give participants about 5 minutes to write their answers on the flip charts.

Once participants have returned to their seats, review each flip chart, filling in as needed from the content below. Remind participants that different actions carry different levels of risk.

Step 2: Pass out small cards, markers, and tape or Bostik to participants. Tell everyone that they are modern artists who have been asked to design a new graffiti wall in their town, called *HIV Transmission Behaviors*. Begin the activity by saying, “People can get HIV by...” and then ask participants to think about ways of finishing the sentence (i.e. with a behavior that puts a person at risk for HIV). Ask participants to write different types of HIV risk behaviors on the small cards (one behavior per card) using the suggested statements from the content below and making up some of their own. Each participant should think of some HIGH RISK, LOW RISK, and NO RISK behaviors. Then ask participants to post these cards on the graffiti wall—from HIGH RISK to LOW RISK to NO RISK. Debrief by discussing what makes each behavior either HIGH, LOW, or NO risk.

Step 3: Explain that Peer Educators have an important role to play in teaching young people living with HIV how to prevent transmission of HIV to other people. Ask the group:

- *What are the ABCs of HIV prevention?*
- *Can you think of other ways to prevent the transmission of HIV, especially among young people?*

Write responses on flip chart. Facilitate a discussion by filling in content as needed from below, including discussing the role of treatment and male circumcision in prevention.

Step 4: Continue the discussion by stating the following statistics about youth and HIV:

- *Almost half of all new HIV infections in the world are among people under 25.*
- *An estimated 2,500 young people become infected with HIV every day.*
- *Globally, 5 million young people are living with HIV.*

- *Young women under age 25 are at increased risk of becoming infected with HIV, and make up 60% of infected youth.*
- *Young people remain the most vulnerable group to HIV infection.*

Ask the group the following question to facilitate discussion and write responses on flip chart. Fill in using the content below.

- *Why do you think young people are so at-risk for HIV?*

Step 5: Debrief by emphasizing the role of Peer Educators in helping their peers understand the facts about HIV transmission, prevention, and reducing risky behaviors.

KEY INFORMATION

HIV is most easily transmitted in these body fluids:

- Semen (cum)
- Vaginal fluids
- Blood
- Birthing fluids
- Breast milk

HIV is not usually transmitted in these body fluids, unless there is also blood:

- Urine (pee)
- Feces (poop)
- Saliva (spit)
- Sweat
- Mucous (snot)
- Pus

Ways HIV is transmitted

Sexual transmission:

- Unprotected sexual intercourse with an infected person—this includes male-female sex, male-male sex, and female-female sex
- Direct contact with the body fluid of an infected person (blood, semen, or vaginal secretions)
- Most HIV transmission worldwide is sexual transmission
- HIV transmission is more likely if:
 - One or both people have advanced HIV infection or AIDS
 - One or both people have just recently been infected with HIV (because at this time there is a lot of HIV in the blood)
 - One or both people are eligible for ART and are not taking it or have poor adherence

Remember: Taking ART the right way, every day lowers the chance of transmitting the virus to sexual partners and babies.

Mother-to-child transmission (MTCT):

- During pregnancy
- During labor and delivery (most MTCT happens at this stage)
- During breastfeeding

Blood-to-blood transmission:

- Transfusion with infected blood
- Direct contact with infected blood/body fluids

Use of unsafe sharp objects:

- Injecting drugs and sharing needles with an infected person
- Piercing, tattooing, or cutting with unclean knives or other objects

Ways HIV is NOT transmitted:

- Wearing someone else's clothing
- Sharing food, cups, and plates with a person with HIV
- Swimming in a swimming pool, river, or waterhole with a person or people with HIV
- Travelling on crowded buses with a person or people with HIV
- Sharing a latrine/toilet
- Using condoms
- Mosquitoes or insect bites—even if they carry human blood, HIV cannot live outside of humans
- Living with or sleeping in the same room as a person with HIV
- Hugging
- Kissing
- Shaking hands
- Coughing or sneezing
- Caressing, massaging
- Masturbation

Suggestions for participant activity on HIV Transmission Behaviors

- Kissing on cheeks (*no risk*)
- Sleeping in the same room as someone living with AIDS (*no risk*)
- Having an injection with a new needle at a local pharmacist's or clinic (*no risk*)
- Being tattooed (*low risk*)
- Using a public latrine (*no risk*)
- Oral sex without condoms (*low risk*)
- Anal sex without condoms (*high risk*)
- Having sex within marriage (*may be low or high risk*)
- Hugging someone who is infected (*no risk*)
- Having a blood transfusion with HIV (*no or low risk*)
- Using someone else's toothbrush (*no risk*)
- Being bitten by bedbugs (*no risk*)
- Ritual circumcision (*may be high risk*)
- Swimming in a pond with someone living with HIV (*no risk*)
- Caring for someone living with AIDS (*no risk as long as...*)
- Being bitten by a mosquito (*no risk*)
- Having many sexual partners and using condoms with most of them (*high risk*)
- Having your ears pierced (*no risk if instruments are new*)
- Tongue kissing (*no risk*)
- Witchcraft (*no risk*)

Facts About Youth and HIV

- Almost half of all new HIV infections in the world are among people under 25.
- Estimates show 2,500 young people become infected with HIV every day.
- Globally, 5 million young people are living with HIV.
- Young women under age 25 are at increased risk of becoming infected with HIV, and make up 60% of infected youth.
- Young people remain the most vulnerable group to HIV infection.

5 million young people are living with HIV. All young people need to know how HIV can be prevented and how to reduce the risk of getting HIV or giving it to someone else!



HIV Prevention: The ABCs of preventing sexual transmission of HIV:

A#1: Abstinence (not having sex at all)—this approach works best for younger adolescents

A#2: Adherence to ART—take your ART the right way, every day. Keeping your viral load (the amount of HIV in your body) low protects your sexual partner from HIV infection. There is more about “treatment as prevention” in *Module 10*.

B: Be faithful to your partner (whether or not your partner is living with HIV or is HIV-negative).

C#1: Consistent and correct condom use (male or female)—every time—for “dual protection” against pregnancy and HIV

C#2: Circumcision—male circumcision can reduce the risk of sexual HIV transmission from women living with HIV to HIV-negative men (see the box below)

D: Delay initiation of sexual intercourse.

E: Early and complete treatment of STIs

F: Free and open communication between partners about sex

G: Get to know your HIV-status.

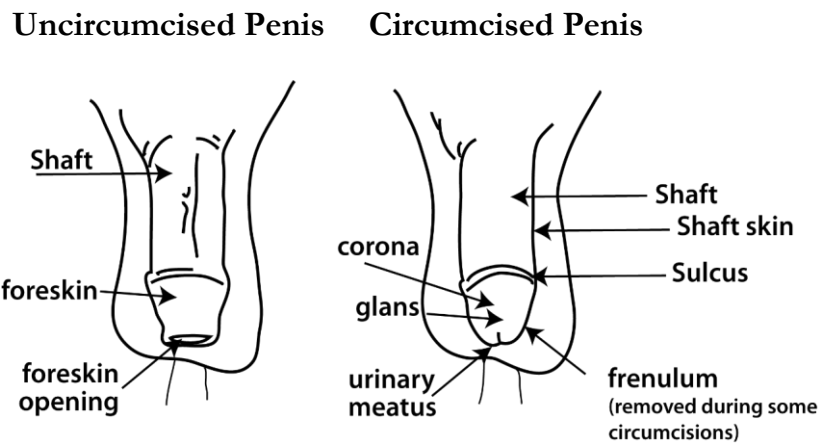
Prevention of mother-to-child transmission:

- Prevention of unwanted pregnancies in the first place (good family planning and communication about family planning between couples)
- Providing lifelong ART to all eligible pregnant women and providing ARVs to women not eligible for lifelong ART during pregnancy and breastfeeding
- HIV testing before deciding to become pregnant
- Good, early antenatal care
- HIV testing as part of antenatal care
- Counseling for mothers and fathers on PMTCT
- Safer sex during and after pregnancy
- Safe, normal delivery at a facility
- Providing ARVs for all babies exposed to HIV (at birth and during breastfeeding)
- Safe infant feeding
- Regular follow-up of mother and baby

Male Circumcision

Male circumcision can reduce the risk of female-to-male sexual transmission of HIV, but should not be used as the only risk reduction method. Circumcision involves removal of the foreskin on the penis, as shown in the drawing below. Babies or adults can be circumcised but the procedure should only be done by trained doctors at a health facility.

- Circumcision has NOT been shown to reduce the risk of male-to-female sexual transmission of HIV.
- Studies are still being done to see if circumcision affects male-male sexual transmission of HIV.
- Circumcision is not recommended for men living with HIV.
- It is important for a man to use condoms and to get tested for HIV even if he is circumcised.



Future HIV prevention options:

Microbicides and **“PrEP”** are new interventions that can protect HIV-uninfected individuals when they are exposed to HIV.

- **Microbicides** refer to a new type of product being developed that people could use in their vagina or rectum to protect themselves from HIV, and possibly other STIs. A microbicide could be produced in many forms, including gels, creams, suppositories, films, or as a sponge or ring that releases the medicines over time. Microbicides are still being tested in clinical trials and are not for sale yet.
- **PrEP** stands for “pre-exposure prophylaxis.” It means using medicine in advance (before you are exposed to something) to prevent yourself from getting a disease or condition, in this case HIV. When we talk about PrEP for HIV, we are referring to the idea of HIV-negative people taking certain ARVs in order to reduce their risk of becoming infected with HIV if they are exposed to it. Although recent studies have shown that PrEP works in preventing new HIV infections, we are still waiting to see how research findings will be translated into guidelines and use for the general public. Until we know more about how to implement PrEP, it will not be available for general use.

See *Module 10* (page 10-22) for more information on treatment as prevention, microbicides, and PrEP.

Other ways young people can prevent transmission of HIV:

Young people should have information about and be encouraged to:

- **Delay sexual activity.** Abstain from sex until married or in a stable relationship.
- **Know their partner's HIV-status.**
- **Learn how to use condoms and use them correctly.** Adolescents should practice using condoms before becoming sexually active. If young people are already sexually active, it is important to make sure they know how to use condoms correctly.
- **Stick with one partner or limit the number of partners you have.**
- **Avoid high-risk partners.**
- **Adhere to HIV care and treatment,** including taking ARVs the right way, at the same time, every day. Good adherence helps keep the viral load (the amount of HIV in the body) low, and can protect sexual partners from getting HIV. But remember, it's always important to also use condoms during sex.
- **Recognize symptoms of STIs.** If a person experiences burning with urination (peeing), discharge from the penis/vagina, and/or genital sores, he or she and his or her partner should not have sex and should come to the clinic for treatment.
- **Discuss sexual issues with your partner.** Young men and women must feel comfortable communicating with their partners about sex and their sexual histories.



Why are adolescents more at-risk for HIV infection?

Adolescents are more physically at-risk of getting infected with HIV:

- The bodies of young women are still maturing and growing. Their genital tract is more susceptible to infection.
- Women often do not show symptoms of chlamydia and gonorrhea (the most common STIs). A person is more likely to become infected with HIV when he or she has unsafe sex if he or she has another STI. Adolescent females become infected with HIV at twice the rate that adolescent males do.

Adolescents are more socially and economically at-risk of getting infected with HIV:

- Adolescents lack basic information about the symptoms, transmission, and treatment of STIs.
- Adolescents often have multiple, short-term sexual relationships and do not consistently use condoms.
- Youth sometimes face dangerous practices such as genital cutting, anal intercourse to preserve virginity, and scarification.
- Gender inequality: in some cultures, girls are not empowered to say no.
- Sexual violence, lack of formal education (including sexuality education), inability to negotiate with partners about sexual decisions, and lack of access to reproductive health services put young women at especially high risk.
- Sexual intercourse is often unplanned and spontaneous.
- Adolescent males may have their first sexual experiences with sex workers.
- Adolescent females may have their first sexual experiences with older men.
- Adolescents often do not have accurate knowledge about their bodies, sexuality, and sexual health.
- Adolescents often have little access to income and may do sex work for money or favors.
- Adolescents are more likely to use alcohol, tobacco, and other drugs. When a person is under the influence of drugs or alcohol, he or she is more likely to have unprotected sex.
- Homeless adolescents are at high risk for HIV infection if they are exchanging sex for drugs or money.

Adolescents are very vulnerable to HIV, especially young women. ALHIV need to understand how they can prevent new HIV infections. Peer Educators need to know about and tell others how to practice the ABCs of HIV prevention, including practicing safer sex!



SESSION 3.4: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Divide participants into 2-3 teams, depending on the size of the group. Ask each team to work together to assign 1 person to be the official captain/spokesperson for the team. The trainer can suggest that teams select the captain randomly (e.g. based on who has the most siblings).
- Step 2:** Ask the teams what they think are the key points of this Module. Tell them that each team will have 5 seconds to respond with a key point. Teams can discuss amongst themselves but the captain should announce the key point. Explain that the first team to reach 10 points wins the game.
- Step 3:** Give each team 1 point for each key point they remember.
- Step 4:** Cover any key points not already mentioned.
- Step 5:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 6:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Peer Educators should know the facts about HIV and AIDS and help correct myths and rumors among clients, caregivers, family members, and in the community.
- People can be healthy and HIV-infected for many years before getting sick and developing AIDS. But, they can still spread HIV to other people so it is important for people to get tested so they know their HIV-status.
- HIV attacks a person’s immune system and makes it hard for the body to fight off diseases and infections.
- Specifically, HIV attacks the CD4 cells in the body. The CD4 cells are like guardian angels that protect the body from illnesses. Eventually, HIV attacks so many of the CD4 cells that the body cannot fight infections anymore, and the person develops AIDS.
- If they are not on ART, babies and children with HIV usually progress from HIV to AIDS very quickly.
- It is very important that Peer Educators know all the ways HIV can and cannot be passed from person to person and that they help people prevent new infections.
- HIV lives in semen, vaginal and birthing fluids, blood, and breast milk.

- HIV can be passed through unsafe sex with a person living with HIV, from a mother living with HIV to her child, through blood-to-blood contact, and through sharing needles, knives, and other sharp objects.
- Adolescents are more physically and socially vulnerable to HIV infection than adults.
- Peer Educators should know the ABCs of preventing sexual transmission of HIV:
 - A#1:** Abstinence—this approach works best for younger adolescents
 - A#2:** Adherence to ART—take your ART the right way, every day. Keeping your viral load (the amount of HIV in your body) low protects your sexual partner from HIV infection.
 - B:** Be faithful to your partner (whether or not your partner is living with HIV or is HIV-negative).
 - C#1:** Consistent and correct condom use (male or female)—every time—for “dual protection” against pregnancy and HIV
 - C#2:** Circumcision—male circumcision can reduce the risk of sexual HIV transmission from women living with HIV to HIV-negative men
 - D:** Delay initiation of sexual intercourse.
 - E:** Early and complete treatment of STIs
 - F:** Free and open communication between partners about sex
 - G:** Get to know your HIV-status.
- Adolescents can prevent HIV transmission by delaying sexual activity, knowing their partners’ status, using condoms, limiting the number of partners, avoiding high-risk partners, adhering to their HIV care and treatment, and recognizing the symptoms of sexually transmitted infections (STIs) and getting treatment for themselves and their sexual partner.
- Taking ART the right way, at the same time, every day, lowers the risk of passing HIV to sexual partners and babies.
- Microbicides and “PrEP” are new interventions that can protect HIV-uninfected individuals when they are exposed to HIV. We know from research studies that these interventions work to prevent HIV, but we are waiting to see how they can best be used in the general population. For now, microbicides and PrEP are not available for use in the general population.



MODULE 4: Communicating with Your Peers



DURATION: 360 minutes (6 hours)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Discuss their own attitudes, values, and beliefs and how these may affect communication with other ALHIV
- Describe the importance of effective communication skills as a Peer Educator
- Discuss the basic principles of counseling and behavior change
- Discuss the challenges to building trust and rapport with young clients and how Peer Educators can overcome them
- Recall what is meant by shared confidentiality and why it is important for Peer Educators
- List the 4 main stages of a one-on-one Peer Education session
- Demonstrate the 7 essential communication skills required of Peer Educators
- Practice using the Talking Tree to facilitate Peer Education sessions and help clients come up with their own solutions and make decisions



CONTENT:

Session 4.1: Introduction: The Story of the Monkey and the Fish—
Understanding Yourself and Others

Session 4.2: Understanding the Basic Principles of Counseling and
Behavior Change

Session 4.3: Let's Talk!: Key Communication Skills for Adolescent Peer
Educators

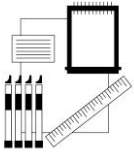
Session 4.4: Classroom Practicum on Communication

Session 4.5: Module Summary



METHODOLOGIES:

- Large group discussion
 - Interactive trainer presentation
 - Values clarification
 - Case studies
 - Role play
 - Small group work
 - Game
 - Homework assignment
-



MATERIALS NEEDED:

- Flip chart
 - Markers
 - Tape or Bostik
 - Extra copies of *Appendices 4A, 4B, and 4C* for each participant
-



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
 - Practice the role plays in *Session 4.3* with co-trainers or with participants who volunteer to help with this session.
 - Make enough copies of the Talking Tree, Talking Tools Board Game, and Communication Skills Checklist (*Appendices 4A, 4B, and 4C*) so that each participant has multiple copies.
 - Review the case studies for *Session 4.4* and adapt to the local context as needed.
-

SESSION 4.1: Introduction: The Story of the Monkey and the Fish—Understanding Yourself and Others (45 minutes)



TRAINER INSTRUCTIONS

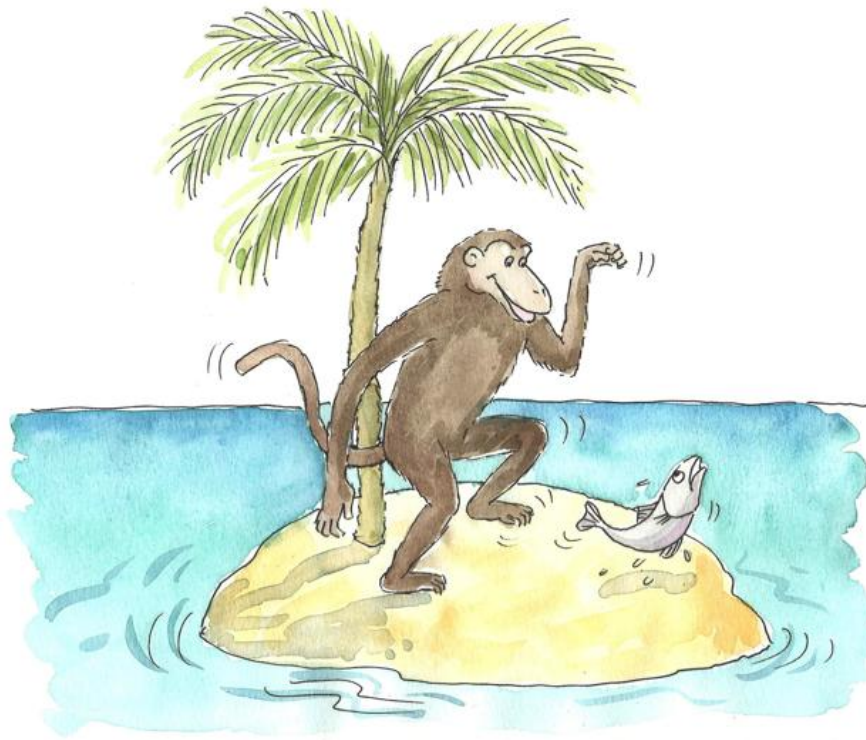
Methodologies: Large Group Discussion, Interactive Trainer Presentation, Values Clarification

- Step 1:** Review the Module learning objectives.
- Step 2:** Read the story of the monkey and the fish in the content below to the group. Then ask participants:
- *What do you think this story is telling us? What is the moral of the story?*
- Step 3:** Reinforce that the moral of the story is that good intentions are not enough. If you wish to help the fish, you must understand its nature. Explain that understanding yourself and others is a necessary skill for every Peer Educator. It is important to understand how our own attitudes, values, and prejudices affect our thoughts and opinions about situations. We cannot expect others to be “just like us.” Explain that our own attitudes, values, and prejudices should not be a part of communication with clients. Facilitate discussion by reviewing the definitions of the key terms below: attitude, prejudices, and being self-aware.
- Step 4:** Divide participants into small groups. Explain that you will read out some sentence fragments (see below). After you read one phrase, each group should decide how they would finish the sentence. Emphasize that participants should pay attention to their first reactions to each phrase. When the groups have responded to one statement, ask participants to explain their viewpoints.
- Step 5:** Remind participants that even though everyone can have his or her own opinions, it is very important to be respectful and non-judgmental when working as a Peer Educator and communicating with clients and other community members.

KEY INFORMATION

The Story of the Monkey and the Fish

Once upon a time, in a land far, far away, there lived a monkey. This monkey actually lived on an island. One day it began to rain and rain. The rain never seemed to end and the island began to flood. The rain and the waters kept coming and coming until, one day, the monkey was left with only a little bit of land and one tree. As he was sitting up in his tree, he noticed another animal in the water. It was moving back and forth. The monkey was so worried about the little animal and wanted to rescue it. So, the monkey risked its own life to go out to the end of one of the tree’s branches and snatch the animal out of the water to prevent it from drowning. He put the animal on the ground to dry out under the sun and get warm. The animal flopped around and the monkey thought it looked so happy, it must be jumping around in excitement. Then, the animal lay perfectly still and the monkey thought it looked so peaceful. Of course, the animal was a fish.



Peer Educators should always:

- Remember that everyone is different and never assume anyone is “just like us.”
- Think about the issues related to their own attitudes, values, and prejudices and how these issues affect their ability to give effective support services to clients.
- Be sensitive to the culture, values, and attitudes of their clients, even if they are different from their own.
- Make all people feel comfortable and that it is “safe” to talk with them openly and honestly.

Key terms:

- **Attitudes and values** are feelings, beliefs, and emotions about a fact, thing, behavior, or person. For example, some people believe that having multiple sexual partners is okay as long as you practice safer sex, while other people believe that this is wrong.
- **Prejudices** are negative opinions or judgments made about a person or group of people before knowing the facts. For example, assuming that an adolescent with HIV must be promiscuous is a prejudice.
- **Being self-aware** means knowing yourself, how other people view you, and how you affect other people.

Remember: Prejudice and negative attitudes drive the HIV epidemic so Peer Educators should avoid them!

Suggested statements for the values clarification activity:

1. "People infected with HIV are...."
2. "Condoms should be freely available to...."
3. "A young woman who is HIV positive and pregnant should...."
4. "Prostitution is...."
5. "An HIV-infected young woman should...."
6. "Men who have sex with men are...."
7. "Girls who sleep with multiple partners are...."
8. "Drug users should get...."
9. "It is alright for men to...."
10. "Young women should never...."



It's important for Peer Educators to be self-aware and to never impose our values or opinions on other people!

SESSION 4.2: Understanding the Basic Principles of Counseling and Behavior Change (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Case Studies

- Step 1:** Introduce the Session by explaining that while Peer Educators are not counselors, some of their work will involve supporting, helping, and advising ALHIV in the context of group work, and sometimes also individual conversations with clients. Therefore, it is important to understand some basic principles of communication, counseling, and behavior change.
- Step 2:** Begin the discussion by saying that counseling is a **process**. This process is based on a **relationship** that is built on empathy (or understanding another person's feelings), acceptance, and trust. Within this relationship, the Peer Educator uses good communication to focus on the client's feelings, thoughts, and actions, and then helps clients to:
- *Cope with their issues and life situation*
 - *Explore options*
 - *Make their own decisions*
 - *Take responsibility for those decisions*
- Step 3:** Ask participants to describe a time when they received good counseling from someone (e.g. a doctor, nurse, teacher, friend, family member, Peer Educator, spiritual leader, etc.) Ask participants:
- *What made the counseling good?*
 - *Why was the counseling helpful?*
- Step 4:** Continue by facilitating a discussion about the purpose of counseling and both what counseling is and is not, using the content below. Write responses on flip chart.
- Step 5:** Explain that many of the topics of counseling are about changing behavior (for example, helping a client adhere better to his or her medicines or helping a client understand the importance of practicing safer sex with his or her partner). Behavior change is gradual. It is a process, rather than a single event. Ask participants to think about a habit or behavior they wanted to/tryed to change in their own lives. Ask if some participants want to share their experiences with the larger group. Review the continuum of behavior change below and work through an example suggested by one of the participants. Ask the following questions:
- *What made you decide to change? OR Why did you want to change?*
 - *Were there good things you thought would happen if you changed? If so, what were they?*

- *What steps did you take to change? OR What did you do to change?*
- *Were you able to change? If yes, how long did it take to change?*
- *Did you ever go back to the old behavior? Why?*

Step 6: Debrief by emphasizing the following points:

- *We often become aware of the need to change by getting new information. But, information by itself is usually not enough to cause a change in behavior.*
- *Often, we actually begin to change as a result of a personal experience or crisis that motivates us to try to change our behavior or lifestyle.*
- *When trying to change a behavior, almost all of us stumble along the way either because of our own personal obstacles or obstacles that others put in our way.*
- *To succeed in changing a behavior, most of us receive some form of support, either from something we find within ourselves or from our peers, family, or others who are important to us.*
- *As Peer Educators, we must be patient with our clients as they try to change their behaviors.*

Step 7: Explain that one of the most important factors influencing the relationship between the Peer Educator and the person being counseled is trust. Ask participants to define trust.

Continue the discussion about trust by introducing the definition of confidentiality. Describe the importance of confidentiality during counseling as well as in the community setting. Use the content below to fill in as needed. Then read the following case study to the group:

A___ is 18 years old and is a client at the HIV clinic. A___'s Peer Educator has been encouraging him to come back to the clinic more often. One day, A___ sees his Peer Educator in town and overhears the Peer Educator casually announce to some people that A___ has HIV. A___ is so upset and ashamed that other people now know that he is HIV-positive that he never returns to the clinic.

Discuss the following questions:

- *What are the consequences of this lack of confidentiality?*
- *Have you ever had your confidentiality violated or broken in the clinic?*
- *How did that make you feel?*

Step 8: Discuss the concept and definition of **shared confidentiality**. Brainstorm about some situations in which Peer Educators may need to share information about a client with other members of the clinical team. Also, introduce the idea of referrals and brainstorm about situations in which clients may require other follow-up services (e.g. professional mental health or counseling services). Explain that participants will learn more about how to assist with referrals in Module 5. Read this second case study to the large group and discuss whether

shared confidentiality is important in this situation:

M___ is 16, HIV-positive, and lives with her boyfriend. Both of her parents have died. She sees you at the ART clinic and tells you that last night her boyfriend came home really late. He was drunk again. They started arguing and he got on top of her and forced her to have sex. M___ starts crying and says that she feels ashamed and worthless.

- *What would you do next with M___?*
- *How and when would you talk about M___ with the multidisciplinary care team and/or the Peer Education Supervisor?*

Step 9: Remind participants that confidentiality is a very important piece of the counseling experience and that building trust is especially important when working with adolescents. Confidentiality is also very important in HIV programs because of the stigma surrounding HIV and because of discrimination against ALHIV. Lastly, emphasize again that Peer Educators need to speak regularly with their supervisor and other members of the multidisciplinary care team so they can respond effectively to complex problems and make sure the client gets the best possible care.

KEY INFORMATION

Peer Educators should understand the basics about counseling and behavior change so they can be effective helpers!



What is counseling?

- Counseling is a two-way communication process that helps people look at their personal issues, make decisions, and plan how to take action.
- The goal of counseling is not to solve every problem but to improve the client's coping skills.
- Counseling helps people talk about, explore, and understand their thoughts and feelings.
- Counseling helps people work out what they want to do and how they will do it.

Counseling includes:

- Establishing supportive relationships
- Having conversations with a purpose (not just chatting)
- Listening attentively
- Helping people tell their stories without fear of stigma or judgment
- Giving correct and appropriate information
- Helping people to make informed decisions
- Talking about options and alternatives
- Helping people to see and build on their strengths

- Helping people to develop a positive attitude toward life
- Respecting everyone’s needs, values, culture, religion, and lifestyle

Counseling does not include:

- Solving another person’s problems
- Telling another person what to do
- Making decisions for another person
- Blaming another person
- Interrogating or questioning another person
- Judging another person
- Preaching or lecturing to another person
- Making promises that cannot be kept
- Imposing one’s beliefs on another person



Always remember to be respectful and non-judgmental when communicating with clients and other community members!

Behavior Change

- Behavior change is a step-by-step process of change from one behavior to another.
- Usually a person moves from being uninterested in changing, to considering a change, to deciding and preparing to make a change.
- Behavior change happens gradually over time; it is a process. It does not happen overnight, and setbacks are normal and part of changing behavior.
- We often realize we should change our behavior after getting new information—but information alone is usually not enough to cause us to change our behavior.
- Often, we actually begin to change as a result of a personal experience or crisis that motivates us to try to change our behavior or lifestyle.
- When trying to change a behavior, almost all of us stumble along the way, either because of our own personal obstacles or because of obstacles that others put in our way.
- To succeed in changing a behavior, most of us receive some form of support, either from something we find within ourselves or from our peers, family, or others who are important to us.
- As Peer Educators, we must be patient with our clients as they try to change their behaviors.

Confidentiality:

In order for clients to trust Peer Educators with their feelings and problems, it is important for them to know that this information will be kept confidential. This means that Peer Educators and other members of the multidisciplinary care team will not tell other people what the client says, that the client is HIV-positive, or any other information about the client. Confidentiality is especially important in HIV programs because of the stigma surrounding HIV and the discrimination against ALHIV in the home, at work, at school, and in the community.

Because multidisciplinary care teams take care of clients, sometimes they need to discuss a client's needs and health status with one another so they can provide the best care possible to the client. This is called **shared confidentiality**. **In most cases, the multidisciplinary care team members will all know the HIV-status of PLHIV. However, there might be other important information about the client that needs to be discussed—such as information about their mental health, personal safety, information about their family or home situation, information about their sexual and reproductive health, etc.**

Shared Confidentiality

Shared confidentiality means that information about a client is disclosed to another person involved in the client's care—a member of the multidisciplinary care team, a community health worker, a treatment supporter, etc.—*with the client's consent*.

Peer Educators often come from the same community as their clients. This might make some people who know them uneasy, especially in the beginning. Peer Educators need to tell clients that they will NOT discuss their concerns, health, or problems with people in the community.

Privacy:

PRIVACY is a very important part of quality counseling. Even though space is a challenge in many clinics, it is important that the multidisciplinary care team work together to create private areas where counseling can take place. It is important that other people cannot see or hear a private counseling session and that there are no interruptions while counseling is taking place.

ALWAYS tell the Peer Educator Supervisor or a member of the multidisciplinary team (e.g. nurse or social worker) IMMEDIATELY if the client:

- ✓ Talks about suicide
- ✓ Talks about wanting to hurt someone
- ✓ Reports any kind of physical or sexual abuse
- ✓ Talks about abusing drugs or alcohol
- ✓ Shows any signs of severe behavioral, emotional, or mental health problems (like if a client reports hearing voices)
- ✓ Tells you about a new or worsening medical condition or problem
- ✓ Acts aggressive or threatening
- ✓ Asks for information you do not have or know

Always review client information with the Educator Supervisor and/or multidisciplinary care team after the individual session to ensure the best possible care for the client!



SESSION 4.3: Let's Talk!: Key Communication Skills for Adolescent Peer Educators (120 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Role Play, Small Group Work, Game

- Step 1:** Tell participants that in this Session, they will learn how to effectively conduct a one-on-one Peer Education session with a client. Again, although Peer Educators are not qualified counselors, it is important they learn and use good communication skills in order to effectively help their clients.
- Step 2:** Begin by reviewing the 4 phases of a one-on-one Peer Education session: (1) Establishing the Relationship; (2) Understanding the Client's Needs; (3) Creating an Action Plan; and (4) Ending the Session, using content below. Explain the importance of deciding on an "action plan" of immediate next steps with each client. Goal setting should be part of every individual session, and these goals should be reviewed at every session. Tell participants that they will have the opportunity to practice helping clients set their own goals later in *Session 4.4*.
- Step 3:** Ask all participants to sit on the floor in a circle. Explain that participants will be practicing some basic communication skills needed for Peer Education. Explain that 1 trainer will be role playing a Peer Educator and 1 will be role playing a young client. Tell them to watch the interaction that happens between the 2 and to be prepared to discuss their observations (trainers should incorporate common counseling errors). The trainers should then role play the first case study in the content below. After the role play, ask participants to identify what went wrong and what went well during the session. Write their responses on flip chart.
- Note:** There are a number of role plays included in the content below. These should be performed by 2 of the trainers. With adequate preparation, 1 of the participants could also perform part of the role play.
- Step 4:** Review the 7 essential communication skills, which can help Peer Educators in their work. Peer Educators can use these skills when speaking to people individually or when speaking in front of groups. Start with the first skill of non-verbal communication. Explain that we usually think that we only listen with our ears, but we also listen with our eyes, mind, body, and heart. Listening helps the speaker to express his or her true feelings and thoughts, and this is the foundation of any relationship. Ask participants to turn to the person sitting next to them. One person should start by talking about the best day of his or her life and the other should just listen without saying anything. After 2 minutes, ask the pairs to switch roles. Then debrief by asking how it felt to be the speaker and how it felt to be the listener.
- Step 5:** Continue by working through each of the 7 essential communication skills. For each skill, first explain why it is important. Then trainers should briefly role play

what to do and what not to do for each skill, using the content and suggested role plays listed under each skill below. Then ask the group to work in pairs using the original case study to practice each of the skills. Participants should take turns being the Peer Educator and the client. After reviewing and practicing all 7 skills, ask 2 participants to re-enact the original role play using some of the skills that they have learned.

Step 6: Bring the group back together. Read some examples of common counseling mistakes from the content below. Ask the group to explain why each statement is incorrect and then ask for a volunteer to demonstrate the correction.

Step 7: Remind participants that their communication approach will be slightly different for each client. For example, communication with older adolescents is very different from counseling younger adolescents. Some younger adolescents may want to express their thoughts and feelings but have difficulty verbalizing them. Ask participants:

- *What do you think you need to think about when talking to younger adolescents?*
- *What can Peer Educators do to encourage younger adolescents to talk about their feelings during a one-on-one session?*

Write responses on flip chart and fill in content as needed.

Step 8: Facilitate discussion by asking participants what skills they found most challenging and which ones they found easiest. Remind the group that they will be using the skills learned in this Module throughout the entire training and every day in their work as a Peer Educator. Emphasize that the communication skills they are learning are not only helpful at the clinic, but also in life and in all of their relationships with family members, friends, partners, and community members.

KEY INFORMATION

Phases of a One-on-One Peer Education Session

There are 4 main phases in a one-on-one Peer Education session:

1. Establishing the Relationship
2. Understanding the Client's Needs
3. Creating an Action Plan
4. Ending the Session

1. Establishing the Relationship

- To establish a relationship, you must quickly build trust with the person. Smile, introduce yourself, and give a short explanation of your role. Choose a space or room to talk that is private and where people do not walk through so that there are few, if any, interruptions or disturbances. For younger children, you may want to sit on the floor.
- Confidentiality: explain that what is discussed in counseling is confidential, which means that it is not talked about with other people—it is private. Explain, however, that sometimes there may be a need to talk about a client's health information with someone else in the clinic to ensure the best possible care for the client. Explain that Peer

Educators may only talk about this information in the clinic with other health workers and never in the community.

- Ways to begin a counseling session after introducing yourself and explaining confidentiality: *“Can you tell me why you came here today?”*
- If you show a positive and caring attitude from the beginning, this will help you develop a trusting relationship with clients.

2. Understanding the Client’s Needs

- Be patient and let the client describe what is happening. Listen as the person talks about his or her thoughts, feelings, and actions around the situation he or she is experiencing.
- Use the 7 essential communication skills to encourage conversation.
- There may be different problems or points to address. Help the client decide which is the most important.

3. Creating an Action Plan

- The Peer Educator should give the client practical information, referrals, or perhaps just emotional support (i.e. make a plan to visit the ART clinic together, refer the client to a peer support group, etc.).
- It is very important that the decision-making come from the client. The Peer Educator can help the client explore the options, but in the end it is up to the client to make a decision.
- Write down the client’s decision and immediate next steps (e.g. make a plan to visit the ART clinic together, attend a support group for ALHIV, etc.).
- **Remember: you may need to get assistance from the Peer Education Supervisor or a member of the multidisciplinary care team if the client’s situation is serious or complicated (e.g. if the client is very sad and thinks about suicide).**

4. Ending the Session

- Summarize what was discussed during the session, including the next steps and action points.
- Talk about any future Peer Education sessions and make needed appointments for the client.

Always help clients set their own goals and establish an action plan of immediate next steps!



Case study for role play (to be used to practice each of the 7 communication skills):

S__ is a 15-year-old young woman and a client at the HIV clinic. She comes to you and says: *“I just started seeing this guy. We have spent quite a bit of time together and I really like him. We have been really careful and had protected sex. He knows I have HIV and is pretty accepting. It has been about 2 months and now my boyfriend does not want to use a condom. He says that if I trust him, I should not ask him to use a condom. I am so confused. I do not know what to do.”*

There are 7 essential communication skills that Peer Educators should practice and use in their work when speaking to individuals and in front of groups:

- Skill 1: Use helpful non-verbal communication
- Skill 2: Actively listen and show interest in your client
- Skill 3: Ask open-ended questions
- Skill 4: Reflect back what your client is saying
- Skill 5: Show empathy, not sympathy
- Skill 6: Avoid judging words
- Skill 7: Help your client set goals and summarize each Peer Education session

The 7 essential communication skills are not only helpful at the clinic, but also in life and in all of our relationships with family members, friends, partners, and community members!



Skill 1: Use helpful non-verbal communication

- Make eye contact.
- Face the person.
- Be relaxed and open with your posture.
- Sit next to the person you are counseling. Do not sit behind a desk!
- Dress neatly and respectfully.
- Use good body language—nod your head and lean forward.
- Smile.
- Do not look at your watch, the clock, or anything other than the person you are talking with.
- Try not to write during a conversation with a client, unless you are writing down key information for the client to take home or for your records. Turn your mobile phone off and never take calls during a counseling session.

Role play	
Non-verbal communication	
What NOT to do Non-verbal communication	What to do Helpful non-verbal communication
Client walks in	Client walks in
Peer Educator: Hi. My name is _____ (<i>name</i>). (Peer Educator is filling in the register from behind a desk)	Peer Educator: Hello. My name is _____ (<i>name</i>). (Peer Educator is filling in the register from behind a desk)
Client: Um, I have some questions about how a person gets HIV.	Client: I have some questions about how a person gets HIV.
Peer Educator: Yeah, cool..... (speaking in a hurried fashion). What do you want? (Peer Educator still looking at the register)	Peer Educator: (Looks at client, stops writing in the register, and moves chair so that it is not behind the desk) Would you like to sit down? What were your questions? (Leans forward, not crossing legs)
Peer Educator: (No response and still filling in the register)	Peer Educator: (Looks warmly, yet with concern, at client. Optional: demonstrate appropriate touch)
Client: Well, I'm worried about giving my girlfriend HIV.	Client: Well, I'm worried about giving my girlfriend HIV.
Peer Educator: (No response and still filling in the register)	Peer Educator: (Looks warmly, yet with concern, at client. Optional: demonstrate appropriate touch)
Client: (Clears throat to get Peer Educator's attention)	----
Peer Educator: Oh sorry (she finally stops writing and looks at watch). Yeah, go ahead, you said that you are concerned that your sister might be infected? (Peer Educator's hands are folded, legs crossed and facing away from client, looking across the room with expression of disinterest)	Peer Educator: You look really concerned, why do you think she might get infected? (Peer Educator looks at client, leaning forward and not crossing legs)
Client: Well no, actually it was my girl..., actually, it's okay. Don't worry, sorry to have bothered you.	Client: (Proceeds to tell her story)

Always remember to use good body language, make eye contact, and minimize distractions when you are speaking with a client!



Skill 2: Actively listen and show interest in your client

Active listening skills:

- Listen in a way that shows respect, interest, and caring.
- Show the client you are listening by saying “okay” or “mmm hmm.”
- Use a calm tone of voice.
- Listen to the content of what the client is saying.
- Listen to how they are saying it—do they seem worried, angry, etc.?
- Allow the client to express her or his emotions. For example, if she is crying, allow her time for this.
- Never judge clients or impose your own values on them. Use non-judgmental language. Avoid saying, “You should...” Instead say, “You can...” or “You may want to think about...”
- Keep distractions to a minimum and try to find a private place to talk.
- Do not do other tasks while talking to a client.
- Do not interrupt the client.
- Ask questions or gently probe if you need more information.
- Don’t be afraid of silence. Silence gives the client time to think about what to say next.

Role play Active Listening
Peer Educator: What do you think your best friend’s reactions might be if you told her that you have HIV?
Client: There’s no way I could tell her. She would think all sorts of bad things about me.
Peer Educator: Mmm hmm (<i>nods sympathetically</i>).
Client: I think she would stop talking to me.
Peer Educator: You are afraid she won’t understand or support you?
Client: Yeah, she’ll think I got it because I slept around with a bunch of guys.
Peer Educator: Yeah, I understand. It must be really tough for you. It sounds like you could use some extra support since disclosing to your best friend sounds like something you’re scared about doing.



Listening carefully is one of the best ways a Peer Educator can help with a client’s problems. Use your body language and tone of voice to show clients you are listening well and that you are interested!

Skill 3: Ask open-ended questions

- Ask questions to help you clearly understand the client’s problems or worries and to help the client get a deeper understanding of what is going on.
- Questioning should be centered around the concerns of the client and not around the curiosity of the Peer Educator.

These are the different types of questions:

Closed Questions

- A closed question limits the response of the client to a one-word answer—usually “yes” or “no.”
- For example:
 - *“Do you practice safe sex?”*
 - *“Do you know how to use a condom?”*
- Closed questions do not give the client an opportunity to really think about what they are saying.

Open-ended questions

- An open-ended question requires more than a one-word answer.
- They invite the client to continue talking.
- For example:
 - *“If you were to tell your status to your girlfriend, how do you think she would react?”*
 - *“If your boyfriend found out from your best friend that you were pregnant, what do you think would happen?”*
 - *“If you asked your brother to help with the cooking, what do you think his response would be?”*

Leading questions

- A leading question is one that already suggests the answer.
- For example:
 - *“You do practice safe sex, don’t you?”*
 - *“Do you agree that you should always use a condom?”*
- These questions are usually judgmental. Try not to use them.

Additional Practice on Closed- and Open-Ended Questions	
Closed-ended questions	Open-ended questions
Do you have safer sex with your boyfriend?	How do you have safer sex with your boyfriend?
Do you have more than one partner?	There are a lot of ways to reduce risk for HIV—like not having sex, being faithful to your partner, and using condoms. Which would work best for you based on your situation?
Do you use condoms?	What challenges do you have using condoms with your partner?
Do you know how to prevent HIV?	Can you tell me the ways you know of to protect yourself from HIV?
Are you taking your ARVs?	Tell me more about how it’s going with your medicines. What are some of the challenges you are having? What is working well?

Role play	
Open-ended questions	
What NOT to do Closed-ended questions	What to do Open-ended questions
Client walks in	Client walks in
Peer Educator: Hi, how are you? I'm ____ (<i>name</i>). I am a Peer Educator. I'd like to talk with you about taking your medicines.	Peer Educator: Hi, how are you? I'm ____ (<i>name</i>). I am a Peer Educator. I'd like to talk with you about taking your medicines.
Client: OK	Client: OK
Peer Educator: Did you take all of your pills this month?	Peer Educator: How was it taking your medicines this month?
Client: Yeah, I think so.	Client: Well, it went pretty well but sometimes remembering to take my pills after school was hard.
Peer Educator: OK, great. And did you have any problems or side effects?	Peer Educator: Were there times this past week when you forgot to take your pills?
Client: Um, no, I don't think so.	Client: Ok, yesterday I remembered to take my medicines in the morning. But after school, I stayed out with my friends and forgot completely. My mother was at my grandmother's house. There was no one at home to help remind me.
Peer Educator: OK, cool. So it seems like things are fine. I'll see you next time you come to the clinic.	Peer Educator: Let's review your adherence plan together and think of ways you can remember to take your medicines.

Always remember to ask open-ended questions to help clients describe their situation. Start your questions with words and phrases like, '*how,*' '*why,*' and '*tell me about...*'!



Skill 4: Reflect back what your client is saying

- Summarize briefly what the client told you by paraphrasing his or her words
- Try to understand the client’s feelings and let him or her know that you have understood these feelings

Reflecting can:

- Give feedback to the client and lets him or her know that he or she has been listened to, understood, and accepted
- Encourage the client to say more
- Show that the Peer Educator has understood the client’s story
- Provide a good alternative to always answering with another question

For example, the Peer Educator can use the following formulas for reflecting:

- *“You seem to feel that _____ because _____.”*
- *“So I sense that you feel _____ because _____.”*
- *“I’m hearing that when _____ happened, you didn’t know what to do.”*
- When reflecting back, try to say it in a slightly different way. Do not just repeat what the client said. For example, if a client says, *“I can’t tell my girlfriend that I have HIV,”* the counselor could say, *“Talking to your partner about your HIV-status sounds like something that you are not comfortable doing.”* Then say, *“Let’s talk about that.”*

Role play Reflecting	
Example 1	Example 2
Client: I really wanted to meet my friends yesterday, but I had too much housework to do so I couldn’t go.	Client: I told my boyfriend to go to hell!
Peer Educator: It seems like you felt pretty sad because you could not meet your friends yesterday?	Peer Educator: You were mad at him?



Reflecting is summarizing what a client says in a slightly different way. Peer Educators can use this skill with both individuals and groups to show that they really understand what was said!

Skill 5: Show empathy, not sympathy

- Empathy is trying to put yourself in another person’s shoes.
- Empathy is different from sympathy. When you sympathize, you feel sorry for a person and look at him or her from your own point of view.
- For example, if the client says, *“Taking these medicines every day is so hard. I’m sick of it. I just want to feel normal and be like everyone else,”* the Peer Educator could reflect back by saying, *“You are feeling kind of stressed out and upset?”*
- However, if the Peer Educator responds by saying, *“You poor thing. I really know how you feel. When I first started taking ARVs, it was so hard for me as well. I felt really angry that I had to take these medicines for the rest of my life. It seemed impossible. I had no support from my family....,”* this is sympathizing because the attention is now on the Peer Educator and her experiences rather than on the client.

Role play	
Showing empathy vs. sympathy	
What NOT to do Sympathizing	What to do Empathizing
Peer Educator: What do you think about asking your partner to use condoms?	Peer Educator: What do you think about asking your partner to use condoms?
Client: I’d really be afraid that he might hit me, or even worse.	Client: I’d really be afraid that he might hit me, or even worse.
Peer Educator: Yes, I know what you mean, that happened to my sister. She actually did ask her boyfriend to use condoms and you know what? He hit her then he made her leave the house. He didn’t let her come back for two full days.	Peer Educator: It sounds like you’re afraid of how your boyfriend will respond.
Client: So did your sister go back?	Client: Yeah, I am. He’s jealous and he has accused me of cheating in the past and has become really violent with me.

It’s important for Peer Educators to understand the client’s point of view. Always remember—
EMPATHIZE but don’t
SYMPATHIZE!



Skill 6: Avoid judging words

- Judging words are words like “right,” “wrong,” “well,” “badly,” and “properly.” Using the words “these people” or “those people” to describe people living with HIV is also judgmental.
- If a Peer Educator uses these words when asking questions, the client may feel that he or she is wrong, or that there is something wrong with his or her actions or feelings.
- However, sometimes Peer Educators need to use the “good” judging words to build a client's confidence.

Role play	
Avoiding judging words	
What NOT to do Using judging words	What to do Avoid words that sound judging
Peer Educator: What do you think about asking your boyfriend to use condoms?	Peer Educator: What do you think about asking your boyfriend to use condoms?
Client: NO way.	Client: NO way.
Peer Educator: (Surprised) Really? That's the wrong way to feel! Have you had a good conversation about condoms?	Peer Educator: Mmm hmm.
Client: No, not really.	Client: I tried to get him to use condoms before, but he says sex doesn't feel as good when he uses them.
Peer Educator: He's stupid isn't he? I hope you get some sense and have a good conversation about condoms and how condoms prevent STIs and pregnancy.	Peer Educator: Yeah, I've heard other people say that as well. Have you ever had a talk with him about using condoms to protect his and your health?
Client: Yes, I will.	Client: That's a good idea, maybe I'll try that.

Never use judging words or make a client feel bad about something he or she has said. Remember—we need to work WITH our clients and not against them!



Skill 7: Help your client set goals and summarize each Peer Education session

Summarizing:

The Peer Educator summarizes what has been said during a session and clarifies the major ideas and next steps.

Summarizing:

- Can be useful to make sure you have understood the main issues raised during a session
- Is best when both the Peer Educator and client participate and agree with the summary
- The Peer Educator could say, *“I think we’ve talked about a lot of important things today. (List main points.) We agreed that the best next steps are to _____. Does that sound right? Let’s plan a time to talk again soon.”*

Goal setting and deciding on “immediate next steps”:

Towards the end of a Peer Education session, the Peer Educator works with the client to decide what he or she is going to do in the immediate future (e.g. in the next few days) and to come up with “next steps” to solve the client’s issues in the short and long term.

Next steps and goals:

- Should be developed by the Peer Educator and client together
- Try and help the client make realistic short- and long-term goals and actions
- Must be clear enough to help people measure their own progress (people feel good when they achieve something they have set out to do)
- To start, the Peer Educator could say, *“Okay, now let’s think about some things you will do this week based on what we talked about.”*

During a Peer Education Session, it’s important for Peer Educators to always help clients make their own decisions, set goals, and decide on an action plan of immediate next steps!



Common Communication Mistakes to Avoid:

Peer Educators should do their best to avoid these common mistakes when speaking with clients!



1. Avoid exclamations of surprise.

Client: "I slept with my boyfriend last night and we did not use a condom."

Wrong: "Oh, my goodness. Has your boyfriend been tested for HIV?"

Correct: "Tell me more about that."

2. Avoid preaching.

Client: "I feel really bad. I slept with 2 different people last weekend."

Wrong: "You should feel bad. The Bible says that you are only to have sex with your husband."

Correct: "You said you feel really bad. Can you describe that a little more?"

4. Avoid being critical.

Client: "I did it again: I went to the bar last night and drank too much and then went home with someone I didn't know."

Wrong: "I do not know if I can continue to counsel you if you do not start making good decisions."

Correct: "Tell me more about what happened and how you're feeling now."

5. Avoid making false promises.

Client: "I have had a really miserable week."

Wrong: "Next week is bound to be better."

Correct: "What made this week so miserable?"

6. Avoid threats.

Client: "I had unprotected sex again this last week."

Wrong: "If you do not stop having unprotected sex, you are going to give her HIV."

Correct: "How are you feeling about that?"

7. Avoid burdening others with your own difficulties. Do not bring up your problems and concerns with a client.

Client: "I do not have enough money to pay the rent next month."

Wrong: "I hear you. I don't have enough to pay for electricity. I don't know what I'm going to do."

Correct: "Sounds like you have some real financial concerns. Let's talk more about that."

8. Avoid appearing impatient—this could be impatience at the client's continued grief or depression. It could also be impatience caused by not having the time to talk to the client at that moment. Be direct and reschedule a time when you can talk to the client.

Client: (crying) "I miss my mother so much and cannot seem to stop crying."

Wrong: "It has been 6 months since your mother passed away. It is time you moved on."

Correct: "It's so painful to miss someone."

9. Avoid sharing your personal beliefs or values.

Client: "The church I attend says it is wrong to have sex before marriage. What do you think?"

Wrong: "The church is absolutely right. That is why AIDS has spread so rapidly."

Correct: "Tell me more about what you think and feel about it."

10. Avoid arguing.

Client: "I am so stupid. I cannot believe I failed the exam."

Wrong: "You are not stupid."

Correct: "How does failing the exam make you stupid?"

Tips for Communicating with Younger Adolescents:

- They need time to feel safe and to trust. Maybe start the session by doing something together, like playing a game.
- They may feel scared and fear being judged.
- They may feel anxious or embarrassed when asking for help, especially when it's about contraception or other reproductive health issues.
- They need some time to observe you! Do not expect them to talk right away. Allow plenty of time and be patient.
- Explain things in simple terms.
- Just because he or she is not asking questions does not mean that he or she is not thinking about what is being said.
- Do not force him or her to share. Positively reinforce his or her effort to express him- or herself
- If a youth is rude or aggressive, remember that it may not be directed at you. He or she may be feeling angry with adults for treating him or her badly or letting him or her down. Be patient and don't take it personally.

Activities for Younger Adolescents:

- Reading a book or educational material together
- Drawing about their family, followed by some questions to encourage them to share their feelings:
 - "Tell me about your drawing"
 - "What happened here?"
 - "How did you feel then?"
 - "How do you feel now?"
- Talking while playing a board game
- Making a photo collage about their family
- An "All About Me" Box: use magazines, paper, and markers to decorate a shoe box so that it represents different aspects of their personality and life
- Help them write a letter to a friend or family member about what is happening

SESSION 4.4: Classroom Practicum on Communication (120 minutes)



TRAINER INSTRUCTIONS

Methodologies: Game, Interactive Trainer Presentation, Large Group Discussion, Small Group Work, Role Play, Case Studies

- Step 1:** Break the participants into small groups of approximately 3-4 people and introduce the Talking Tools Board Game (*Appendix 4A*). Pass out a stone, coin, or another object that participants can use as a game token. Explain that participants should take turns reading and answering the various questions on the game board. Participants should then move their token the number of spaces indicated. The first group to reach the end of the game wins.
- Step 2:** Then, ask each group to read the case studies in the Participant Manual. Also ask them to select 1 person who will play the role of the Peer Educator and 1 who will play the role of the client—the others will play the role of observers.
- Step 3:** Introduce the participants to some helpful tools that can help Peer Educators guide and structure a Peer Education one-on-one session: the Talking Tree (*Appendix 4B*) and the Communication Skills Checklist (*Appendix 4C*). Review instructions for the Talking Tree and the checklist using the content below. Explain that this activity can be particularly useful with younger adolescents and is a hands-on way to promote expression and to explore a client's specific situation. Tell participants that they will continue to practice using different versions of this Talking Tree throughout the remainder of the training.
- Step 4:** Ask the groups to start their role plays. The client should spend 5-10 minutes talking to the Peer Educator about his or her concerns. The Peer Educator will practice using the Talking Tree and as many of the essential communication skills as possible in the time given. The Peer Educator should also help the client form an action plan of "immediate next steps" and write these on the Talking Tree according to the instructions.
- Step 5:** After 5-10 minutes, stop the exercise and ask the observers to give feedback on each of the skills and techniques they saw used during the role play, using the Communication Skills Checklist as a guide. Encourage observers to be very specific and to give examples such as: "*your tone of voice showed you cared,*" "*the way you asked the question sounded like you were annoyed or irritated,*" or "*you didn't look too interested. You kept looking at your phone.*"
- Step 6:** As time allows, repeat this exercise until everyone has had an opportunity to practice the role of Peer Educator. The trainers should circulate and participate in the small groups.
- Step 7:** Bring the large group back together to debrief the activity. If time allows, ask some of the small groups to perform their role play for the large group. Close the session by reminding participants that Peer Educators **never** act all by themselves and that good counseling and care of clients is the responsibility of

the entire multidisciplinary care team. One person will never have all the answers! Emphasize the importance of regular meetings with the team and working closely with the Peer Education Supervisor.

KEY INFORMATION

Instructions for the Talking Tools Board Game (see *Appendix 4A*):

1. Divide the participants into small groups. Ideally, there should be 3-4 people in each group.
2. Pass out a copy of the Talking Tools Board Game to each group and give each group a stone, coin, or another small object that they can use as a game token.
3. Each person in the group should take a turn reading and answering the various questions on the game board. Participants should then move their token the number of spaces indicated.
4. The first group to reach the end of the game wins.

Instructions for the Talking Tree (see *Appendix 4B*):

Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue they are experiencing—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's

resources—the "*things you have going for you*," such as inner strengths, talents, skills, and spiritual resources to help in coping.

6. Then ask: "*What is the next step in achieving your goal or hope for the future?*" Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client's situation and "next steps" with the program supervisor or a member of the multidisciplinary care team.

Instructions for the Communications Skills Checklist (see *Appendix 4C*):

1. Pass out copies of the Communication Skills Checklist to participants.
2. Ask those acting as "observers" in the group to refer to the checklist while the "Peer Educator" and "client" act out the role play based on one of the case studies.
3. Using the checklist as a guide, the "observers" should take notes about each of the skills and techniques they saw used during the role play so they can give feedback afterwards.

Case Studies for Classroom Practicum

Case Study 1:

M___ is an 18-year-old client you see regularly at the ART clinic and who you recognize from school. He tells you that he has a male partner that he sees on the weekends and that he has not disclosed to his status to him. He is very worried that his family and his friends at school will find out that he is HIV-positive and sometimes has sex with men. He is scared to open up and really talk to you about these issues.

How do proceed with M___?

Suggested responses for Talking Tree:

1. **Main issues for this client:** disclosure to partner about HIV-status, disclosure to family/friends about HIV and sexuality, fear/uncertainty about their response and possible consequences, fear about confidentiality at school/in the community
2. **Cause of issue:** fear of consequences when he discloses to partner and others
3. **Roots:** talk about who supports him in his life: partner, friends, teachers, other family members, church, etc.; talk about who knows about his sexual orientation, who (if anyone) knows about his HIV-status
4. **Hope for future/goal:** to disclose to partner about HIV-status, talk about advantages and disadvantages of disclosing to his partner and his expectations of the process; talk about eventual disclosure to his family, reinforce that disclosure is an ongoing process
5. **Branches/options/coping/potential solutions:** talk about how/when he can disclose to his partner; role play some examples of how to start the conversation; talk about the importance of safer sex and how to prevent HIV transmission to partner
6. **Next steps:** plan for disclosure, get his partner tested, attend support group for ALHIV, come back to the clinic to talk more with Peer Educator about preparing for disclosure to family
7. **Summarize main points:** referral to support group, next appointment time and date, praise the client and acknowledge the difficulty of disclosure, emphasize the importance of his partner knowing his status and being tested, reinforce confidentiality/privacy of information discussed
8. **Review the main points of the discussion with a program supervisor** and/or member of the multidisciplinary care team, to obtain guidance and input on next steps with client.

Case Study 2:

N___ meets with you after testing positive for HIV. He is very angry and tells you the test must be wrong because he has only had sex with 2 people in his whole life and that they were very healthy and not “bad girls.”

How do you proceed?

Suggested responses for Talking Tree:

1. **Main issues for this client:** acceptance and understanding of HIV-status, possible fear about confidentiality at school/in the community
2. **Cause of issue:** lack of confidence in clinic and testing procedures, denial, difficulty with accepting diagnosis; talk about HIV and how it is transmitted, explain that one of the girls probably has HIV and maybe does not know that she is HIV infected
3. **Roots:** talk about who supports him in his life: partner, friends, teachers, other family members, church, etc., people who can offer support during this time
4. **Hope for future/goal:** talk about engaging in care, even if he is feeling healthy and living positively with HIV
5. **Branches/options/coping/potential solutions:** talk about when he will come back to the clinic for checkups; talk about safer sex and HIV prevention; talk about the benefits of peer and other social support; talk about ways to contact him if he misses a clinic visit or doesn't come back; talk about why he might be afraid to come back or not want to come back
6. **Next steps:** plan for care and treatment, potentially get his partners tested, attend support group for ALHIV, come back to clinic to talk more with Peer Educator
7. **Summarize main points:** referral to support group, next appointment time and date, praise client and acknowledge the difficulty of situation, emphasize the importance of his partner knowing his status and being tested, emphasize importance of coming back to the clinic, reinforce confidentiality/privacy of information discussed
8. **Review the main points of the discussion with a program supervisor** and/or member of the multidisciplinary care team, to obtain guidance and input on next steps with client.

Case Study 3:

B___ is 15 years old and HIV-positive. Her father died of an AIDS-related illness. Her mother is also HIV positive, so B___ is the one mostly taking care of her 3 siblings. As a result, she is not always able to go to school. She comes to the clinic today and is very depressed. She is crying says that she feels hopeless.

How do you support B___?

Case Study 4:

T___ is 10 years old. He comes to the clinic and you sit down with him in a private room. He seems embarrassed to talk to you but it seems like he has something on his mind.

How do you proceed?

Case Study 5:

The nurse asks you to speak with a young woman named L___ about some adherence challenges she is having. When you come into the waiting area where L___ is sitting, you realize that she is someone you dated about a year ago.

How do you proceed?



Peer Educators are not counselors and should never work alone. Always remember to talk with your supervisor and other members of the multidisciplinary care team about any important issues!

Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

Colton, T., Costa, C., Twyman, P., Westra, L., & Abrams E. (2009). *Comprehensive peer educator training curriculum, Trainer manual, Version 1.0*. New York: ICAP.

Family Health International. (2006). *Community counselor training toolkit, Basic counseling skills, Module 2*.

Family Health International. (2006). *Community peer educator training toolkit, action with youth - HIV/AIDS and STD: A training manual for young people; Second edition*. International Federation of Red Cross and Red Crescent Societies.

REPSI. (2007). *Mainstreaming psychosocial care and support: A manual for facilitators*.

Senderowitz, J., Solter, C., & Hainsworth G. (2004). *Comprehensive reproductive health and family planning training curriculum. 16: Reproductive health services for adolescents*. Watertown, MA: Pathfinder International.

World Health Organization. (2010). *IMAI one-day orientation on adolescents living with HIV, Facilitator guide*. Geneva, Switzerland: WHO Press.

SESSION 4.5: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Homework Assignment

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving to the next Module.
- Step 6:** Lastly, request that participants complete a special homework activity. Ask participants to practice at least 3 of the essential communication skills at home or in the community, with friends, partners, family members, or even someone they don't know well. Ask participants to write down notes in their Participant Manual about the skills they practiced, how they used them in their communication, what was easy/difficult, and what the reaction was of the person they were talking with. Tell participants that they will discuss and debrief about their experiences tomorrow morning.

KEY INFORMATION

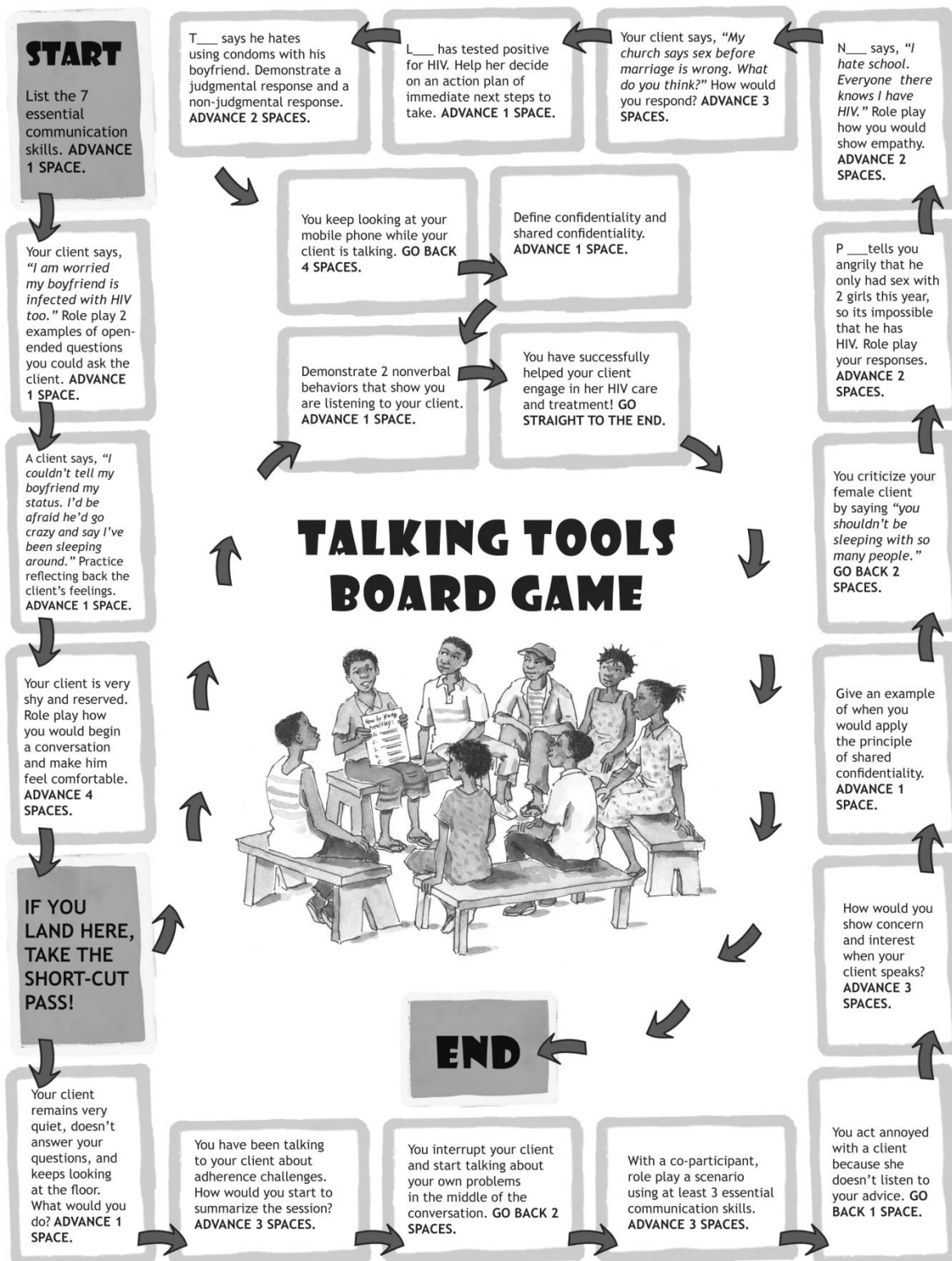


LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Our own attitudes, values, and prejudices should not be a part of communication and counseling with clients and other community members.
- Peer Educators are not qualified counselors, but it is important to understand the basic principles of counseling and behavior change in order to be effective helpers.
- Counseling is a way of working with people to understand how they feel and of helping them decide what they think is best to do in their situation.
- Peer Educators are not responsible for solving all of the client's problems.
- Peer Educators' role is to support and assist the client's decision-making process.
- Behavior change happens gradually over time; it is a process. It does not happen overnight and setbacks are normal and part of changing behavior.
- It is important for clients to know that what they say will be kept private. Peer Educators should practice shared confidentiality.

- Peer Educators should make sure that there is privacy when speaking with a client and that they are not interrupted for any reason.
- There are 4 phases of a one-on-one Peer Education session: (1) Establishing the relationship; (2) Understanding the client's needs; (3) Creating an action plan; and (4) Ending the session.
- These are the 7 essential communication skills that Peer Educators should always use in their work—when they speak to individuals and when speaking in front of groups:
 1. Use helpful non-verbal communication.
 2. Actively listen and show interest in your client.
 3. Ask open-ended questions.
 4. Reflect back what your client is saying.
 5. Show empathy, not sympathy.
 6. Avoid judging words.
 7. Help your client set goals and summarize each counseling session.
- Younger adolescents sometimes need a different counseling approach. Allow plenty of time, be patient, and use an activity-based approach to encourage expression.
- The Talking Tree, Talking Tools Board Game, and Communication Skills Checklist are all helpful tools that can guide Peer Educators in their work with clients.
- Peer Educators should never work alone. They should always work closely and communicate regularly with a supervisor and/or a member of the multidisciplinary care team.

APPENDIX 4A: Talking Tools Board Game



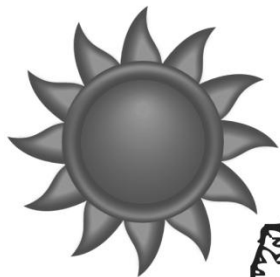
APPENDIX 4B: Talking Tree

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

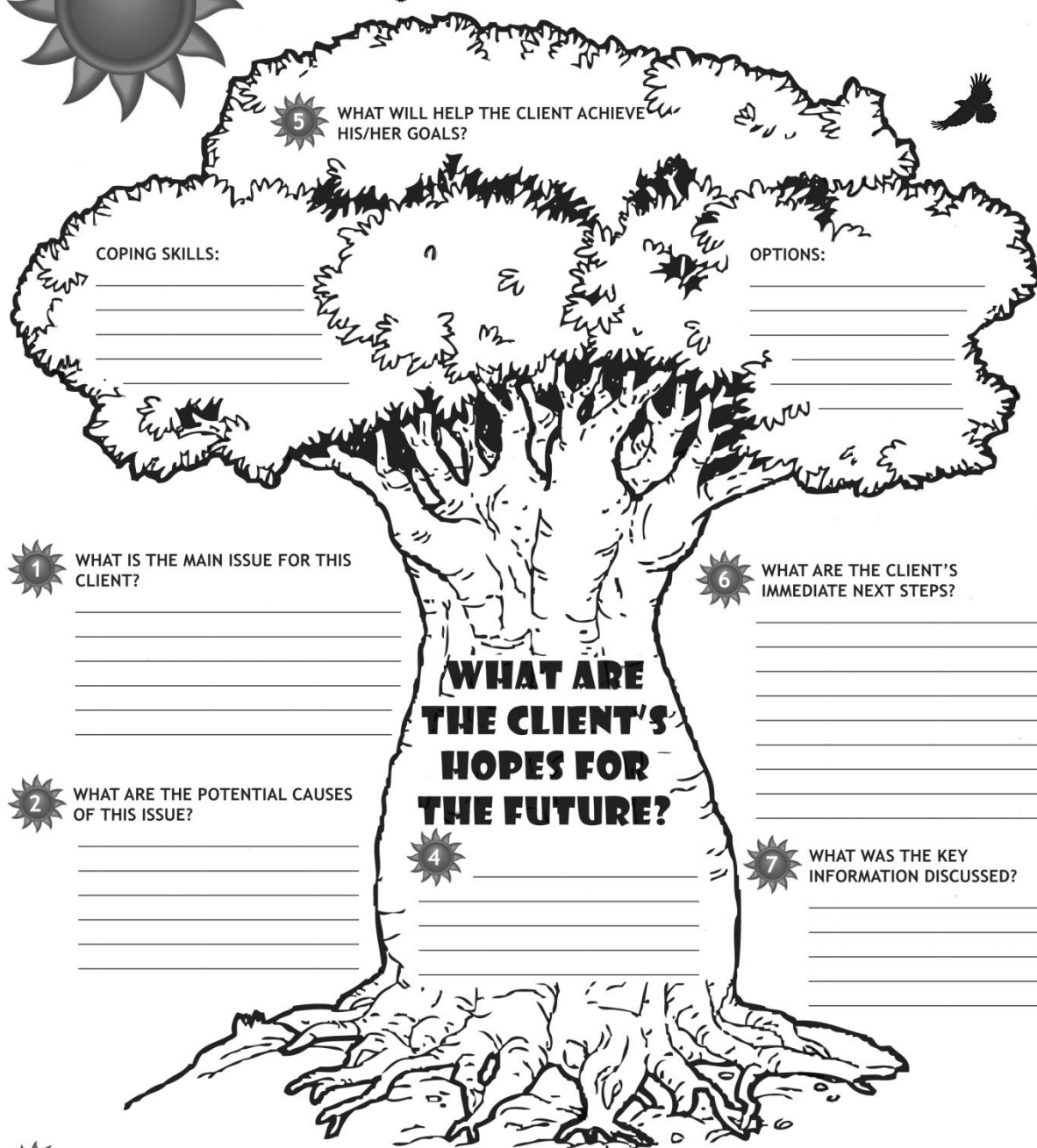
Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue they are experiencing—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” such as inner strengths, talents, skills, and spiritual resources to help in coping.
6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

TALKING TREE



DATE: _____
 CLIENT NAME: _____
 PEER EDUCATOR NAME: _____
 NAME OF CLINIC: _____



5 WHAT WILL HELP THE CLIENT ACHIEVE HIS/HER GOALS?

COPING SKILLS:

OPTIONS:

1 WHAT IS THE MAIN ISSUE FOR THIS CLIENT?

6 WHAT ARE THE CLIENT'S IMMEDIATE NEXT STEPS?

2 WHAT ARE THE POTENTIAL CAUSES OF THIS ISSUE?

4 _____

7 WHAT WAS THE KEY INFORMATION DISCUSSED?

3 WHAT SUPPORT DOES THE CLIENT HAVE?

FAMILY:

PEERS:

COMMUNITY:

APPENDIX 4C: Communication Skills Checklist

		Counseling and Communication Skills		
	Skill	Specific Strategies, Statements, Behaviors	(√)	
Establishing the Relationship	Skill 1: Use helpful non-verbal communication	• Make eye contact.		
		• Face the person (sit next to her or him) and be relaxed and open with posture.		
		• Use good body language (nod, lean forward, etc.).		
		• Smile.		
		• Do not look at your watch, the clock or anything other than the client.		
		• Do not write during the session.		
Understanding the Client's Needs	Skill 2: Actively listen and show interest in your client	• Nod and smile. Use encouraging responses (such as “yes,” “okay” and “mmm hmm”).		
		• Use a calm tone of voice.		
		• Allow the client to express emotions.		
		• Do not interrupt.		
		• Other (specify)		
	Skill 3: Ask open-ended questions	• Use open-ended questions to get more information.		
		• Ask questions that show interest, care, and concern.		
		• Ask questions to clearly understand the client's problems		
		• Other (specify)		
	Skill 4: Reflect back what your client is saying	• Reflect emotional responses back to the client.		
		• Other (specify)		
	Skill 5: Show empathy, not sympathy	• Demonstrate empathy: show an understanding of how the person feels.		
		• Avoid sympathy.		
		• Other (specify)		
Skill 6: Avoid judging words	• Avoid judging words such as “good,” “bad,” “correct,” “proper,” “right,” “wrong,” etc.			
	• Use words that build confidence and give support (e.g., recognize and praise what a client is doing right).			
	• Other (specify)			
Creating an Action Plan and Ending the Session	Skill 7: Help your client set goals and summarize each session	• Work with the client to come up with realistic “next steps”		
		• Summarize the main points of the Peer Education session.		
		• Other (specify)		

Note: This checklist was adapted from: WHO & CDC. (2008). *Prevention of mother-to-child transmission of HIV generic training package: Trainer manual.*

MODULE 5: Comprehensive HIV Care and ART



DURATION: 270 minutes (4 hours, 30 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Define comprehensive HIV care for ALHIV
- Describe the key components of comprehensive HIV care for ALHIV and the importance of each
- Discuss some common medical problems for ALHIV, including opportunistic infections (OIs), and ways to prevent them
- Describe the goals and benefits of ART
- Explain who needs ART and when someone should start ART
- List some of the common ART regimens and side effects of ARVs
- Discuss internal and external referrals



CONTENT:

Session 5.1: Introduction: What is Comprehensive HIV Care?

Session 5.2: Prevention and Treatment of Illnesses Common Among ALHIV

Session 5.3: Understanding ART: Who, What, When, Why, and How?

Session 5.4: The Importance of Referrals in Comprehensive HIV Care

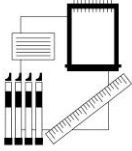
Session 5.5: Classroom Practicum on Comprehensive HIV Care and Treatment

Session 5.6: Module Summary



METHODOLOGIES:

- Game
- Large group discussion
- Interactive trainer presentation
- Small group work
- Case studies



MATERIALS NEEDED:

- Ball
- Flip chart
- Markers
- Tape or Bostik
- Samples of the commonly-used ARVs and cotrimoxazole for participant activities in *Sessions 5.2* and *5.3*
- Copies of Talking Tree (*Appendix 5A*)



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- Check the national ART guidelines and make sure all trainers are familiar with the clinical and laboratory monitoring schedules for ALHIV.
- Invite a pharmacist to participate in *Session 5.3*.
- Prepare cards for *Session 5.4*.
- Collect all referral forms used within hospitals and health centers where Peer Educators will be working and make copies for each participant.
- Make copies of the Talking Tree (*Appendix 5A*) for each participant.
- Review the case studies for *Session 5.5* and adapt to the local context as needed.



SESSION 5.1: Introduction: What is Comprehensive HIV Care? (45 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Game

- Step 1:** Review the Module learning objectives.
- Step 2:** Explain to participants that all ALHIV need to be enrolled in HIV care, whether or not they are taking ART. Ask all participants to stand up and form a circle. Ask participants to think about what kinds of care they receive at the hospital, primary health clinic, health center, or in the community. Start by holding the ball and saying one component of comprehensive HIV care out loud. Throw the ball to one of the participants, who should then state another component of comprehensive HIV care. Continue on until participants have listed most of the components of comprehensive care. Fill in, as needed, using the content below.
- Step 3:** Ask participants:
- *Why are all HIV care services for young people just as important as ART?*
- Step 4:** Explain the difference between HIV care and treatment using the content below, emphasizing that all ALHIV should be given care services (prevention and treatment of medical problems, adherence support, psychological and nutritional support, positive living support, etc.), but not all people in care need to be on ART. Briefly cover the goals of comprehensive HIV care as well as the importance of one-stop shopping for ALHIV and family-focused care.
- Step 5:** Next ask participants to think about how often ALHIV need to come to the clinic. Using the blank chart in the content below, lead an exercise where participants collaboratively fill in the information for the different groups—ALHIV who are not eligible for ART, ALHIV starting ART, ALHIV who have been on ART for 3 months or less, and ALHIV who have been stable on ART for more than 3 months. Use the following questions to guide the exercise, asking participants to draw on their own experiences:
- *How often should ALHIV in each category come to the clinic?*
 - *What happens at these visits?*
 - *What happens at the lab during each type of visit?*
- Step 6:** Next, lead a group discussion using the following questions as a guide:
- *What are some of the consequences of not coming to the clinic for regular care?*
 - *What motivates people who are feeling healthy and/or who are not on ART to come back to the clinic for regular care services?*

- *How can Peer Educators help people understand how important it is to come back to the clinic often for care, even if they are healthy and not on ART?*

Step 7: Remind participants that comprehensive care also includes families, partners, friends, and other community members, so it is important to ask about them at every visit!

Step 8: Lastly, remind participants that Peer Educators play a big part in motivating youth to enroll in and STAY in HIV care services for life, even if they are feeling healthy and not on ART.

KEY INFORMATION

Comprehensive care for ALHIV includes:

- Provision of ART, including adherence monitoring and support
- Prevention, diagnosis, and treatment of opportunistic infections (OIs) and other illnesses, such as tuberculosis
- Treatment for diarrhea and malaria
- PMTCT and antenatal care
- Sexual and reproductive health care
- Positive living and positive prevention counseling
- Psychosocial assessment, counseling, and support, including for disclosure
- Nutritional counseling and support
- Ongoing monitoring of health status through lab tests and physical exams
- Immunizations
- Informational materials on HIV, prevention, treatment, adherence, positive living, and legal rights
- Effective referral systems with follow-up, including linkages with family, community, NGO, and youth services (e.g. education, material support, food, income-generation activities), as well as legal services
- Services to support the transition to adult care
- Education, care, and support for family members/caregivers/parents (discussed throughout this curriculum, see pediatric guidelines for more information)

There is a lot people with HIV can do to stay healthy (care), even if they are not on ART (treatment). As part of their care, all ALHIV should come to the clinic for regular checkups, tests, counseling, and medicines to help prevent medical problems, including OIs, and to stay healthy.

Also, if people come back to the clinic regularly for CD4 testing and checkups, they can start ART right away if they become eligible. In some places, people think that ART is only for very sick and dying people, but this is not true. **Starting ART as soon as possible once eligible lowers the chances that a person will become very sick and die.**

All ALHIV need care, and many ALHIV (but not all) also need treatment with ART.

Once a person tests positive for HIV, he or she should be enrolled in the care program at the hospital or clinic and should also be linked to needed community resources. Over time, the

person will probably also need to be enrolled in treatment, which should begin as soon as possible once he or she is eligible.

The goals of comprehensive HIV care are to:

- Reduce HIV-related illness and death among ALHIV
- Improve the health and quality of life of ALHIV
- Improve the lives of families and communities affected by HIV
- Prevent further spread of HIV

The Importance of One-Stop Shopping for ALHIV

- Offering all of the services ALHIV need together under one roof (sometimes called “one-stop shopping”) and making sure that services are youth-friendly will increase adolescent clients’ ability to access and benefit fully from these services over time.

The Importance of Family-focused Care

Family-focused care means that all members of the multidisciplinary care team, including Peer Educators, think about the needs of all family members (not just those of the adolescent client). It also means thinking about the connections between the individual client, their family, and the community as a whole. Peer Educators should make it a normal practice to ask clients about their family members, other household members, close ties or friends, and partners. They should also encourage clients to bring these people to the clinic for services if needed.



We should make sure all young people feel comfortable and welcomed at the clinic. The clinic should be a safe place for young people to get services, to “hang out,” and to meet other young people.

Clinical and Laboratory Monitoring Schedule for ALHIV (fill in as a group, according to your national guidelines)

	How often should these ALHIV come to the clinic?	What will the nurse or doctor do at these visits?	What lab tests will ALHIV need at these visits?	What other services will ALHIV need? (counseling, adherence support, medicine pick up, etc.)
ALHIV not eligible for ART				
ALHIV starting ART				
ALHIV - first 3 months on ART				
ALHIV stable on ART (more than 3 months)				

ALL ALHIV need lifelong HIV care! Peer Educators play a big part in motivating youth to enroll in and STAY in HIV care services, even if they are feeling healthy and not on ART. Remember that comprehensive care includes families, partners, friends, and other community members, so it is important for Peer Educators to ask about them at every visit!



SESSION 5.2: Prevention and Treatment of Illnesses Common Among ALHIV (45 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Game

- Step 1:** Ask participants what they know about common illnesses and problems that ALHIV may experience and how they can be prevented and/or treated. If participants feel comfortable, ask them to share their own stories. Review the definition of opportunistic infections (OIs).
- Step 2:** Review common illnesses experienced by ALHIV and their symptoms, using the content below. Encourage participants to share their own experiences preventing and/or treating each of the illnesses as you go along.
- Step 3:** Facilitate a discussion about the importance of cotrimoxazole (CTX) and its role in preventing some of these infections. Ask participants the following questions (and, if available, pass CTX around the room):
- *Who takes cotrimoxazole?*
 - *Why is cotrimoxazole important for ALHIV?*
 - *Why is adherence to cotrimoxazole an important part of HIV care?*
- Step 4:** Ask for 6 volunteers to come to the front of the room. Organize a game, assigning each volunteer one of the illnesses or problems from the list below (e.g. TB, thrush, diarrhea). Give each volunteer the pre-prepared card that matches his or her assigned illness. Then ask volunteers to take turns acting out how their infection affects the body or to speak as if they were that infection (for example, *“I’m the infection that makes people cough a lot and have a fever. It is easy to pass me from one person to the next, especially when in a closed room.”*). After each turn, ask the other participants to guess which infection or medical problem the person represents (in this case, TB) and then lead a discussion about ways it can be prevented and treated.
- Step 5:** Debrief by explaining that one of a Peer Educator’s important responsibilities is providing ALHIV with basic information about how to prevent and treat the common medical problems they may experience. Peer Educators can play a big role in helping ALHIV seek immediate care for these issues!

KEY INFORMATION

ALHIV may experience a number of illnesses and problems, especially if they are not on ART or if they have adherence challenges. Peer Educators can help ALHIV understand, prevent, and seek treatment for these illnesses.

Opportunistic infections:

- Opportunistic infections, or OIs, are the infections that make ALHIV sick because their body's immune systems are weakened and cannot fight back. ALHIV, especially people not on ART, can get many OIs.

Some illnesses, problems, complications, and symptoms common among ALHIV (Peer Educators should always talk with the health providers if any of their peers have these kinds of problems):

LUNG PROBLEMS

Tuberculosis (TB) is the most common OI among PLHIV, usually affecting the lungs. Adolescents are very susceptible to TB because they are growing quickly.

Signs and symptoms:	Cough, fever, weight loss, night sweats
Prevention:	Cover mouth with a tissue or handkerchief when coughing or sneezing, keep windows open, and try to keep younger adolescents and children away from people with active TB. In some countries, doctors give preventative medicines to adults or young children who have been exposed to someone with active TB.
Treatment:	Usually 6-9 months of daily medicine

Pneumonia is a serious lung infection that often affects PLHIV. There are many kinds of pneumonia, but bacterial pneumonia and PCP (*Pneumocystis jiroveci* pneumonia) are the most common among PLHIV.

Signs and symptoms:	Coughing, weakness, and shortness of breath. PCP comes on slowly whereas bacterial pneumonia comes on suddenly. Bacterial pneumonia is usually not as serious or life-threatening as PCP.
Prevention:	Take cotrimoxazole (CTX) and wash hands with soap before eating and after using the toilet.
Treatment:	A doctor will prescribe antibiotics and sometimes oxygen.

MOUTH PROBLEMS

Sores or pain in and around the mouth may be caused by thrush, herpes, malnutrition, Kaposi's sarcoma (a form of cancer), or dental problems.

Signs and symptoms:	Pain in or around the mouth, white patches (thrush), blisters, sores, cracks, dark spots, infected gums, loose teeth
Prevention:	Brush teeth, tongue, and inside of mouth at least 2 times per day, rinse the mouth with warm salt water. ART will usually prevent thrush and other mouth problems by keeping the immune system strong.
Treatment:	Rinse the mouth with salt water, lemon juice, or gentian violet solution (dark blue crystals). Doctors may prescribe antifungals, antibiotics, or antivirals.

SKIN PROBLEMS

Skin problems may be due to thrush, warts, bacterial infections, shingles, allergies, pressure sores, Kaposi's sarcoma (a form of cancer), or many other causes.

Signs and symptoms:	Rash, itchy skin, sores, very dry skin, boils or abscesses, pain (in the case of Kaposi's sarcoma, purple spots on the skin and swelling of the face, genitals, and limbs)
Prevention:	Keep the skin clean and dry, wash with soap and water, try not to scratch, cool the skin with clean water, massage pressure areas, and, for bedridden patients, change positions often.
Treatment:	Use calamine lotion to soothe itching, use gentian violet solution to help clean the skin, use hydrogen peroxide to clean wounds and sores, use safe local remedies. Doctors may prescribe antibiotics or other medicine.

GENITAL PROBLEMS

Most genital problems are the result of sexually transmitted infections (STIs). Common STIs, including chlamydia and gonorrhea, will be discussed in more detail in *Module 10*.

Signs and symptoms:	Sores or rash in the genital or anal areas, unusual discharge from the penis or vagina, pain during urination. Sometimes there are no symptoms, especially in women.
Prevention:	Practice safer sex, use condoms, avoid sex if you or your partner have an STI
Treatment:	The doctor may prescribe antibiotics, depending on the type of STI. Do not have sex while treating an STI, take all medicines, and have all partners treated as well.

GASTRO-INTESTINAL PROBLEMS

PLHIV may experience diarrhea frequently, which can lead to dehydration and weight loss.

Signs and symptoms:	Frequent loose, watery stools, stomach cramps, stomach pain, fever, bleeding, lightheadedness or dizziness from dehydration, poor growth, weight loss
Prevention:	Wash hands with soap (especially before eating and after using the toilet); use only safe, clean, boiled water for drinking and cooking; avoid eating undercooked meat, fish, and eggs; only use pasteurized milk products
Treatment:	Drink a lot of clear fluids, eat soft foods that are not spicy or greasy, increase food intake. Doctors may prescribe medicine if the diarrhea continues for a long time.

LIVER PROBLEMS

Hepatitis B virus infection is a serious liver infection that can lead to liver dysfunction, liver cancer, and death. It is spread through unsafe sex, through sharing contaminated needles, and from mothers to their babies.

Signs and symptoms:	Some people have no symptoms while others may feel tired; may have belly pain, nausea, vomiting, fever, joint pain, jaundice (yellow skin and yellow eyes); or may vomit blood.
Prevention:	Use of the Hepatitis B vaccine; practice safer sex; avoid using contaminated needles; avoid body piercing and tattoos
Treatment:	Doctors may prescribe medicines to treat Hepatitis B infection (some of the same medicines used to treat HIV are also used to treat Hepatitis B).

Note: There are other types of Hepatitis, including Hepatitis A and Hepatitis C. Hepatitis C is often associated with intravenous drug use and can cause serious, chronic liver disease. Hepatitis A is usually less serious and resolves on its own.

BRAIN PROBLEMS

Encephalopathy and central nervous system disease – HIV can affect the brain, resulting in problems with brain function (memory, learning, understanding) as well as motor function (walking, moving, etc). Encephalopathy, a severe form of brain disease, is common in young children with perinatal HIV infection who do not get treatment.

Signs and symptoms:	Depending on the type of brain disease, common symptoms are loss of memory; problems with learning, motor skills; and concentration; and depression.
Prevention:	Taking ART
Treatment:	Doctors will provide specific instructions for care, treatment, and rehabilitation, such as physical or occupational therapy.

CANCERS

Lymphoma - Cancer of the lymphatic system can affect PLHIV. The lymphatic system helps defend the body against germs like viruses, bacteria, and fungi that can cause illnesses.

Kaposi sarcoma (KS)(see skin problems) – Cancerous lesions (sores, spots) on the skin and/or organs caused by blood vessels growing incorrectly.

Signs and symptoms:	Kaposi sarcoma usually looks like pink or purple painless spots on the surface of the skin or in the mouth. It can also appear in the intestines, lymph nodes, and lungs, and can attack the eyes. Lymphoma usually causes swollen glands and tumors in the chest or abdomen.
Prevention:	Taking ART
Treatment:	Doctors will provide specific instructions for care and treatment.

Cervical cancer is a common cancer in women, and especially females living with HIV. It usually develops very slowly. Almost all cervical cancers are caused by HPV (human papilloma virus). HPV is a common virus that is spread through sexual intercourse. It starts as a precancerous condition that can be detected by a Pap smear and is 100% treatable. This is why it is so important for young women to get regular Pap smears or other special tests that may be available.

Signs and symptoms: Most of the time, early cervical cancer has no symptoms. Symptoms that may occur include: abnormal vaginal bleeding between periods or after intercourse, unusual vaginal discharge, or heavier periods that last longer than usual.

Prevention: Routine screening for sexually active females can identify those with pre-cancerous cells so that they can be treated and monitored before more serious disease develops. A vaccine to prevent cervical cancer is now available in some places. Using condoms also reduces a person's risk of HPV and other sexually transmitted diseases.

Treatment: The doctor may prescribe treatment and may surgically remove the cancer. There is a vaccine to prevent HPV infection, but it is not yet widely available.

Cotrimoxazole (CTX)

Cotrimoxazole, sometimes shortened to CTX, is an antibiotic medicine (not an ARV) important in the care of ALHIV:

- If taken the right way, every day, CTX can help prevent many dangerous and life-threatening infections among ALHIV, including pneumonia and many others.
- When a person takes medicines to prevent infections from happening in the first place, we call this prophylaxis. Peer Educators may hear the phrase CTX prophylaxis in the clinic.
- Some adolescents who are not yet taking ART need to take CTX every day. Health care workers will decide based on the adolescent's CD4 count and the stage of his or her illness.
- ALL adolescents who are taking ART should also be taking CTX every day.
- It is very important that adolescents taking CTX adhere to this medicine because it will help prevent illnesses and infections and will help them stay healthy.
- Peer Educators can remind clients about why it is so important to take CTX every day, can make sure clients know it is safe, and can help support clients' adherence to CTX over time.

There is a lot Peer Educators can do to help ALHIV understand, prevent, and seek immediate care and treatment for illnesses and other problems. Remember: safer sex; good adherence to care, CTX, and ART; and getting vaccinations help prevent a lot of these illnesses from happening in the first place!



SESSION 5.3: Understanding ART: Who, What, When, Why, and How? (75 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Small Group Work

Note: In preparation for this Session, make sure you know which ARVs are available in the country as well as the first-line ART regimens for ALHIV. Adapt the content below based on your national guidelines. It is recommended that a pharmacist (and any other health care workers that are available) be invited to this part of the training to serve as co-trainer and resource person.

- Step 1:** Ask if any of the participants remember how HIV affects the body (discussed in *Module 3*). For example, ask what HIV does to the CD4 cells. If needed, review information from *Module 3* on how HIV affects the body. Lead a discussion using the content below on how ART works in the body and why it is necessary to take a combination of ARVs to fight HIV. Also discuss the goals and benefits of ART. Keep the explanations as simple as possible to make sure all participants understand.
- Step 2:** Write “ARVs” on one flip chart paper and “ART” on another. Ask participants to brainstorm how to define each term as well as what the difference is between the two terms. Fill in as needed using the content below. Tell participants that there are only a few circumstances when a person would be given only 1 or 2 ARVs instead of 3 or more ARVs at the same time.
- Step 3:** Ask participants who are taking ART to talk about when they started treatment. Acknowledge that some youth are perinatally infected and therefore they may have been on ARVs since early childhood. These youth may not remember when they started taking ARVs or all of the names of the ARVs they have taken. Guide the discussion with these questions:
- *How did you (or your caregiver) know you were ready to start ART?*
 - *How did you (or your caregiver) get ready to start taking ARVs? What did/did not make you feel ready?*
 - *What are some of the issues we can help people (ALHIV, caregivers, etc.) think about to make sure they are ready and able to take medicines every day for their whole life?*
- Fill in using the content below.
- Step 4:** Ask participants to brainstorm all of the ARV names they have ever heard of. Review the first line regimens applicable to your country, using the chart below and co-facilitating with a pharmacist if possible. Ask participants the following questions to facilitate discussion and pass around samples of commonly-used ARVs to the large group.

- *What is important for any person taking ART to know about his or her medicines (e.g., name, dose, timing, whether to take with or without food, possible side effects, etc.)?*
- *What are the similarities and differences between ARVs for adults, for children, and for adolescents (remind participants that ARV doses for children change and are based on weight, but once an adolescent reaches a certain size, weight, or age, they take the same ARV doses as adults)?*
- *Why may it be hard for a client to have to switch to a different ARV brand?*

Step 5: Explain that ARVs are strong medicines. Many adults and children will have some kind of side effects when they start taking a new ARV. Most of the time side effects are not severe and will go away with time, as the body gets used to the medicines. However, some side effects can be dangerous and the person should go see a doctor right away. Also, some side effects can last a long time. Ask participants who take ART what kinds of side effects they have had. Use the following questions to guide the discussion and fill in using the content below:

- *Have you had any side effects?*
- *What side effects have you had?*
- *How long did the side effect(s) last?*
- *What did you do to manage the side effect(s)?*
- *Which side effects/signs do you think might be dangerous and mean you have to call or go to the doctor or nurse right away?*
- Remind participants that Peer Educators play an important role in helping clients prepare for, prevent, and manage side effects. It is very important that people with dangerous side effects call their doctor or come to the clinic right away. It is also important that they never stop taking their ARVs without first talking with their doctor or nurse.

Step 6: Break participants into small groups and tell them that they have been hired by the district to do a special, youth-friendly public health campaign about ART. Assign each group a common first line ART regimen based on national guidelines. Groups can be assigned the same regimen if necessary. Ask each group to create a public radio announcement or health poster for ALHIV that includes:

- *goals and benefits of ART*
- *the common names of the ARVs in the regimen (and any other names the medicine is called – e.g., brand and generic names, abbreviated names, etc.)*
- *how often the medicines are taken (e.g., once per day, twice per day, etc.)*
- *some possible side effects of the medicines, using participants’ own experiences with the medicines when possible*
- *an adherence message*
- *other important messages about ARVs*

After about 25 minutes, bring the large group together again and ask each of the small groups to present their “campaign material.”

Step 7: Debrief by summarizing the main messages about ARVs, including the importance of adherence for life, using content below.

KEY INFORMATION

When on ART, we take a combination of 3 or more ARVs from at least 2 different classes of drugs. This is because each medicine does something different in the body. There are different ARV medicines that:

- Prevent HIV from entering the CD4 cells
- Prevent HIV from growing inside the cells
- Prevent HIV from leaving the cell to infect other cells

How does ART work?

As we learned, HIV attacks the body's immune system and CD4 "guardian angel" cells. HIV goes into the CD4 cells and reproduces itself to make more of the virus.

When a person takes ART the right way, every day, for life, it helps CD4 cells fight against HIV and the virus does not attack as many cells. This means the person has more healthy CD4 cells that can help the body protect itself from infection.

Goals and benefits of ART:

- Keeps the person healthy by increasing the number of healthy CD4 cells
- Prevents HIV from reproducing in the person's CD4 cells
- Prevents HIV from leaving one cell and infecting other cells
- Prevents transmission of HIV from a mother to her baby
- Keeps the immune system strong so the body can prevent and fight infections
- Makes the person feel healthier and able to work, take care of self and family, and be an active member in the community

What is the difference between ARVs and ART?

Antiretrovirals (ARVs) are the drugs or medicines that people take to fight HIV. Antiretroviral therapy (ART) is the overall HIV treatment that is usually made up of a combination of 3 or more ARVs.

Who needs ART?

Not everyone who is living with HIV needs to start ART right away (except for, in most cases, infants and young children). Only the health care team together with the client can make the decision about when to start ART.

For ALHIV to start ART, they must have an HIV-positive test result and they must meet clinical and/or immunologic (CD4 cell) criteria. Check your national guidelines.

Client readiness for ART (check your national ART guidelines):

It is important that a client be ready to start taking ART. *Module 6* contains more on adherence preparation and support, but listed here are some of the key issues that should be addressed before a person starts ART. Remember, these are not all mandatory for a person to start ART, but are highly recommended to help the person be ready. Sometimes, when a person is very sick

or has a very low CD4 count, the most important thing is that he or she start treatment right away to prevent death.

It is important that a client:

- Wants ART and is committed to taking it correctly
- Has received pre-ART education and counseling (there is more on this in *Module 6*)
- Understands that ART is a lifelong commitment
- Understands possible side effects and how to manage them
- Has an adherence plan
- Has support to address any psychosocial barriers to adherence
- (*For younger adolescents*) Has a caregiver(s) who shows “readiness”—the caregiver(s) understands, accepts, and supports the child’s HIV care and treatment
- Will accept a phone call or home visit from a Peer Educator, community health worker, or health care provider if he or she misses an appointment at the clinic



Common ART regimens for adolescents (adapt to your national ART guidelines):

Common regimens	Drug name and dose		Timing	Possible side effects
AZT+3TC+NVP AZT+3TC+EFV TDF+3TC+NVP TDF+3TC+EFV TDF+FTC+NVP TDF+FTC+EFV d4T+3TC+NVP* d4T+3TC+EFV* *No longer recommended as first-line therapy, but still in use in many places	AZT (or ZDV)	zidovudine 300 mg	Twice daily or every 12 hours	Nausea, headache, vomiting, fatigue, anemia, muscle pain, weakness
	TDF	tenofovir 300 mg	Once daily	Nausea, vomiting, diarrhea, flatulence (gas), kidney problems
	3TC	lamivudine 150 mg	Twice daily or every 12 hours	Stomach pain, nausea, numbness or tingling in hands and feet, vomiting
	FTC	emtricitabine 200 mg	Once daily	Diarrhea, headache, nausea, rash
	NVP	nevirapine 200 mg	Once daily for 14 days, then twice daily or every 12 hours	Nausea, headache, vomiting, fever, rash. Rashes can be very serious—see a doctor right away.
	EFV	efavirenz 600 mg (400 mg if <40 kg)	Once daily (at night). Do not take with a high fat meal. Should not be taken during first trimester of pregnancy.	Rash, nausea, dizziness, diarrhea, headache, sleeplessness, bad dreams
	d4T (Note: d4T is being phased out in many places)	stavudine 30 mg if <60 kg 40 mg if >60 kg	Twice daily or every 12 hours	Changes in body shape, weight loss, fatigue, stomach pain, numbness in hands and feet. If person has numbness in hands or feet, should see a doctor.

Note: In the case of younger adolescents, dosing of ARVs depends on their weight and age.

Changing brands, shapes, sizes, and packaging

- Sometimes clients may have to switch brands of the same medicine, depending on what is available in the country.
- This can be hard for clients because the shape, size, packaging, and dosing of the medicine may change, even though they are still on the same regimen.
- Peer Educators should work with the pharmacist so they always know of any drug changes. This way they can help clients prepare for this change and make sure their adherence is kept up.

For some people, one of the hardest parts of starting ART can be managing the side effects of the different medicines.

- It is important for clients to know that starting ART is not an immediate cure for feeling bad. The medicines will help them feel much better over time, but sometimes not right away.
- The body needs time to adjust to any new medicine. Many side effects will go away after a few weeks of starting ART. It is important to be patient. During this time, clients still need to take their medicines the right way, every single day.
- There is a difference between minor side effects that will go away (where the client should keep taking the medicines) and more serious side effects that mean the person should see doctor or a nurse right away.
- Some minor side effects of ARVs can be nausea, vomiting, headaches, and diarrhea. These are usually not serious and will go away in a couple of weeks.
- A person should never make the decision alone to stop taking some or all of his or her medicines. He or she should only stop taking any medicines after speaking with health care workers at the ART clinic.
- If a client is having problems with taking ARVs, he or she should come to the clinic right away.
- A client should always be asked if he or she is having any side effects to the medicines and should always be ready to tell the doctor or nurse about them.

A side effect is a reaction in the body to a medicine – it can be good or bad, expected or unexpected.

Some important ARV side effects to know about

Rash and skin problems:

- May go away, but may be a bad reaction if taking NVP
- **Peer Educators can advise clients to:**
 - Keep skin clean and dry
 - Only use mild soaps
 - Drink a lot of clean, boiled water to keep skin healthy
 - See the doctor or nurse if the itching is severe; if the skin is peeling, looks infected (for example, has pus), is blistering, or has open sores; if the client has a fever; or if the rash is in the eyes or mouth
 - **If client is taking NVP and has any kind of rash, call or see the doctor or nurse right away**

Numbness or tingling feelings:

- Can be caused by taking d4T, ddI, other ARVs, TB medicines, or because of an infection. Can also be caused by diabetes or drinking too much.
- **Peer Educators can advise clients to:**
 - Wear loose socks and shoes to protect the feet
 - Check the feet to make sure there are no infections or open sores
 - Keep feet uncovered when in bed
 - Soak feet in warm water and massage them if this feels good
 - Keep feet up
 - Do not walk too much at one time and take breaks
 - Eat healthy foods and take multivitamins every day
 - Tell the doctor or nurse if numbness/tingling starts. There are some medicines that may be able to help.

Nausea and vomiting:

- Usually go away in 2-4 weeks
- **Peer Educators can advise clients to:**
 - Take medicines with food
 - Eat small meals more often
 - Eat crackers or dry bread
 - Chew on ginger or drink ginger tea
 - Stay away from fried, greasy, and fatty foods
 - Stay away from very spicy foods
 - Drink a lot of clean, boiled water, weak tea, or lemon water
 - Do not drink too much coffee or strong tea
 - Stop using traditional medicines that may be making things worse
 - **See the doctor or nurse if client has a fever, is vomiting excessively, cannot drink, has stomach pains, is dehydrated, or feels very confused**

Headaches:

- Usually go away in 2-4 weeks
- **Peer Educators can advise clients to:**
 - Rest in a quiet, dark room
 - Put a cold cloth over the face and eyes
 - Stay away from strong tea and coffee
 - Take paracetamol or aspirin
 - **See the doctor or nurse if client's headache does not go away with paracetamol or if he or she has a fever, vomiting, blurry vision, or convulsions**

Diarrhea:

- Usually goes away in 2-4 weeks
- **Peer Educators can advise clients to:**
 - Not stop eating or drinking
 - Eat small meals during the day
 - Eat soft foods like rice and bananas
 - Stay away from spicy, greasy, and fatty foods
 - Drink sips of clean, boiled water, weak tea, oral rehydration salts, or lemon water

- See the doctor or nurse if there is blood or mucous in the client’s diarrhea, if the client has a fever, if diarrhea occurs more than 4-5 times in a day, if diarrhea occurs for more than 5 days in a row, or if client loses more than 2 kg

Cannot sleep or has nightmares:

- Usually goes away in 2-4 weeks (most common with clients taking EFV)
- **Peer Educators can advise clients to:**
 - Take ARVs at bedtime
 - Avoid heavy meals before going to sleep
 - Avoid drugs or alcohol
 - Avoid foods or drinks with sugar or caffeine before going to sleep
 - Talk about feelings and worries with Peer Educators, friends, or family members
 - **See the doctor or nurse if client feels really depressed or wants to hurt him- or herself**

Tiredness:

- This is very common and can be caused by many things.
- **Peer Educators can advise clients to:**
 - Avoid alcohol and drugs
 - Do light physical activity, like taking a walk
 - Eat lots of fruits and vegetables and make sure to get enough iron
 - Take multivitamins
 - Try to get enough sleep at night and rest during the day if needed
 - **See the doctor or nurse if client has a drug or alcohol problem or feels really depressed**

Long-term side effects: Many of the side effects people have when starting ART will go away over time. However, there are some long-term side effects that Peer Educators should know about. These include:

- Changes in body shape, which is a long-term side effect that can be caused by ART (especially regimens with d4T). Some PLHIV may develop more fat on their stomach, breasts, or other areas and they may lose fat in their face, arms, and legs.
- A build-up of lactic acid in the body, which can cause weakness, nausea, and other symptoms
- Increased fat and sugar levels in the blood
- Changes to different organs in the body, but this is rare

Peer Educators can advise clients to:

- Eat well and exercise
- Discuss any changes in their bodies with the doctor or nurse (there may be medicines that can be given to limit these changes)
- Attend all of their clinic visits and get lab tests on schedule
- Continue taking the ARVs

Serious Side Effects that Require Immediate Care at a Health Facility

Advise the client to come to the clinic right away if he or she has:

- A red rash that is getting worse
- A rash in the eyes or mouth
- A severe headache with a stiff neck
- A high fever that will not come down
- Vomiting for more than 3 days
- Diarrhea 5 times or more in a day, diarrhea for more than 5 days, or diarrhea with blood in it
- Problems breathing
- Severe abdominal pain
- Dehydration or cannot drink
- Blurry vision
- Depression or thoughts of suicide
- A lot of confusion
- Seizures or convulsions

Main messages about ARVs for debriefing after participant activity:

- ARVs are drugs that control HIV.
- ARVs are not a cure for HIV infection or AIDS.
- ARVs make it possible for HIV positive people to live longer.
- ARVs have side effects that can be managed.
- Adherence to ARVs is very important. Never stop taking your ARVs—always go to the clinic first.
- ART is for life. Once you start taking it, you do not stop even if you feel better.
- Not everyone who is living with HIV needs to start ART right away (except for, in most cases, infants and children). Only the health care team together with the client can make the decision about when to start ART.
- There are a number of factors that determine whether a person starts ART. These include both medical factors (stage of disease and CD4 cell count) and non-medical factors (like their ability to understand and adhere to treatment). Clients (with the health care team) should take part in the decision to start ART.
- There are special kinds of ARVs for babies and children, and the dose is based on their weight. Children should not be given adult ARVs unless told to do so by a doctor.
- Peer Educators do not need to memorize every ARV medicine or ART regimen that exists, but they should be familiar with the names and instructions for the most common regimens.
- Knowing more about the drugs can help when speaking with the clinical staff, who may use drug names or abbreviations that clients do not understand.
- Peer Educators should talk with clients about the medicines they are taking, why they are taking the medicines, how often, and how they take each one.

Remember, clients should not stop taking their medicines if they have side effects! The decision to stop or change ARVs should be made by the client and a health care worker together.



SESSION 5.4: The Importance of Referrals in Comprehensive HIV Care (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Explain that no one person or organization can “fix a situation” and provide a client and his or her family with all of the needed comprehensive care and support services. That is why it is important to have a strong referral system in place. Lead a discussion on referrals using the content below. Using examples, explain the difference between internal and external referrals.
- Step 2:** Ask participants to think about a time they were referred to another service within the same health facility or a time when they were referred to another health facility.
- Ask 2-3 participants to volunteer to share a time when they were referred and they went to the other service successfully. What helped them go to the referral service?
- Then, ask 2-3 participants to volunteer to share a time when they did not go to the place where they were referred. Why didn't they go and what could have helped them go to the referral service?
- Step 3:** Explain that it is necessary for the entire multidisciplinary care team to understand how referrals are made and followed up. Pass out copies of the clinic's referral forms to participants. Briefly review these forms so that Peer Educators are familiar with the content and discuss the process and procedures for referrals in your facility.
- Step 4:** Ask participants what they think Peer Educators can do to make referrals easier for clients. Review the tips for successful referrals below, discussing each one individually.

KEY INFORMATION

Referring:

- No one person or organization can provide a person and his or her family with all of the needed comprehensive care and support services. That is why it is important to have a strong referral system in place.
- Making a referral means that you formally send a person and/or family members to another place in the hospital, another health facility, or another organization for services. There are two basic kinds of referrals:
 - **Internal referrals** are from one part of the health facility to another part of the same health facility (for example, from the VCT to the ART clinic or from the PMTCT unit to the ART clinic).

- **External referrals** are from the facility to a community organization or from a community organization to the health facility (for example, a Peer Educator refers a person to a ALHIV support group or a home-based care worker refers a client to the hospital to get a CD4 test).
- Peer Educators play an important role in both internal and external referrals.
- The **“referral network”** should include organizations and people in a defined geographical area that provide services and support needed by ALHIV, their caregivers, and their families.

Helping people get from place to place in the health facility:

People often need different services at the hospital or health facility on the same visit. This can be very overwhelming for people who are not familiar with where things are or how to get from place to place, especially if they are not feeling well or have to wait a long time at each place. A key role of the Peer Educator is to help people get from one place to another within the health facility as easily as possible.

Key steps to successful referrals:

- Talk with members of the multidisciplinary team about the referral system so everyone is clear on how referrals are made and followed-up. Depending on the health facility’s referral policy, certain groups of clients will be “priority referrals,” such as pregnant adolescents, adolescents initiating ART, etc.
- Make sure you know which days and which hours during the day different services are offered; where each service is at the hospital or clinic; and the fastest way to get there. It is helpful to walk around the facility alone first and then you will be able to better help clients.
- Make sure you know where people are being referred and why. What services do they need when they get there? For example, if someone is being referred to the lab, what tests does he/she need?
- It is best if there is a referral form where the doctor or nurse writes exactly why someone is being referred. Peer Educators should be familiar with any referral forms used at the health facility.
- Tell health care workers when you think a client needs to be referred. Peer Educators may have knowledge about clients’ social support needs that other members of the multidisciplinary team are not aware of.
- Peer Educators should help people understand why they are being referred and why it is important to get these services. People often do not understand why they have been referred and sometimes just leave. This is common with referrals from PMTCT services to ART services.
- If possible, walk with the person to the other part of the hospital or health center and make sure that he/she has a comfortable place to wait.
- Peer Educators should wait with the person at the referral point. This is a good time to provide education and support.
- To decrease waiting time, Peer Educators should tell staff that the client is waiting and talk with the doctor or nurse to try and get the person seen as soon as possible. This is especially important if the client is pregnant. One of the biggest reasons why people do not get care is because they do not want to wait a long time.
- If people need other services or need to get more referrals, stay with them until they leave the health facility. Continue to explain why each service is important and walk them from place to place.

SESSION 5.5: Classroom Practicum on Comprehensive HIV Care and Treatment (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

Step 1: Briefly review the different phases of the Peer Education session, the 7 essential communication skills, and other helpful tools introduced in *Module 4*, such as the Talking Tree (*Appendix 5A*). Ask participants what they remember about why setting goals and deciding with each client on “immediate next steps” about care and treatment is important. Remind the group that Peer Educators are there to help clients make care and treatment decisions based on options, information, and understanding. BUT, it is the client’s responsibility to act on the information once he or she clearly understands it.

Step 2: Read each case study out loud to the large group. Try and use the Talking Tree for at least 2 of the case studies to help decide what the client’s barriers to care and treatment are and how the Peer Educator can work with the client to come up with solutions. For each case study, lead a discussion about how to support the client and ask the following questions:

- *How can you help this client decide on his or her “next steps” about his or her HIV treatment and care (using the Talking Tree, if applicable)?*
- *What other issues do you think are important to consider in this situation (e.g. age of client, client’s mental readiness and understanding of ART, family support, etc.)?*
- *Do you think a referral might be necessary in this case? Why?*

Write responses on a flip chart.

Step 3: Remind the group that Peer Educators never act alone. They are part of the multidisciplinary care team and this team can give them ongoing support, supervision, and guidance. Creating a plan for HIV care and treatment is the responsibility of the client, the Peer Educator, and the entire team.

KEY INFORMATION

Phases of a Peer Education Session (review from *Module 4*)

There are 4 main stages or phases in the process of a counseling session:

1. Establishing the Relationship
2. Understanding the Client’s Needs
4. Creating an Action Plan
5. Ending the Session

There are 7 essential communication skills that Peer Educators should practice and use in their work (review from *Module 4*):

- Skill 1: Use helpful non-verbal communication.
- Skill 2: Actively listen and show interest in your client.
- Skill 3: Ask open-ended questions.
- Skill 4: Reflect back what your client is saying.
- Skill 5: Show empathy, not sympathy.
- Skill 6: Avoid judging words.
- Skill 7: Help your client set goals and summarize each Peer Education session.

Remember, when helping clients to set goals and to decide on “immediate next steps”:

- Peer Educators help the client by making sure that he or she is able to make care and treatment decisions based on options, information, and understanding.
- It is the client’s responsibility to act on the information once he or she clearly understands it.

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue they are experiencing—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” such as inner strengths, talents, skills, and spiritual resources to help in coping.

6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

Case Studies for discussion:

Case Study 1

L___ is an 18-year-old female who recently started ART. She complains that she is feeling very tired, has frequent headaches, and often feels nauseous. She thinks that her ARVs are making her sick and wants to stop taking them. She has come to you and the nurse for advice.

What would you say to L___?

Suggested responses for Talking Tree:

1. **Main issues for this client:** problems with possible side effects of ARVs; problems may affect her adherence; there may be another cause of the problems; client needs evaluation by health provider
2. **Cause of issue:** needs motivation and information to help her manage side effects
3. **Roots:** talk to client about who supports her with ART adherence in her life: partner, family members, treatment buddy, etc.; talk about benefits of treatment buddy if she does not have one
4. **Hope for future/goal:** maintain perfect adherence; take her medicines right way every day
5. **Branches/options/coping/potential solutions:** talk about how medicines will help her feel much better over time, but probably not right away because her body needs some time to adjust to any new medicine; many side effects will go away after a few weeks of starting ART so it is important to be patient; during this time, she still need to take their medicines the right way, every single day; talk about the benefits of peer support
6. **Next steps:** refer to a health provider for evaluation; make referral to ALHIV support group; make another appointment with Peer Educator for ongoing support around adherence
7. **Summarize main points:** referral to support group; referral to clinical team; review plan for ART adherence; remind client of next appointment; praise/encourage the client and acknowledge her challenges
8. **Review and discuss the client’s situation and “next steps” with the program supervisor or member of the multidisciplinary care team.**

Case Study 2

N___ is a 14-year-old who was diagnosed with HIV last year and who is eligible to start ART. N___ often misses her appointments at the clinic and when she does come, her aunt (who cares for her) does not usually come with her. N___ sometimes gets annoyed with you for asking so many questions and says she doesn’t like to share her business with everyone. She also says that she doesn’t like coming to the clinic because she is afraid that she will see someone she knows. And anyway, she says, she feels good and doesn’t need treatment.

What would you say to N___?

Suggested responses for Talking Tree:

1. **Main issues for this client:** client's acceptance and understanding of her HIV-status; her possible fear about confidentiality; her dislike of/feeling unsafe at the clinic; focus on building a relationship with the client/talk about her interests or school first to build trust
2. **Cause of issue:** client's lack of confidence in the clinic; she needs more information about the importance of ART in keeping her body healthy
3. **Roots:** talk with client about who supports her with ART adherence in her life: partner, family members, treatment buddy, etc.; talk about benefits of treatment buddy if she does not have one
4. **Hope for future/goal:** preparing for ART
5. **Branches/options/coping/potential solutions:** talk about how/when the client will engage in care and treatment; Peer Educator should talk about his or her own experiences with care and treatment, especially ART, if applicable
6. **Next steps:** planning for care and treatment; referral to Nurse/clinical team to talk about starting ART; make referral to ALHIV support group; come back to clinic to talk more with Peer Educator
7. **Summarize main points:** referral to support group; remind client of next appointment; offer support and acknowledge the difficulty of the situation; emphasize the importance of any partners knowing their status and being tested; talk again about confidentiality/privacy of information discussed
8. **Review and discuss the client's situation and "next steps" with the program supervisor or member of the multidisciplinary care team.**

Case Study 3

D___ is an 11 year old on ART who lives with a family member with TB. His mom brings him to the clinic because he has been coughing and has a fever. She tells you and the nurse that she is worried that he will catch TB.

What would you say to D___ and his mom?

Case Study 4

S___ is an 18 year old who is not yet eligible for ART. She tells you that she sees no point in coming back to the clinic because this is an ART clinic and she doesn't need ART.

What would you say to S___?

Remember that creating a plan for a client's HIV care and treatment is everyone's responsibility—the client, the Peer Educator, and the entire multidisciplinary team!





Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

Colton, T., Costa, C., Twyman, P., Westra, L., & Abrams E. (2009). *Comprehensive peer educator training curriculum, Trainer manual, Version 1.0*. New York: ICAP.

Community Media Trust. *Siyayinqoba Beat It! - HIV Prevention and Treatment Literacy Manual*. Retrieved from <http://www.beatit.co.za/treatment-information-download-workbooks/index>

WHO/UNICEF. (2008). *Global consultation on strengthening the health sector response to care, support, treatment and prevention for young people living with HIV*. Geneva, Switzerland: WHO/UNICEF.

SESSION 5.6: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

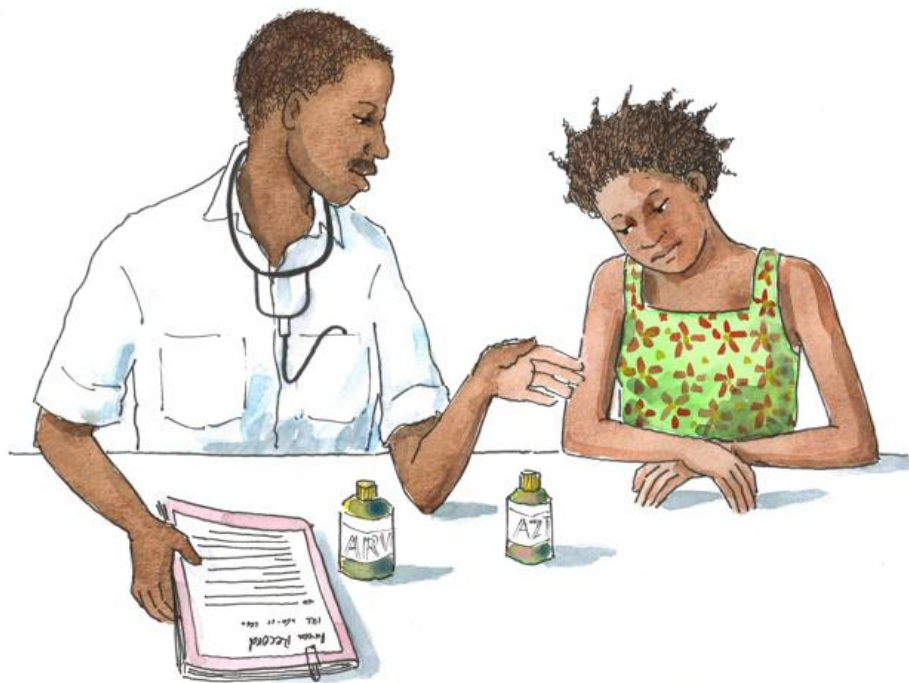
- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- All ALHIV should be enrolled in care!
- Peer Educators should counsel all ALHIV to enroll in care services at the clinic or hospital, even if they feel healthy and are not on ART.
- Important components of care that can help all ALHIV include: checkups by health care workers, preventing and treating OIs (especially by taking CTX), regular CD4 tests, counseling on positive living, nutrition, disclosure, and linkages to support groups.
- One of the most important parts of HIV clinical care is to get a CD4 test done at least every 6 months, whether the person is on ART or not.
- Coming back often for care means clients can be identified and started on treatment as soon as they are eligible, instead of waiting until they are very sick.
- OIs attack the body when the immune system is weak.
- One of the best things ALHIV can do to stay healthy is to prevent OIs and other complications by living positively, by taking certain medicines to prevent getting sick, and by going to see the nurse or doctor right away when something is wrong.
- Tuberculosis (TB) is the most common illnesses among PLHIV.
- ARVs are antiretroviral medicines used to fight HIV.
- ART means antiretroviral treatment, which is the overall HIV treatment and is usually made up of a combination of 3 or more ARVs.
- ART is a lifelong commitment, meaning people have to take the medicines every day at the same time of day for their entire lives—even if they feel good.
- ART is not a cure for AIDS, and HIV can still be spread when taking ART.

- Some people on ART have side effects that make them feel badly. Many side effects go away within a few weeks of starting ART or a new drug. It is important to be patient because it takes time to get used to all new medicines. Some side effects, like changes in body shape, are long-term and probably will not go away.
- Peer Educators play a key role in referring clients for services, in helping them understand why they are being referred, and in taking them to the referral point when possible.



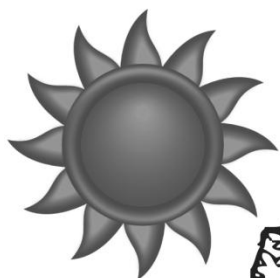
APPENDIX 5A: Talking Tree

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

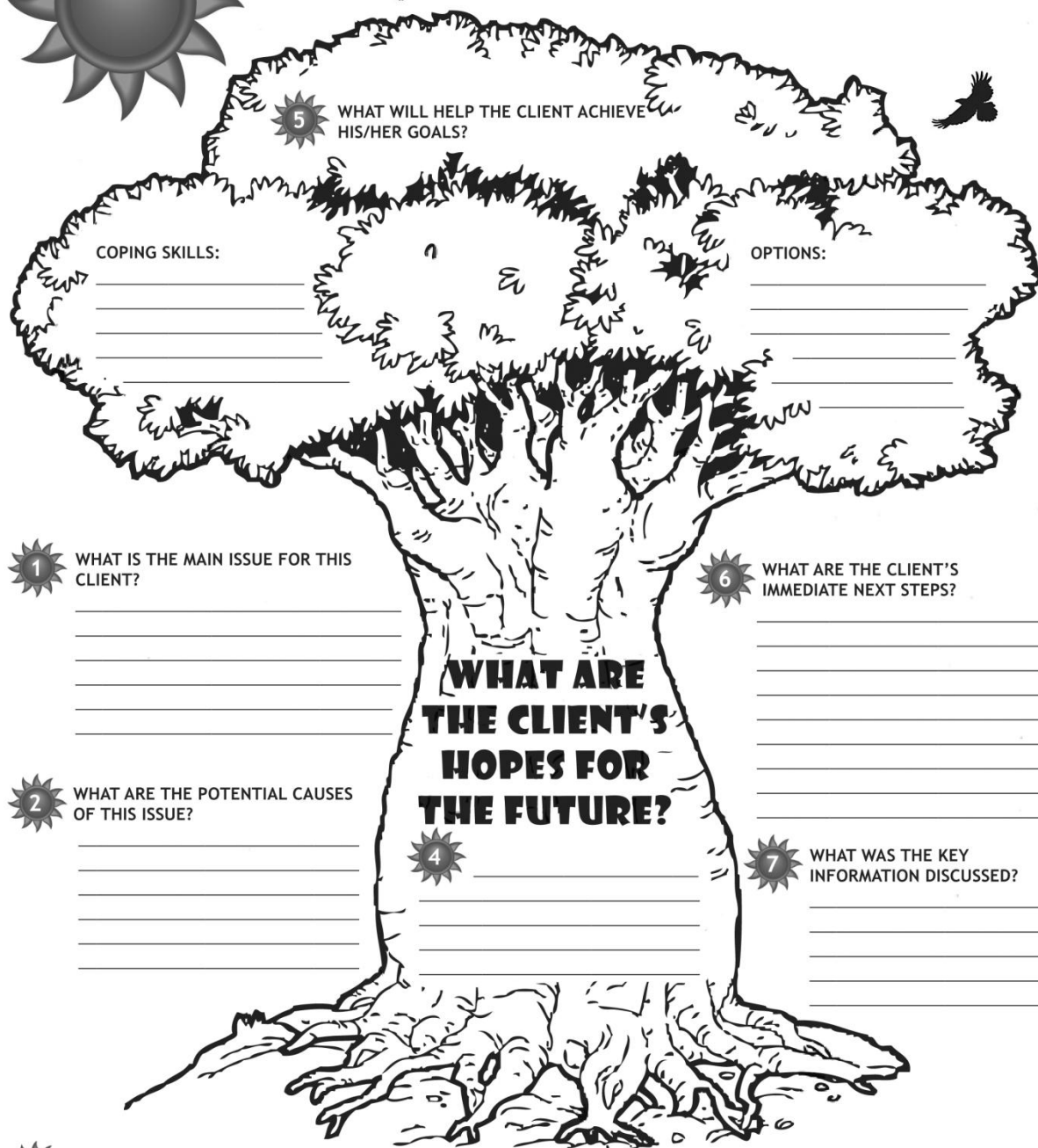
Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue they are experiencing—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” such as inner strengths, talents, skills, and spiritual resources to help in coping.
6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

TALKING TREE



DATE: _____
 CLIENT NAME: _____
 PEER EDUCATOR NAME: _____
 NAME OF CLINIC: _____



5 WHAT WILL HELP THE CLIENT ACHIEVE HIS/HER GOALS?

COPING SKILLS:

OPTIONS:

1 WHAT IS THE MAIN ISSUE FOR THIS CLIENT?

6 WHAT ARE THE CLIENT'S IMMEDIATE NEXT STEPS?

2 WHAT ARE THE POTENTIAL CAUSES OF THIS ISSUE?

4 WHAT ARE THE CLIENT'S HOPES FOR THE FUTURE?

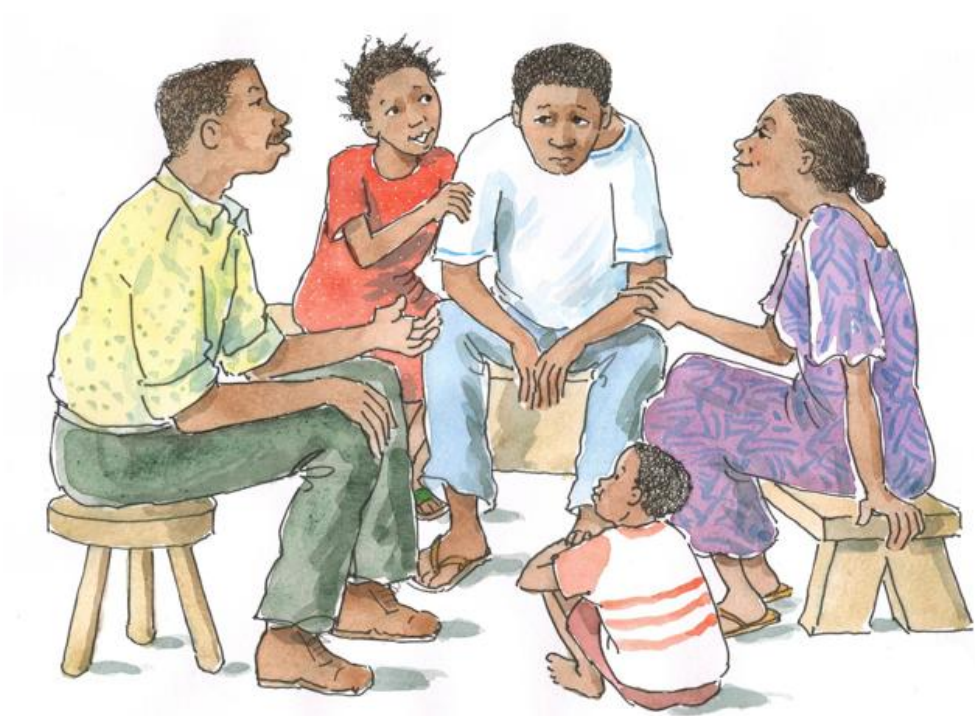
7 WHAT WAS THE KEY INFORMATION DISCUSSED?

3 WHAT SUPPORT DOES THE CLIENT HAVE?

FAMILY:

PEERS:

COMMUNITY:



MODULE 6: Supporting Adherence to HIV Care and Treatment



DURATION: 255 minutes (4 hours, 15 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Define retention, adherence to care, and adherence to medicines
- Discuss the importance of adherence in HIV prevention, care, and treatment programs for ALHIV
- Describe common factors affecting retention and adherence to care and medicines among ALHIV of different ages and developmental stages
- Provide basic adherence preparation support and education to ALHIV and caregivers
- Help ALHIV and caregivers come up with practical adherence strategies and solutions
- Provide ongoing follow-up adherence support to ALHIV and their caregivers



CONTENT:

Session 6.1: Introduction: What Do We Mean by Adherence and Why is it Important for ALHIV?

Session 6.2: Common Challenges to Retention and Adherence for ALHIV

Session 6.3: Helping ALHIV and Caregivers Prepare for and Adhere to ART

Session 6.4: Providing Ongoing Adherence Support to ALHIV

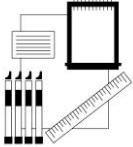
Session 6.5: Classroom Practicum on Adherence Support

Session 6.6: Module Summary



METHODOLOGIES:

- Interactive trainer presentation
 - Large group discussion
 - Small group work
 - Brainstorming
 - Case studies
 - Role play
-



MATERIALS NEEDED:

- Flip chart
 - Markers
 - Tape or Bostik
 - National pediatric and adult/adolescent ART guidelines (specifically any sections related to adherence preparation and support)
 - Commonly used adherence reminder tools (e.g., pill boxes, medicine calendars, etc.)
 - Copies of the Adherence Support Tree (*Appendix 6A*) and the Communication Skills Checklist (*Appendix 6B*) for each participant
-



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
 - Adapt the content to reflect the national ART (and adherence, if available) guidelines in your country (e.g., the number of group and one-on-one sessions suggested before a person starts ART).
 - Collect any tools used to help clients with adherence (e.g., pill boxes, medicine diaries, calendars, etc.).
 - Prepare enough copies of the Adherence Support Tree (*Appendix 6A*) and the Communication Skills Checklist (*Appendix 6B*) so that each participant has multiple copies.
 - Review the case studies for *Session 6.5* and adapt to the local context as needed.
-

SESSION 6.1: Introduction: What Do We Mean by Adherence and Why is it Important for ALHIV? (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Small Group Work

- Step 1:** Review the Module learning objectives.
- Step 2:** Write “RETENTION,” “ADHERENCE TO CARE,” and “ADHERENCE TO TREATMENT” on flip chart paper. Ask participants what is meant by these phrases and discuss. Write key points on the flip chart, filling in as needed from the content below.
- Step 3:** Ask 1-2 participants to volunteer to speak about why retention in care and adherence to care and treatment is so important to living positively with HIV. Ask another 2-3 participants to share more about what adherence means to them in their own lives.
- Step 4:** Write “NON-ADHERENCE” on a flip chart paper and ask participants to discuss what this phrase means. Write participants’ responses on the flip chart and fill in using the content below. Discuss the implications of non-adherence (such as becoming sick, drug resistance, and treatment failure). Explain that Peer Educators have a key role in communicating the negative effects of non-adherence to clients and caregivers and in helping them plan for and solve adherence challenges.
- Step 5:** Ask participants to turn to the person sitting next to them and to spend a few minutes discussing these questions:
- *Why is retention in care and adherence to care and treatment important for ALHIV?*
 - *What happens when a person does not adhere to his or her medicines?*
 - *What does it mean if HIV is resistant to ARVs and how does someone’s adherence affect this?*
- After a few minutes, bring the large group back together and ask participants to share some of their ideas. Write them on flip chart and fill in using the content below.
- Step 6:** Conclude the Session by reminding participants that adherence is very important but it is also difficult and it changes over time. This is why all clients (and their caregivers and treatment buddies) need:
- *Services and systems that support their retention in care*
 - *A lot of adherence support when starting HIV care and ART and ongoing over time*
 - *Education, preparation, and ongoing support for adherence challenges*

KEY INFORMATION

Retention:

- Retention refers to keeping (or “retaining”) clients in the care program. In this case, that means that all ALHIV continue with lifelong HIV care and treatment services. A goal of all HIV care and treatment programs is to retain clients in the full program of care.
- Retaining clients in care is the responsibility of the health care team. We need to do all that we can and set up services and systems that help retain young clients in care.

Definition of adherence:

The standard clinical definition of adherence has been when a person takes more than 95% of his or her medicines the right way, at the right time. Over time, this definition has been broadened to include more factors related to continuous care, such as following a care plan, attending scheduled clinic appointments, picking up medicines on time, and getting regular CD4 tests.

Adherence describes how faithfully a person sticks to and participates in his or her HIV prevention, care, and treatment plan.



Adherence:

- Includes active client (and caregiver) participation in the client’s care plan
- Includes adherence to both medicines and care
- Depends on a shared decision-making process between the client (and caregivers) and health care providers
- Determines the success of HIV prevention, care, and treatment programs
- Is not static—in other words, it changes over time, as ALHIV age and as they go through different developmental stages and life changes

Adherence to care includes:

- Starting and continuing on a lifelong care and treatment plan
- Going to appointments and tests as scheduled, such as regular CD4 tests
- Taking (or giving) medicines to prevent and treat opportunistic infection (OIs)
- Participating in ongoing education and counseling
- Picking up medicines when scheduled and before running out
- Recognizing when there is a problem or a change in health and coming to the clinic for care and support
- Living a healthy lifestyle and trying to avoid risky behaviors

Adherence to treatment includes:

- Taking (or giving) ARVs the right way, as prescribed, for the person’s whole life, even if the person feels healthy (“every pill, every day”)
- Taking (or giving) other medicines, such as CTX, as prescribed
- Not taking any “treatment breaks”
- Giving medicines to HIV-exposed and HIV-infected babies and children as prescribed

Non-adherence includes:

- Missing one or many appointments at the hospital or health center, lab, or pharmacy
- Not following the care plan
- Missing a dose or doses of medicine
- Sharing medicines with other people
- Stopping medicine for a day or many days, or taking a “treatment break” or “holiday”
- Taking medicines at the wrong times
- Taking medicines without following instructions about food or diet



Remember, no one is perfect. It is important not to judge clients (and caregivers) if they are non-adherent. Instead, we should try to understand why people do not adhere and help clients and caregivers find ways to start having good adherence again as soon as possible.

Why is near-perfect adherence to HIV care and treatment important?

- To make sure that ART and other medicines do their job
- To increase the CD4 cell count and decrease the amount of HIV in the body
- To make sure the virus does not become resistant to certain medicines
- To make sure people get all the benefits that medicines and ARVs have to offer, such as feeling better, not getting as sick, and not getting sick as often
- To prevent mother-to-child transmission of HIV
- To reduce the risk of spreading the virus to others
- To monitor people’s health and also to help them find community support resources
- To keep people looking and feeling good so they can get back to “normal” life, including going to school, working, socializing, and being an active family and community member
- To prevent sickness and death
- To keep children and adolescents growing and developing
- To keep families and communities healthy and productive

What happens when a person does not adhere to their medicines?

- The levels of drugs in the body go down and HIV keeps multiplying (making more of itself).
- The CD4 cell count will go down and the person will start getting more OIs.
- The person is more likely to pass HIV to an uninfected person.
- Children in particular will become ill very quickly. Many children living with HIV will die without ART.
- Children and adolescents may not grow or develop well.
- A mother is more likely to pass HIV to her child during pregnancy, delivery, or breastfeeding.
- The virus can develop resistance to one or all of the drugs, meaning that the drugs will not work anymore even if they are taken correctly again.
- The ARV combination the person was originally taking will not work anymore and the person may have to start taking a new regimen or second-line ARVs. But, there might not be many kinds of these ARVs available so poor adherence can decrease future treatment options.

DRUG RESISTANCE

- When the virus develops **drug resistance** to one or all of the ARVs he or she is taking, it means that the drugs have stopped working and will not work anymore, even if they the person takes them correctly again.
- Drug resistance is one of the main reasons why ART fails!
- HIV is a very “intelligent” virus—it only takes a couple of missed doses for it to become resistant and to learn how to be stronger than the ARVs, to multiply, and take over the body again.
- **NEVER STOP TAKING YOUR ARVS, UNLESS YOUR DOCTOR TELLS YOU TO!**

Adherence equals life!
Adherence to care and
medicines is essential for
ALHIV!



SESSION 6.2: Common Challenges to Retention and Adherence for ALHIV (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Small Group Work

Step 1: Ask participants to take out a sheet of paper and to write down the biggest challenge they have experienced with their own adherence to care. Now ask them to write down the biggest challenge they have experienced with their own adherence to medicines. Remind them that their challenges will be kept confidential. Collect the sheets of paper and read each out loud (without identifying who wrote each challenge).

Based on the challenges expressed by participants, lead a discussion on the many barriers and challenges to retention and adherence faced by PLHIV in general, and ALHIV and their families in particular. Use the content below as a guide, reminding participants that there are many factors that affect retention and adherence both positively and negatively. Remind participants that, as Peer Educators, their most important tasks are to provide ongoing adherence and psychosocial support to their clients and to be role models for good adherence!

Step 2: Ask participants to form 2 groups according to their age:

- *Non-adherence for 10-14 year olds*
- *Non-adherence for 15-19 year olds*

Give each group flip chart paper, markers, and tape or Bostik. Ask each group to write their corresponding statement in the middle of the paper. Give the groups about 20 minutes to think of and write down reasons for non-adherence in each age group, using different colors to note reasons related to:

- Us as young people
- Our families, communities, and culture
- Health services
- The medicines we take

Trainers should circulate and assist each small group.

Step 3: After about 20 minutes, ask each group to present their ideas to the larger group and facilitate discussion, filling in more “root causes” of non-adherence as needed from the content below.

Step 4: Debrief this activity by discussing these points:

- *We often blame clients for not adhering to treatment, but not having access to quality, youth-friendly health services is often one of the biggest barriers to adherence and long-term retention in care.*

- *While Peer Educators are not always able to address all of the root causes and barriers, there are many things that we can address and improve to support clients' adherence and psychosocial wellbeing in our work.*
- *Adherence support is not only the work of Peer Educators. The whole multidisciplinary care team must work together to provide these services to clients and their families.*

KEY INFORMATION

Some of the common factors affecting retention and adherence for adolescents

Things about individual people than can affect adherence:

- Some adolescents are going through a rebellious stage and want to define who they are. They may take more risks and probably have a desire to “fit in” with peers and to appear “normal.” All of these factors can have a negative effect on their adherence to care and medicines.
- Older adolescents may feel self-conscious about taking medicine.
- The level of stigma and discrimination from peers, family, and/or others in the community
- People naturally forget.
- A person may forget when drinking alcohol or using drugs.
- If a person has side effects (feels sick from the medicine)
- If a person runs out of tablets or forgets to go to the pharmacy at end of the month
- If a person has a hard time accepting his or her HIV-status
- How far along a person is in the disclosure process
- The level of family or social support (i.e. they may not have a treatment “buddy” or supporter)
- How sick or well a person feels
- If a person has to travel or migrate
- The amount of time spent away from home (like at school or at work)
- If a person has a mental illness (like depression)

Things about our families, communities, and culture that can affect adherence:

- Poverty
- If there is a lack of food
- The level of stigma and discrimination around HIV
- Younger adolescents may not have enough family support
- Caregivers' availability, health, and understanding of adherence
- Societal discomfort with youth and issues related to HIV (like sexuality)
- The level of disclosure and social support at home, at school, and in the community
- The level of peer support and disclosure to peers
- If there is no child care when a person has an appointment at the clinic (especially for youth-headed households)
- If a person can take time off from school or work to go to an appointment at the clinic
- Gender inequality: In some countries, women are less likely to have access to adequate nutrition to support their treatment, they may depend on men economically, they may sometimes be forced to share their treatment with their husbands, and it may be harder for them to travel to clinics to access treatment.

- Violence
- Forced migration
- Distrust of the clinic/hospital
- Use of traditional medicine
- Political instability or war
- Physical environment (for example, mountains, seasonal flooding, etc.)

Things about health services that can affect adherence and a client's long-term retention in care:

- Youth-friendliness of services/availability of youth-friendly services
- The level of confidentiality
- If there are drug stock-outs
- The distance to the clinic/transportation costs
- The convenience of clinic hours
- If there are patient record and tracking systems (and how well they work)
- The number and type of health care workers at the clinic or hospital
- The language(s) spoken by the health care workers
- The attitudes of the health care workers
- Waiting times
- The availability of space for private counseling
- The existence of linkages between different services
- The existence of referral systems
- The existence of linkages to social and material support in the community
- The existence of linkages to home-based care services
- The availability of support groups
- PLHIV involvement at the clinic or hospital, including ALHIV
- The cost of health services or medicines

Things about ARV medicines that can affect adherence:

- Side effects
- The number of pills in the regimen
- The timing of the doses
- Changing pediatric doses as the child grows and ages
- The availability of reminder tools, such as pill boxes, calendars, alarms, etc.
- The taste of the medicines
- Changes in drug supplier (the labeling, pill size, color, or formulation may change)



We often blame clients for not adhering to care and treatment, but not having access to quality, youth-friendly health services is often one of the biggest barriers to adherence. Also, Peer Educators must remember to be nonjudgmental and always be supportive when clients share their adherence challenges!

SESSION 6.3: Helping ALHIV and Caregivers Prepare for and Adhere to ART (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Brainstorming, Small Group Work, Case Studies, Role Play

Step 1: Remind participants that, as Peer Educators, they will be working with some ALHIV who have been taking ART for many years (some since they were babies), and others who will just be starting ART. Ask participants to discuss the following questions:

- *Can you remember when you started ART? What kind of education and support did you and/or your caregivers get at the clinic?*
- *What was good about the adherence preparation you got? What could have been better?*
- *What do you think Peer Educators can do to help ALHIV and their caregivers get ready to start ART?*

Step 2: Review the national guidelines related to adherence preparation of ALHIV starting ART. Explain that Peer Educators play an important role in helping clients and their families/caregivers get ready to start taking ART. Emphasize that, for most ALHIV, adherence preparation and readiness should not be a reason to delay starting ART. It is important to provide adherence preparation education and support, but most of all, to give ongoing adherence support to ALHIV and their caregivers at every clinic visit and over time. Ask participants:

- *What topics do you think should be talked about with ALHIV and caregivers during ART adherence preparation?*
- *What are some considerations for younger adolescents in terms of adherence readiness and preparation for ART?*
- *Based on your personal experience, what are some practical suggestions about adherence to medicines that Peer Educators can give to clients and caregivers? What helps you to remember your medicines and to come to the clinic for routine checkups?*

Fill in as needed using the content below. Highlight that each client should have AT LEAST 1 individual support session with a member of the multidisciplinary team before starting ART (this will also depend on national guidelines). Ideally, this session should also include a Peer Educator. If needed, clients should have more than 1 session.

Step 3: Explain that Peer Educators can use a helpful tool called the Adherence Support Tree to help clients and caregivers prepare for adherence to ART. Hand out copies of the Adherence Support Tree (*Appendix 6A*) to participants and review the instructions. Using this tool as a guide, the trainer should role play with 1

participant how to conduct an adherence support session. Explain that this form can also be adapted as needed to their specific Peer Education program.

Step 4: Ask participants to break into groups of 2 and assign each pair one of the case studies. One person should play the role of the Peer Educator and the other should play the role of the client. Give participants 15 minutes so the Peer Educators can practice helping their clients (and caregivers in some cases) prepare for ART by developing an adherence plan. They should use the Adherence Support Tree as a guide. Then, have participants switch roles and assign each another case study. Give them another 15 minutes to practice. The trainers should circulate around the room to observe and mentor participants. If time allows, ask some of the small groups to present to the larger group.

Step 5: Debrief by emphasizing that one of the most important contributions a Peer Educator can make when speaking to clients and caregivers about adherence is giving practical suggestions about strategies that helped them in their own lives. Remember, Peer Educators have a priceless tool: the wisdom of their own personal experience!

KEY INFORMATION

The importance of adherence preparation and support for clients and caregivers:

- Group education sessions are useful for giving many people key information at one time.
- However, ALHIV initiating care and treatment should also be given time to speak to a counselor, nurse, and/or Peer Educator alone and in private.
- At least one individual counseling session (more is better) should be provided to all clients (and caregivers) before they begin taking ART. A Peer Educator can assist the nurse or counselor during these sessions.
- This is a good time to see what the client (and caregiver) has absorbed from any group education sessions they have attended, and in which areas they need extra support.
- The Peer Education session should include working with the client (and caregiver or treatment buddy) to talk about any adherence challenges he or she may face and to make an adherence plan.

What is a treatment buddy?

A client about to start ART sometimes chooses a **treatment buddy** or **treatment supporter** to provide him or her with ongoing support for adherence to care and treatment.

A treatment buddy is usually a client's friend, family member, or another PLHIV who is also enrolled in care and is a trusted person to whom a client can disclose his or her status. Generally, a treatment buddy gets some basic education on HIV, adherence, and positive living, and can then give psychosocial and adherence support to the client throughout the course of his or her care. Having a treatment buddy provides a client with another key aspect of comprehensive care.

When helping adolescents and their caregivers prepare for adherence, always address the WHO, WHAT, WHEN, and HOW of the medicines:

- ✓ **WHO** will help you remember to take your medicine every day at the same time? Is there someone who can help you come to the clinic for appointments?
- ✓ **WHAT** medicines are you taking? What is the dose and how often will you take it? What will you do when you are about to run out of your medicines? What will you do if you miss a dose of your medicine?
- ✓ **WHEN** will you take your medicines? Establish a routine.
- ✓ **WHERE** will you take your doses of ARVs (e.g. at school, at home, at work, etc.)? Where will you store your ARVs?
- ✓ **HOW** will you remember to take your medicines every day and at the same time? When you are at school or work? When you are away from home? When you are with your family? When you are with your friends?

Strategies that Peer Educators can use with younger adolescents and their caregivers to promote adherence to medicines:

- Work closely with the nurse, counselor, your supervisor, or another member of multidisciplinary care team to support adherence and help the nurse or counselor to prepare and educate younger adolescents and their caregivers.
- Be a good role model and give practical suggestions based on your own personal experience with overcoming adherence challenges.
- Help the nurse or counselor explain to the caregivers and their children what is meant by adherence, using easy-to-understand language.
- Reinforce the importance of good adherence to the child's health.
- Tell the caregivers that, with good adherence, children and younger adolescents with HIV can live long, healthy, and productive lives.
- Talk about the need for open, honest communication with the child and the health care team.
- If the adolescent hasn't been disclosed to, talk about the need for him or her to know about his or her HIV-status and how this will help with adherence (see *Module 9*).
- Help the client and caregivers identify a treatment buddy.
- Use the Adherence Support Tree to help the client and caregivers form an adherence plan.

Instructions for the Adherence Support Tree:

Each instruction below goes with a number on the Adherence Support Tree. The Peer Educator should follow these instructions in order.

1. Start on the trunk. Begin by explaining what we mean by adherence to treatment and why near-perfect adherence is important.
2. Continue by helping the client make an ART adherence plan: address the WHO, WHAT, WHEN, WHERE, and HOW of the medicines. The lines around the left-hand side of the tree are spaces for writing down important information related to the client's adherence plan. This is a chance for the Peer Educator to reinforce what the nurse or counselor has told the client about the right ways to take ARVs!
 - ✓ **WHO** will help you remember to take your medicine every day at the same time? Is there someone who can help you come to the clinic for appointments?
 - ✓ **WHAT** medicines are you taking? What is the dose and how often will you take it? What will you do when you are about to run out of your medicines? What will you do if you miss a dose of your medicine?
 - ✓ **WHEN** will you take your medicines? Establish a routine.
 - ✓ **WHERE** will you take your doses of ARVs (e.g. at school, at home, at work, etc.)? Where will you store your ARVs?
 - ✓ **HOW** will you remember to take your medicines every day and at the same time? When you are at school or work? When you are away from home? When you are with your family? When you are with your friends?
3. Ask the client to imagine him- or herself as a tree. The roots are “*where you come from, your home, your family, and your community,*” they are “*what support and ground you.*” Ask the client who will support him or her with his or her adherence plan and write this under “peers, family, and community” in the roots of the tree. Also write down if the client has a treatment buddy.
4. Discuss the possible challenges to adherence in the client’s (and caregiver’s) life. Write these under “What are the Anticipated Adherence Challenges?”
5. The branches are the client’s adherence strategies. These are things she or he can do to have perfect adherence, like using reminders, routines, using a treatment buddy, etc. Give the client practical suggestions and help him or her plan ways of remembering to take medicines and to come to the clinic for appointments.
6. Always plan a follow-up session and write down any action points under “Immediate Next Steps.” Tell the client that you will always be available to talk more with him or her. Adherence and follow up to the adherence plan should be discussed during every Peer Education session!
7. Lastly, summarize the main points that were discussed during the adherence support session, talk about any necessary referrals, and arrange another time to talk (if necessary).
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

It is important for Peer Educators to help the multidisciplinary care team provide adherence education. But most of all, it is important for Peer Educators to give ongoing adherence support to ALHIV and their caregivers **at every clinic visit and over time.**



Adherence preparation case studies:

Case Study 1:

M___ is 11 years old and is going to begin taking ART. Her auntie is her primary caregiver and will be responsible for giving M___ her medicines every day. M___ understands that she has HIV and needs to take medicines every day, but her auntie is worried about how she will manage. The nurse asks you to join a session to talk with them about adherence and about making an adherence plan.

How do you help M___ prepare for adherence?

Possible responses for the Adherence Support Tree:

1. Start on the trunk. Explain the meaning of adherence to HIV treatment and why near-perfect adherence to medicines is important.
2. Help the client and caregiver make an ART adherence plan by addressing the WHO, WHAT, WHEN, WHERE, and HOW of the medicines.
 - ✓ **WHO:** M___'s auntie; also talk about any other adult who can help when M___'s auntie is at work
 - ✓ **WHAT:** M___'s auntie can work with the nurse so she understands how to give the medicines (the nurse can make sure she understands about missed doses, what to do if M___ runs out of medicines, etc.)
 - ✓ **WHEN:** Talk about M___'s and her auntie's daily routine, when medicines will be given (at what time?, with meals?, etc.)
 - ✓ **WHERE:** Talk about where the ARVs will be stored in the home
 - ✓ **HOW:** Talk about possible reminder tools, such as using a pill box, a calendar, a mobile phone alarm, etc. Talk about how M___ will remember to take her medicines when she is away from home or away from her family.
3. **Roots:** Talk about who supports her (her auntie, other family members at home, etc.); Talk about a possible treatment buddy
4. **Anticipated challenges:** Keeping a schedule, remembering to take the pills every day, remembering to take medicines when away from her family, managing side effects, M___'s limited understanding of HIV
5. **Branches/adherence tools and reminders:** The reminder tools discussed in step 2 (pill box, calendar, mobile phone alarm, etc.), keeping a set routine (e.g. taking medicines

before school with breakfast and tea and at the evening meal), talk about what M___ has done in the past if she had to remember something important

6. **Immediate Next Steps:** Attend a ALHIV adherence support group at the clinic, Auntie to make appointment with the nurse
7. **Summarize the main points:** Summarize the adherence plan, give a referral for the ALHIV support group, offer praise and encouragement, reinforce the importance of adherence to medicines, encourage M___ and her auntie to be open about their challenges, offer them a copy of the Adherence Tree to take home as a reminder of M___'s adherence plan
8. **Review and discuss M___'s situation and "next steps" with the program supervisor or another member of the multidisciplinary care team.**

Case Study 2:

P___ is 16 years old and lives on his own. He needs to start taking ART and the nurse asks you to help prepare him for adherence. P___ works during the day as a taxi assistant and you sense that it might be challenging for him to take his medicines the right way because he hasn't disclosed to anyone and he works long hours.

How do you help P___?

Possible responses for the Adherence Support Tree:

1. Start on the trunk. Explain the meaning of adherence and why near-perfect adherence to medicines is important.
2. Help the client and caregiver make an ART adherence plan by addressing the WHO, WHAT, WHEN, WHERE, and HOW of the medicines.
 - ✓ **WHO:** Talk about finding a treatment buddy
 - ✓ **WHAT:** P___ can work with the nurse so he understands how to take his medicines (nurse can make sure P___ understands about missed doses, what to do if he runs out of medicines, etc.)
 - ✓ **WHEN:** Talk about P___'s daily routine and when he will take his medicines (e.g. at what time?, with meals?, etc.)
 - ✓ **WHERE:** Talk about where P___'s ARVs will be stored
 - ✓ **HOW:** Talk about possible reminder tools, such as using a pill box, a calendar, a mobile phone alarm, etc. Talk about how P___ will remember to take his medicines and share your own experiences
3. **Roots:** Talk about who supports him (friends, other family members at home, etc.); Talk about the importance/role of a treatment buddy
4. **Anticipated challenges:** Keeping a schedule, remembering to take his medicines every day, remembering to take medicines when away from his family, managing side effects
9. **Branches/adherence tools and reminders:** The reminder tools discussed in step 2 (pill box, calendar, mobile phone alarm, etc.), keeping a set routine (e.g. taking medicines before work with breakfast and tea and at the evening meal)
10. **Immediate Next Steps:** Attend a ALHIV adherence support group at the clinic, P___ to make appointment with the nurse
11. **Summarize the main points:** Summarize the adherence plan, give a referral for the ALHIV support group, offer praise and encouragement, reinforce the importance of adherence to medicines, encourage P___ to be open about his challenges, offer P___ a copy of the Adherence Tree to take home as a reminder of his adherence plan
12. **Review and discuss the P___'s situation and "next steps" with the program supervisor or another member of the multidisciplinary care team.**

Case Study 3:

D___ is 17 years old and lives with her mother and father. She is going to start taking ART and you and one of the counselors are asked to help prepare her and to help her make an adherence plan. D___ is at the clinic alone and says she doesn't talk much about HIV with her mother and father.

How do you proceed with D___?

Case Study 4:

V___ is a 14-year-old girl who has been on ART for 7 years. Recently, she moved to the capital city to live with her uncle and his family. She is new at the ART clinic. When V___'s aunt brings her to the clinic, you sense that her aunt does not know much about V's care and treatment. The doctor invites you into the session to help talk with V___ and her aunt about adherence.

How do you help V___ and her aunt prepare for adherence?

Peer Educators can use the Adherence Support Tree as a guide for adherence support and preparation with clients and caregivers. Providing good adherence education and support is a very important job and it is too much for one person to do alone! Helping clients and caregivers with adherence is the responsibility of the entire multidisciplinary care team!



SESSION 6.4: Providing Ongoing Adherence Support to ALHIV (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Small Group Work

Step 1: Ask participants to think about a time they or someone they know missed an appointment or many appointments at the clinic. Ask participants:

- *What are some of the reasons ALHIV miss appointments (checkups, refills, lab tests, etc.) at the clinic?*
- *Are there different challenges you can think of based on a client's age or life situation?*
- *What helps you remember to come back to the clinic?*
- *How do you think the clinic can support long-term retention in care among younger adolescents? Older adolescents?*
- *What do you think Peer Educators can do to support clients' long-term retention in care?*

Fill in using the content below.

Step 2: Ask participants to think about a time they or someone they know missed some or many doses of their medicines (ARVs, cotrimoxazole, etc). Ask participants:

- *What are some of the reasons ALHIV miss some or many doses of their medicines?*
- *When is it most difficult to remember your medicines? Why?*
- *What helps you remember to take your medicines at the same time, every day?*
- *How do you think we can support long-term adherence to medicines among younger adolescents? What about older adolescents?*
- *What do you think Peer Educators can do to support clients' and caregivers' long-term adherence to medicines?*

Fill in using the content below.

Step 3: Lead a discussion about the importance of asking about adherence to medicines at EVERY clinic visit. This is important because adherence is not static—meaning it changes over time—especially for ALHIV, who are going through different phases of life and different life situations. This may mean that clients who were previously adherent to care now miss appointments, or that clients who used to be very adherent to their medicines now miss some doses. Discuss the concept of “adherence fatigue” and how this relates to ALHIV and ongoing adherence counseling as a part of HIV care and treatment.

Step 4: Ask participants to think back to what they learned in *Module 4* about asking open-ended questions. Say the following question out loud:

- *Did you take all of your pills this month?*

Ask participants to suggest other, more effective ways to ask a client this question. Next, say the following question out loud:

- *How is your adherence?*

Again, ask participants to suggest other, more effective ways to ask clients about adherence. Offer additional suggestions using the content below.

Step 5: Review the different ways Peer Educators can ask clients (and caregivers) about adherence at each visit. Explain that Peer Educators should review the information listed on the client's Adherence Support Tree and should ask the questions suggested in the content below. Remind participants that Peer Educators should never judge a client that is having adherence challenges. Using the content below, review what Peer Educators should do when clients are adhering well and what to do when clients are having adherence challenges. Also review the different strategies, tools, and reminders that ALHIV can use to improve their adherence.

Step 6: Ask if any participants remember the definition of adherence discussed earlier in the Module (adherence describes how faithfully a person sticks to and participates in his or her HIV prevention, care, and treatment plan). Ask participants:

- *What do you think helps ALHIV participate in their own care?*
- *Thinking back to your own experiences, what has made you want to and able to participate in your own care? What have been the challenges to participating in your own care?*
- *What are some of the ways Peer Educators can work as part of the multidisciplinary care team to encourage ALHIV to participate in their own care?*

Step 7: Close by stressing how important it is for ALL members of the multidisciplinary care team, including Peer Educators, to support clients' adherence to care over time and at each clinic visit. Peer Educators should provide feedback to the relevant team members (individually and during meetings) about clients' adherence and about the challenges they are experiencing.

KEY INFORMATION

There are many factors that affect a client's long-term retention in care. Peer Educators can improve ALHIV's retention by:

- Helping the multidisciplinary care team make sure that HIV services are youth-friendly and that adolescent clients are treated respectfully and non-judgmentally
- Making sure adolescents feel welcomed, comfortable, and safe at the clinic and that they can "hang out" there and meet other young people

- Building a relationship of trust and respect with clients
- Referring or linking clients to support groups and other services for ALHIV
- If the client joins a support group, giving information and suggesting activities to that group that correspond to the client's age
- Making time for private one-on-one sessions if necessary, and ensuring privacy and confidentiality
- Making sure that all clients are given reminders of upcoming appointments and of what was discussed during one-on-one sessions (e.g. by giving them a copy of their Adherence Support Tree with the date and time of their next appointment)
- Helping the multidisciplinary care team support clients and caregivers with adherence, disclosure, sexual and reproductive issues, etc.

Peer Educators can provide ongoing adherence support around HIV treatment:

Assessing adherence is very difficult and there is no perfect way to do it. Only by talking with the client regularly and by looking at the person's response to ART over time can we really learn about his or her adherence. It is very important that Peer Educators help the nurse or counselor assess the client's adherence at each visit.

- The purpose of ongoing adherence monitoring and support is to encourage the client (or caregivers) to express challenges and to be open about any problems they may be facing so that Peer Educators can give them ongoing support.
- Make adherence a normal part of every clinic visit. Remember, clients' adherence and psychosocial support needs change over time and especially as ALHIV go through different stages and experience changes.
- Do not judge clients. Make them feel comfortable instead of fearful that they will be punished or judged if they talk about their adherence challenges.
- Explain to clients that everyone has problems taking medicines the right way all the time.
- Build a trusting relationship and encourage clients to be completely honest with you about adherence. Remember: our job as Peer Educators is to work WITH our clients, not against them!
- Talk about clients' adherence issues at multidisciplinary team meetings so that clinical staff know about them (including common challenges faced by ALHIV).

Anticipate "Adherence Fatigue":

- With time, children and adolescents may get tired of taking medicines.
- With time, caregivers may get tired of giving medicines.
- Do not assume that just because a client has been adherent in the past, that this client will always be adherent.
- This is especially true for ALHIV because they will likely have different adherence challenges at different developmental stages.

How to ask clients (and caregivers) about their adherence:

- *I would like you to think about the last 7 days. How many pills did you take late in the last 7 days? What were the main reasons you took them late?*
- *How many pills did you miss in the last 7 days? What were the main reasons you missed them?*
- *How did the medicines make you feel?*
- *Can you tell me about any changes you have noticed lately (such as in your health)?*
- *Can you tell me about any challenges you have had lately with your medicines?*
- *What support or reminders do you have to take your medicines at the same time, every day?*
- *What questions do you have about your care or your medicines?*

Peer Educators should remember to use open-ended questions when asking clients about their adherence. This will make it easier for clients to describe their challenges as well as what is working.



If, after talking with a client about adherence, you feel that he or she is adhering well:

- Praise the client for good adherence.
- Encourage the client to come back and talk to you if there are any problems.
- Talk about how important it is for the client to be open with health care workers and Peer Educators and to solve challenges together.

If you feel that a client (or caregiver) has had some problems with adherence or if the clinical team thinks there may be adherence problems:

- **Always report back to the multidisciplinary care team and get direction from a nurse, counselor, or supervisor on how to manage these problems!**
- Work with a counselor or nurse to plan an individual Peer Education session.
- Give some practical suggestions and tips to the client about adherence, based on your personal experiences.
- Try to identify the specific challenges that the client or caregiver is having. You may want to use the Adherence Support Tree to guide your sessions with the client so that you can think about possible solutions together.
- Be supportive! Remind clients and caregivers that we all have adherence challenges, especially ALHIV, who are going through changes in their lives and different stages of adolescence.
- Discuss the importance of adherence.
- Be a good role model and share your own experiences with adherence challenges!
- Give referrals to support groups or other organizations.
- Work with a nurse or counselor to plan next steps, including setting up the client's next appointment.
- Praise the client for sharing his or her challenges.
- Record the session on the client's Adherence Support Tree.
- Follow up at the client's next visit.

Practical Adherence Strategies, Tools, and Reminders for ALHIV

- Clients can use pill boxes to store their medicines. These boxes are divided into different sections for each day of the week. They are used to help remind people when to take their medicines and can also be helpful when people need to take their medicines while away from home. If a person has forgotten whether or not he or she has taken a dose, he or she can check if there are still pills in the section for that day or not.
- Using a calendar (a paper calendar or a calendar on a mobile phone) to track appointments and to give themselves written reminders
- Setting a beeping alarm on their mobile phone to remind them to take their medicines
- Keeping a diary
- Planning ahead for weekends or when they are away from home
- Identifying a treatment buddy (someone to help them remember to take their medicines)

- Incorporating their medicines into their daily routine (e.g. always taking their medicines with meals)
- Calling ahead of time to order refills of their medicines
- Attending a support group to expand their network of people who can support them with adherence

It is important for Peer Educators and ALL members of the multidisciplinary care team to support clients' adherence to care at each clinic visit and over time.



SESSION 6.5: Classroom Practicum on Adherence Support (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Small Group Work, Case Studies, Role Play

- Step 1:** Give participants a quick review of the content covered in the Module so far and ask if there are any questions or areas where participants do not yet feel comfortable. Remind participants that one of the most important tasks of Peer Educators is to provide ongoing adherence support to clients. Next, review the Adherence Support Tree (*Appendix 6A*) with participants again.
- Step 2:** Hand out copies of the Adherence Support Tree (*Appendix 6A*) and the Communication Skills Checklist (*Appendix 6B*) to participants. Divide the participants into groups of 3 (Peer Educator, client, and observer). Ask each group to act out 2-3 role plays (depending on time) and ask the participants to take turns being the Peer Educator, client, and observer. The Peer Educator should practice using the Adherence Support Tree with the client. Observers should use the Communication Checklist (*Appendix 6B*) to write down the communication strategies that he or she saw the Peer Educator use. After the role play, observers should give feedback and suggest other communication strategies that could have been useful. Throughout the activity, trainers should move around the room and give feedback to the small groups.
- Step 3:** If there is time, ask some of the groups to perform their role play in front of the larger group and lead a discussion summarizing the skills learned throughout the Module on supporting clients to adhere to care and treatment plans.

KEY INFORMATION

Case studies for role play

Case Study 1:

A 14-year-old youth named V___ has been on ART for 8 years. Usually his adherence is almost perfect and he has been feeling fine when he comes for refills, but this time he says things are not going well. You ask him about what is going on and he tells you that his father was fired from his job and is now staying at home. There is no money to pay the bills, his father is drinking a lot, and his parents are often fighting. He says that he does not feel like going to school because he is not doing well in his classes and has few friends. Within the last few weeks, V___ forgot to take his pills 3 different times. The nurse asks you to speak with V___.

How would you support V___?

Possible responses for the Adherence Support Tree:

1. Start on the trunk. Explain meaning of adherence to HIV care and medicine and why near-perfect adherence to care and medicines is important.
2. Review V___'s ART adherence plan by addressing the WHO, WHAT, WHEN, WHERE, and HOW of the medicines.
 - ✓ **WHO:** Talk about who is at home and can help him remember to take his medicines—mother, grandmother, etc.?
 - ✓ **WHAT:** Maybe his mother or another caregiver can work with nurse so they understand how to help him take his medicines?
 - ✓ **WHEN:** Talk about V___'s daily routine and when he takes his medicines (e.g. at what time?, with meals?, etc.)
 - ✓ **WHERE:** Talk about where V___ stores his ARVs
 - ✓ **HOW:** Talk about possible reminder tools, such as using a pill box, a calendar, a mobile phone alarm, etc. Talk about how V___ remembers to take his medicines and share your own experiences
3. **Roots:** Talk about who supports him (family members, other people in the community, etc.); Talk about the possibility of finding a treatment buddy; Talk about the advantages of going to school and maintaining links with friends
4. **Anticipated challenges:** Problems with his father, remembering to take his medicines every day, managing stress in his home environment, getting money for transport
5. **Branches/adherence tools and reminders:** The reminder tools discussed in step 2 (pill box, calendar, mobile phone alarm, etc.), keeping a set routine, ask V___ what has worked in the past
6. **Immediate Next Steps:** Attend a ALHIV adherence support group at the clinic, come back to clinic to for another session with the Peer Educator
7. **Summarize main points:** Review V___'s adherence plan, give referral to for the ALHIV support group, offer V___ a copy of the Adherence Tree to take home as a reminder of his adherence plan
8. **Review and discuss V___'s situation and “next steps” with the program supervisor or another member of the multidisciplinary care team.**

Case Study 2:

A 16-year-old young woman named B___ tested positive for HIV 6 months ago and enrolled at the clinic. She is caring for her sick mother. She is so busy that she has missed a couple of appointments at the ART clinic, but she feels fine and says she's not eligible to start ART anyway. Her boyfriend is the only one who knows she is HIV-positive, but he has not been tested.

How would you support B___?

Possible responses for Adherence Support Tree:

1. Start on the trunk. Explain the meaning of retention in care and why adherence to care is important.
2. Review the B___'s appointment calendar and talk about how she remembers appointments by addressing the WHO, WHAT, WHEN, WHERE, and HOW.
 - ✓ **WHO:** Talk about who is at home to help with her care—other family?
 - ✓ **WHAT:** Ask what she does to remember her appointments
 - ✓ **WHEN:** Ask how often she comes to the clinic and talk about why it is important to come
 - ✓ **WHERE:** Where is the clinic in relation to B___'s home? Is transport or distance the issue?

- ✓ **HOW:** Talk about reminder tools (e.g. a calendar)
- 3. **Roots:** Talk about who can support B___ with her care and who can help with her mother's care (other family members?)
- 4. **Anticipated challenges:** Managing stress and coping with her sick mother
- 5. **Branches/adherence tools and reminders:** Using reminder tools (calendar, mobile phone, etc.)
- 6. **Immediate Next Steps:** Attend a ALHIV adherence support group at the clinic, come back to the clinic to for another session with the Peer Educator, work with health care workers to identify community-based services that might offer support to her mother
- 7. **Summarize main points:** Review B___'s adherence plan, give a referral to support group and other services, B___ to make an appointment with a health care worker and the Peer Educator, offer B___ a copy of the Adherence Tree to take home as a reminder of her adherence plan
- 8. **Review and discuss B___'s situation and "next steps" with the program supervisor or another member of the multidisciplinary care team**

Case Study 3:

A 13-year-old young woman named D___ comes to you because she "is feeling bad" and wants to stop taking ART. She tells you that she has missed 3 doses in the last month but thinks that taking her medicines most of the time is good enough. She says that she thinks the pills are making her look fat and that she feels self-conscious about her body. She also tells you that she really likes this boy in her class but that she is afraid he thinks she is ugly. She says her classmates tease her when she goes to school and that she does not have many friends.

How would you talk with D___?

Case Study 4:

You meet with a young 12-year-old boy named T___ who has been on ART for the last 6 years. His mother complains that T___ always used to cooperate and take his medicines with no problem. But now he is fighting her with every dose by running away and spitting out his ARVs. The nurse is very busy today and asks you to help her speak with T___ and his mother.

How would you talk to T___ and his mother?



Peer Educators should never forget to use the 7 essential communication skills. Good communication is the key to giving clients adherence support!

Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

Colton, T., Costa, C., Twyman, P., Westra, L., & Abrams E. (2009). *Comprehensive peer educator training curriculum, Trainer manual, Version 1.0*. New York: ICAP.

ICAP. (2008). *Adherence and psychosocial support implementation workshop for multidisciplinary HIV care teams, Facilitator manual*. New York: ICAP.

SESSION 6.6: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving to the next Module.

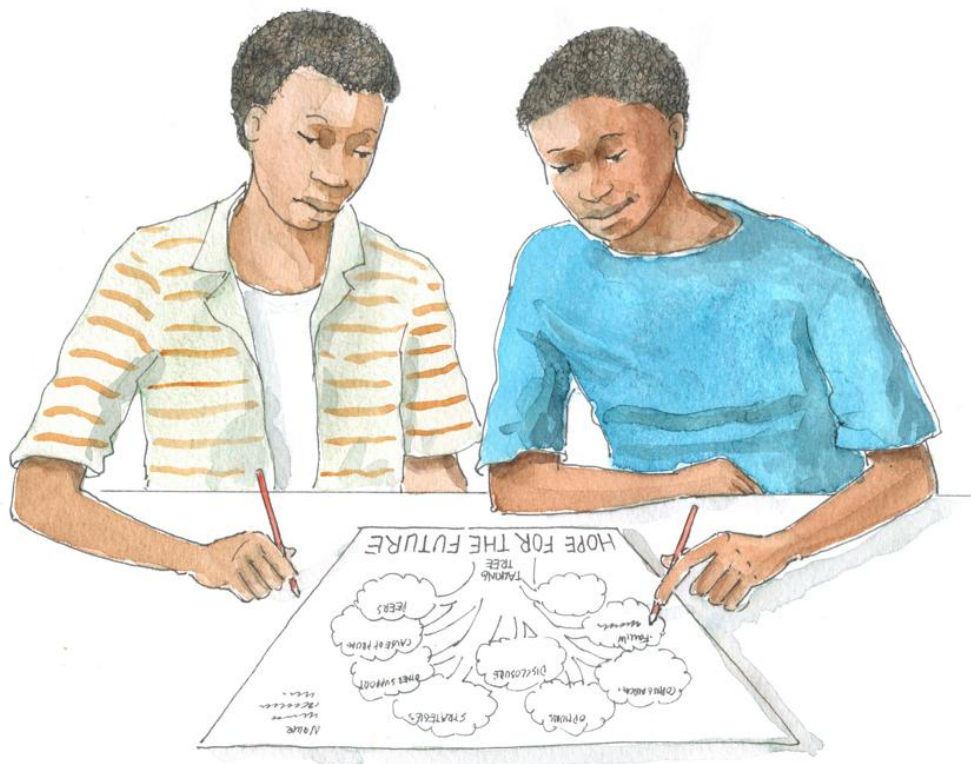
KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Retention refers to keeping (or “retaining”) clients in the care program. In this case, it means continuing with lifelong HIV care and treatment services. A goal of all HIV care and treatment programs is to retain clients in the full program of care.
- Adherence means how faithfully people stick to their care and treatment plan.
- Adherence support is most successful when it is provided by a number of people on the multidisciplinary care team, including Peer Educators, and when it is in partnership with clients and their family.
- Adherence to care is important to make sure people stay healthy, live positively, know when to start ART, and get psychosocial support.
- Adherence to treatment is important to lower the amount of HIV in people’s bodies and to make sure they get all the benefits that OI medicines and ARVs have to offer (feeling better, not getting OIs, etc.).
- Non-adherence to treatment can lead to drug resistance, which prevents the ART from working and makes people sick. Non-adherence can make ALHIV very sick and can also cause problems with their growth and development.
- There are many barriers and challenges to good adherence, including things related to people’s lives, to medicines, and to health services.
- There are many challenges to adherence that are unique to adolescents: they engage in more risk taking behaviors and they have a desire to “fit in” with peers and appear “normal.” They may not take their medicines because they are feeling rebellious and want to be their own person.

- Adherence barriers and challenges change over time, especially for ALHIV as they go through different developmental stages and life changes. It is important to ask clients about adherence at all follow-up visits.
- It is important that Peer Educators build a trusting relationship with clients so that they feel comfortable being completely honest about their adherence support needs.
- Peer Educators play an important role in helping clients and their families/caregivers prepare to start taking ART. The use of tools—such as a pill box, an alarm, or an adherence calendar or diary—can help support adherence.
- Adherence and a client’s adherence plan should be discussed at every counseling session!
- It is important not to judge clients (and caregivers) if they are non-adherent. Instead, we should try to find the root causes of non-adherence.
- It is important to remember to use good communication skills whenever speaking to a client about adherence issues.
- The Adherence Support Tree is a useful tool that can help Peer Educators provide adherence preparation as well as ongoing support.



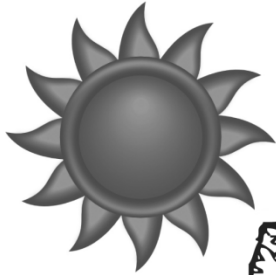
APPENDIX 6A: Adherence Support Tree

Instructions for the Adherence Support Tree:

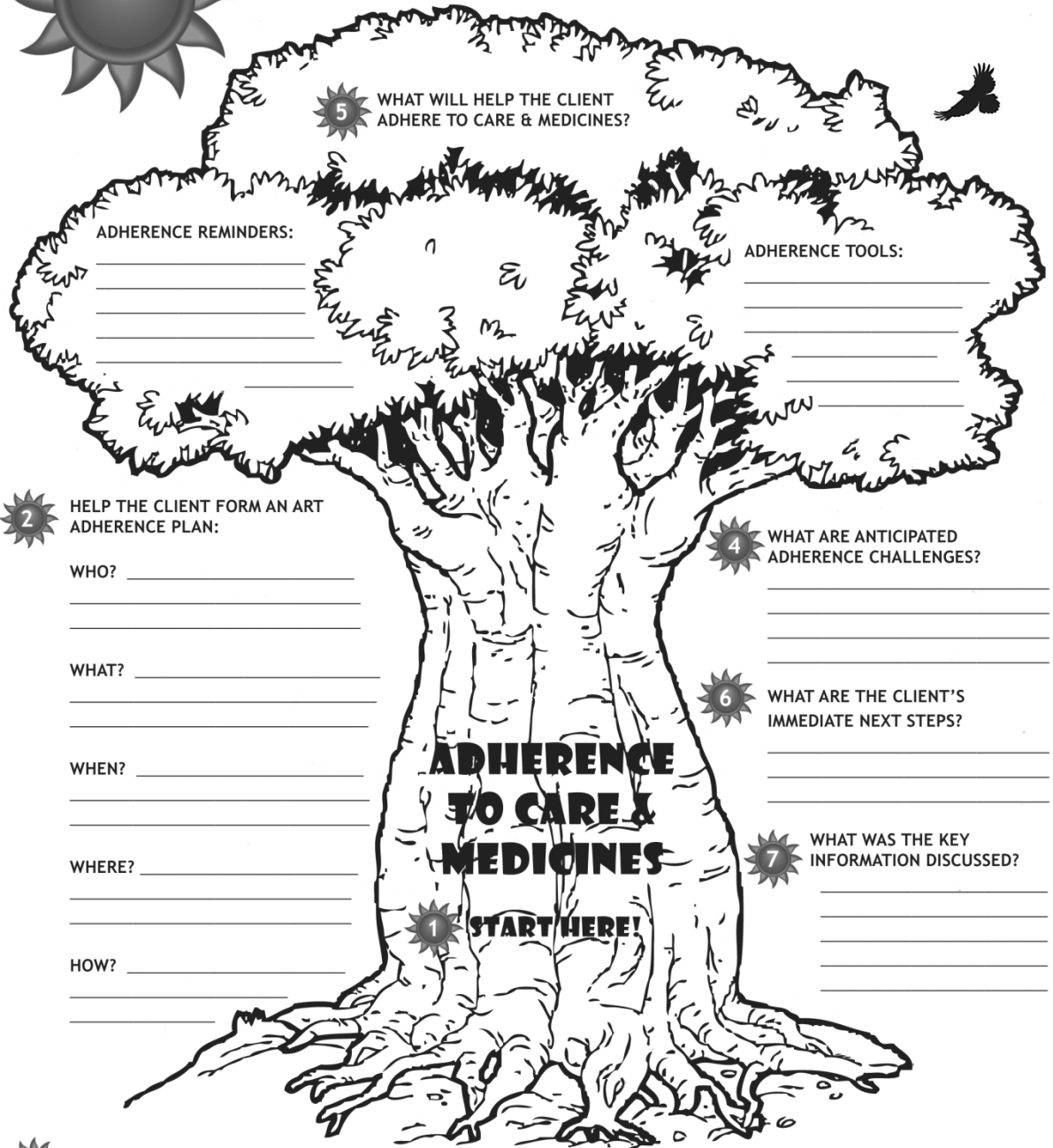
Each instruction below goes with a number on the Adherence Support Tree. The Peer Educator should follow these instructions in order.

1. Start on the trunk. Begin by explaining what we mean by adherence to treatment and why near-perfect adherence is important.
2. Continue by helping the client make an ART adherence plan: address the WHO, WHAT, WHEN, WHERE, and HOW of the medicines. The lines around left-hand side of the tree are spaces for writing down important information related to the client's adherence plan. This is a chance for the Peer Educator to reinforce what the nurse or counselor has told the client about the right ways to take ARVs!
 - ✓ **WHO** will help you remember to take your medicine every day at the same time? Is there someone who can help you come to the clinic for appointments?
 - ✓ **WHAT** medicines are you taking? What is the dose and how often will you take it? What will you do when you are about to run out of your medicines? What will you do if you miss a dose of your medicine?
 - ✓ **WHEN** will you take your medicines? Establish a routine.
 - ✓ **WHERE** will you take your doses of ARVs (e.g. at school, at home, at work, etc.)? Where will you store your ARVs?
 - ✓ **HOW** will you remember to take your medicines every day and at the same time? When you are at school or work? When you are away from home? When you are with your family? When you are with your friends?
3. Ask the client to imagine him- or herself as a tree. The roots are “where you come from, your home, your family, and your community,” they are “what support and ground you.” Ask the client who will support him or her with their adherence plan and write this under “peers, family, and community” in the roots of the tree. Note if the client has a treatment buddy.
4. Discuss the possible challenges to adherence in the client's (and caregiver's) life. Write these under “What are the Anticipated Adherence Challenges?”
5. The branches are the client's adherence strategies. These are things she or he can do to have perfect adherence, like using reminders, routines, using a treatment buddy, etc. Give the client practical suggestions and help him or her plan ways of remembering to take medicines and to come to the clinic for appointments.
6. Always plan a follow-up session and record any action points under “Immediate Next Steps.” Tell the client that you will always be available to talk more with him or her. Adherence and follow up to the adherence plan should be discussed during every Peer Education session!
7. Lastly, summarize the main points that were discussed during the adherence support session, talk about any necessary referrals, and arrange another time to talk (if necessary).
8. Review and discuss the client's situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

ADHERENCE SUPPORT TREE



DATE: _____
 CLIENT NAME: _____
 PEER EDUCATOR NAME: _____
 NAME OF CLINIC: _____



5 WHAT WILL HELP THE CLIENT ADHERE TO CARE & MEDICINES?

ADHERENCE REMINDERS:

ADHERENCE TOOLS:

2 HELP THE CLIENT FORM AN ART ADHERENCE PLAN:

WHO? _____

WHAT? _____

WHEN? _____

WHERE? _____

HOW? _____

4 WHAT ARE ANTICIPATED ADHERENCE CHALLENGES?

6 WHAT ARE THE CLIENT'S IMMEDIATE NEXT STEPS?

7 WHAT WAS THE KEY INFORMATION DISCUSSED?

ADHERENCE TO CARE & MEDICINES
START HERE!

3 WHAT SUPPORT DOES THE CLIENT HAVE?

FAMILY:

PEERS:

COMMUNITY:

APPENDIX 6B: Communication Skills Checklist

Counseling and Communication Skills			
	Skill	Specific Strategies, Statements, Behaviors	(√)
Establishing the Relationship	Skill 1: Use helpful non-verbal communication	• Make eye contact.	
		• Face the person (sit next to her or him) and be relaxed and open with posture.	
		• Use good body language (nod, lean forward, etc.).	
		• Smile.	
		• Do not look at your watch, the clock or anything other than the client.	
		• Do not write during the session.	
		• Other (specify)	
Understanding the Client's Needs	Skill 2: Actively listen and show interest in your client	• Nod and smile. Use encouraging responses (such as “yes,” “okay” and “mmm hmm”).	
		• Use a calm tone of voice.	
		• Allow the client to express emotions.	
		• Do not interrupt.	
		• Other (specify)	
	Skill 3: Ask open-ended questions	• Use open-ended questions to get more information.	
		• Ask questions that show interest, care, and concern.	
		• Ask questions to clearly understand the client's problems	
		• Other (specify)	
	Skill 4: Reflect back what your client is saying	• Reflect emotional responses back to the client.	
		• Other (specify)	
	Skill 5: Show empathy, not sympathy	• Demonstrate empathy: show an understanding of how the person feels.	
		• Avoid sympathy.	
		• Other (specify)	
Skill 6: Avoid judging words	• Avoid judging words such as “good,” “bad,” “correct,” “proper,” “right,” “wrong,” etc.		
	• Use words that build confidence and give support (e.g., recognize and praise what a client is doing right).		
	• Other (specify)		
Creating an Action Plan and Ending the Session	Skill 7: Help your client set goals and summarize each session	• Work with the client to come up with realistic “next steps”	
		• Summarize the main points of the Peer Education session.	
		• Other (specify)	

Note: This checklist was adapted from: WHO & CDC. (2008). *Prevention of mother-to-child transmission of HIV generic training package: Trainer manual.*



MODULE 7: Providing Psychosocial Support



DURATION: 255 minutes (4 hours, 15 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Define psychosocial support
- Describe the common psychosocial needs of younger and older ALHIV
- Discuss different types of stigma and discrimination ALHIV may face and strategies to deal them
- Describe ways that stigma and discrimination negatively affect ALHIV's access and adherence to HIV prevention, care, and treatment services
- Work as part of the multidisciplinary care team to help address the psychosocial support needs of ALHIV and to help with coping, using the Talking Tree
- Give support and referrals to ALHIV who are experiencing crisis



CONTENT:

Session 7.1: Introduction: What Do We Mean by Psychosocial Support?

Session 7.2: Addressing the Psychosocial Support Needs of ALHIV

Session 7.3: Dealing with Stigma and Discrimination

Session 7.4: Identifying and Helping with Crisis

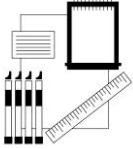
Session 7.5: Classroom Practicum on Psychosocial Support

Session 7.6: Module Summary



METHODOLOGIES:

- Interactive trainer presentation
 - Large group discussion
 - Brainstorming
 - Small group work
 - Role play
 - Case studies
-



MATERIALS NEEDED:

- Flip chart
 - Markers
 - Tape or Bostik
 - Copies of the Talking Tree (*Appendix 7B*) and the Communication Skills Checklist (*Appendix 7C*) for each participant
-



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
 - Read and modify the case studies as needed
 - Make copies of the Talking Tree (*Appendix 7B*) and the Communication Skills Checklist (*Appendix 7C*) for each participant
 - Review the case studies for *Session 7.5* and adapt them to the local context as needed
-

SESSION 7.1: Introduction: What Do We Mean by Psychosocial Support? (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion

Step 1: Review the Module learning objectives.

Step 2: Remind the group about the story of the Monkey and the Fish (see *Module 4*). Ask if anyone remembers the moral of the story. Explain that in order to educate and help people we first need to understand them. Part of understanding people is knowing and understanding how they function—both psychologically and in their environments. Review the definitions of "psycho" and "social" using the content below.

Step 3: Facilitate discussion by asking the group:

- *What do we mean by providing psychosocial support services?*

Explain that giving psychosocial support to ALHIV means helping them with problems on the inside (psycho) and on the outside (social). HIV infection affects all parts of a person's life: physical, psychological, social, and spiritual. Ask the group the following questions and write responses on flip chart:

- *What are some of the ways HIV affects a person psychologically, socially, and spiritually? Why is providing psychosocial support to ALHIV important?*
- *How are the psychosocial support needs of young people different from the psychosocial support needs of adults? How are they different from those of babies and young children?*

Fill in using the content below.

Step 4: Explain that giving psychosocial support is about helping people develop or get back in touch with the resources or tools they can use to solve their own problems. Psychosocial support can help people make informed decisions, cope better with illness, and deal more effectively with discrimination. It improves the quality of their lives. Using the content below, discuss why giving psychosocial support to ALHIV is important.

Remind the group that Peer Educators cannot solve everyone's psychosocial issues, but that they can help them problem-solve and find their own solutions. Emphasize once again that a Peer Educator is not a counselor. However, Peer Educators can offer clients emotional support, education, and linkages to follow-up services and support groups. Peer Educators can also identify ALHIV who may need additional attention from other members of the multidisciplinary care team.

Step 5: Tell the participants that they will understand more about people's psychosocial needs and how to provide psychosocial support as they continue this Module and the rest of the training. Explain that much of the rest of the training will be spent talking about specific psychosocial support issues and needs of ALHIV. This includes issues and needs related to disclosure, adherence support, peer pressure, safer sex, and living positively.

KEY INFORMATION

Definition of psychosocial support:

- **Psycho** refers to the mind and soul of a person. This means a person's feelings, thoughts, beliefs, attitudes, and values.
- **Social** refers to a person's relationships and environment. This includes interactions and relationships with family, peers, at school, and in the community.
- **Psychosocial support** addresses the ongoing emotional, social, and spiritual concerns and needs of people living with HIV, their partners, their family, and their caretakers (in the case of children living with HIV).
- **Psychosocial well-being** is when a person's internal and external needs are met and the person is physically, mentally, and socially well.

Providing psychosocial support to ALHIV is important because:

- HIV affects all parts of a person's life: physical, mental, social, and spiritual.
- ALHIV have normal developmental issues like feeling that they want to be normal and fit in.
- Adolescents' relationships with their parents and caregivers can be difficult as they test limits and move towards independence.
- Psychosocial support can help clients and caretakers get confidence in themselves and their skills (dealing with long-term illness, dealing with stigma or discrimination, dealing with taking medicines every day, caring for an HIV-exposed or HIV-infected child, etc.).
- Psychosocial well-being is related to better adherence to HIV care and treatment.
- Good mental health is closely linked to physical health.
- Psychosocial support can provide or link people with needed social, economic, educational, housing, and legal services.
- Psychosocial support can help people mentally and practically prepare for difficult things like bad health, having an HIV-infected baby, or death.



Peer Educators should try to understand clients' psychosocial needs. This means understanding what they can about each client's mind and environment.

SESSION 7.2: Addressing the Psychosocial Support Needs of ALHIV (45 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Brainstorming

Step 1: Explain that all of us have needs from the time we are born until the time that we die. Explain that we can think of these needs in three different categories: material, social, and psychological. Often, we focus on our material needs and forget about our social and psychological needs. It is very important that we think about ourselves and others as having all three types of needs. Write “MATERIAL,” “SOCIAL,” and “PSYCHOLOGICAL” each on a separate flip chart, writing responses on the appropriate one. Ask the group:

- *What do we need--materially, socially, and psychologically--to grow, develop, and live a healthy and satisfying life?*
- *What are the specific material, social, and psychological needs of younger adolescents living with HIV (10-14 year olds)?*
- *What are the specific material, social, and psychological needs of older adolescents living with HIV (15-19 year olds)?*
- *What might be some specific needs of caregivers of ALHIV?*
- *How do you think the needs of ALHIV change over time?*
- *Do you think young people have different needs and issues depending on how they became HIV-infected (e.g. from birth, through sexual contact, etc.)?*

Fill in using the content below.

Step 2: Remind participants that ALHIV have many unique psychosocial needs, drawing from the list in the content below. Ask participants to brainstorm:

- *How can Peer Educators work with the multidisciplinary care team to figure out what each client's psychosocial issues and needs are over time? What are some of the questions you would ask a younger client? An older adolescent?*
- *How can Peer Educators work with the multidisciplinary care team to provide psychosocial support services to ALHIV (both younger and older)?*
- *How can Peer Educators work with the multidisciplinary care team to provide psychosocial support services to caregivers of ALHIV?*

Write responses on a flip chart and fill in using the content below. Explain that a key role Peer Educators is to regularly check in with clients on their psychosocial

needs. The goal is to help identify areas where they need psychosocial support and to help clients and caregivers get the services and support they need.

Step 3: Re-introduce the Talking Tree from Module 4 (*see Appendix 7C*) and explain how Peer Educators can use this as a tool to help them identify and discuss clients' psychosocial issues. Explain that the Talking Tree can help them talk about coping mechanisms, can help clients decide about future goals, and can help clients find their own solutions to particular problems.

Step 4: Explain that Peer Educators cannot address all of a person's psychosocial needs. That is why the whole multidisciplinary care team must work together to provide these services to clients and their families. Remind participants that it is important to have a strong referral system in place so that clients and their families can be provided with all the comprehensive care and support services they need.

KEY INFORMATION

Common psychosocial support needs of younger ALHIV (ages 10-14):

MATERIAL	SOCIAL	PSYCHOLOGICAL
<ul style="list-style-type: none"> • Food • Shelter • Clothing • Medical Care • Possessions • Education 	<ul style="list-style-type: none"> • Family • Friends • Play/expression 	<ul style="list-style-type: none"> • Parental love and emotional care • Guidance • Security • Protection • Recognition

Common psychosocial support needs of older ALHIV (ages 15-19):

MATERIAL	SOCIAL	PSYCHOLOGICAL
<ul style="list-style-type: none"> • Food • Shelter • Clothing • Medical Care • Possessions • Money/income • Access to secondary or higher education 	<ul style="list-style-type: none"> • Culture • Community • Religion/spiritual support • Family • Friends/peers 	<ul style="list-style-type: none"> • Sense of belonging or fitting in • Self-esteem • Respect • Recognition • Independence • Love/companionship from partner • Awareness and expression of sexuality

Common psychosocial needs of ALHIV:

- Support in understanding and coming to terms with their HIV-status and the effect their status has on their own and their family's lives
- Talking about their opinions about taking medicines when they may not be feeling sick and they just want to fit in and be normal
- Acceptance from caregivers and family members
- Peer support from other people whom they look up to
- Strategies to disclose their HIV-status to their peers, family, and community members

- Talking about ways to encourage their partners and family members to test and, if appropriate, to enroll into care and treatment programs
- Access to education, training, and work opportunities once they have completed school/training
- Access to higher education
- Access to social welfare services
- Access to community-based organizations that support income-generating activities
- Spiritual support and referrals to spiritual counseling
- Getting information about their legal issues and rights
- Mental health support, including for anxiety and depression
- Substance abuse management

Some ways that Peer Educators can help address clients' psychosocial support needs:

- Use good communication skills, actively listen, and provide clients with emotional support.
- Ask how the client is doing (using open-ended questions) at each visit.
- Follow up on psychosocial issues and needs discussed during previous visits.
- Figure out if a client needs a referral for more support (e.g. for school, food, etc.) and tell the multidisciplinary care team.
- Give clients referrals to support groups, youth groups, etc.
- Use the Talking Tree as a tool to guide the conversation during individual Peer Education sessions and to help clients solve their own problems.
- Identify clients in distress who need attention from a trained counselor, mental health provider, or a member of the multidisciplinary care team.
- Act as a role model for adolescent clients and share practical suggestions based on personal experience.
- Report any serious problems to the supervisor and/or multidisciplinary care team.

Remember that Peer Educators are not counselors but they can offer ALHIV much-needed emotional support and education. They can also link ALHIV to follow-up services and support groups to further meet their psychosocial needs!



SESSION 7.3: Dealing with Stigma and Discrimination (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Small Group Work, Role Play

Note: Since the words “stigma” and “discrimination” do not always translate well to other languages, it is important that trainers and Peer Educators be able to explain the terms in everyday words and phrases (see definitions below).

Step 1: First, explain what stigma and discrimination are. One issue that clients may need support on is how to deal with stigma and discrimination because experiencing stigma and discrimination can decrease ALHIV’s psychosocial wellbeing and adherence. Ask participants to think quietly to themselves about a time they faced stigma and discrimination (this may or may not have to do with HIV). To explain a bit more, ask participants:

- *Think about a time in your life when you felt isolated or rejected because you were thought to be different from others.*
- *Think about what happened. How did this make you feel?*

Step 2: If participants feel comfortable, ask them to share their experiences with stigma and discrimination with the person to their right. After about 5 minutes, ask if anyone would like to share a story with the group. People should only share if they feel comfortable.

Step 3: Next, ask participants to again think quietly to themselves, but this time about a time when they may have stigmatized or discriminated against someone else because they thought that person was different. Again, this may or not be related to HIV.

Now ask participants to think about a time when they have stigmatized themselves. Ask a couple of participants who feel comfortable to share their stories.

Step 4: Lead a discussion on the different types of stigma and discrimination using the content below. Ask participants to discuss how experiencing stigma and discrimination around HIV affects everyone, and ALHIV specifically. Fill in, as needed, using the content below.

Step 5: Break up the participants into 2 groups:

Group 1: Stigmatizing language, actions, or practices you might see in the community that stigmatize or discriminate against ALHIV

Group 2: Stigmatizing language, actions, or practices you might see in a health clinic or hospital that stigmatize or discriminate against ALHIV

Ask each group to come up with a skit about their topic. As many group members as possible should have a role in the skit (as clients, staff, family members, community members, etc.). After 20 minutes, call the groups back together and invite each group to present their skit. Ask the participants:

- *Do you think what happened in your skits was realistic?*
- *What do you think are the causes of these stigmatizing behaviors? What are the effects?*
- *How would you, as a Peer Educator, address these situations?*

Step 6: Debrief and discuss the ways Peer Educators can help clients deal with stigma and discrimination individually and how they can help prevent stigma and discrimination in the clinic, referring to the content below. Remind participants about the importance of creating a welcoming and non-judgmental environment in the clinic. The environment should be open to and respectful of all clients, regardless of their HIV-status. Peer Educators can work with the multidisciplinary care team to identify stigma and discrimination within the clinic. Then, Peer Educators and the multidisciplinary care team can work together to make changes!

KEY INFORMATION

Key Definitions

Stigma: When we have a negative attitude toward people that we think are not “normal” or “right.” For example, stigma can mean not valuing PLHIV or people associated with PLHIV.

To stigmatize someone: Labeling a person and seeing him or her as inferior (less than or below others) because of something about this person (e.g. because of his or her job, because he or she is poor, because he or she has a disease, etc.). A lot of times people stigmatize others because they do not have the right information and knowledge. People also stigmatize others because they are afraid.

Discrimination: Treating someone unfairly or worse than others because they are different in some way (for example, because a person has HIV). Discrimination is the action that often follows stigma.

Key points about stigma and discrimination

- All over the world, stigma and discrimination are some of the biggest challenges of living with HIV or being affected by HIV. Stigma and discrimination make it hard for people to access HIV prevention, care, and treatment services. Stigma and discrimination can also prevent PLHIV from accessing community-based services, such as food support.
- We have all felt rejected or isolated at some point in our lives. We have also all probably rejected or isolated another person because we thought of them as different.
- Peer Educators need to help clients understand and deal with stigma and discrimination. They can work with the multidisciplinary care team and the community to fight stigma and to make sure that people have access to the services they need, without discrimination.

There are different kinds of stigma:

- **Stigma toward others:** Rejecting or isolating other people because they are different or because they are seen as different (e.g. being isolated by peers at school or being abandoned by friends)
- **Self-stigma:** When a person adopts the cruel and hurtful views that others may have of him or her. In other words, when a person begins to see him- or herself in a negative way because others see him or her in a negative way. Often, self-stigma can lead people to isolate themselves from their families and communities (e.g. N___ is HIV-positive and is afraid of “giving the disease” to her family, so she keeps to herself and eats her meals alone.)
- **Secondary stigma:** When people are stigmatized by their association with PLHIV. This may include community health workers; doctors and nurses at HIV clinics; and the family members or caregivers of PLHIV. An example of secondary stigma is when, in some countries, police harass HIV activists.

There are different forms of discrimination:

- Facing violence at home or in the community
- Not being able to attend school
- Being kicked out of school
- Not being able to get a job
- Being isolated or shunned from the family or community
- Not having access to quality health care or other services
- Being rejected from a church, mosque, or temple
- Police harassment
- Verbal discrimination: gossiping, taunting, scolding
- Physical discrimination: insisting that a person use separate eating utensils or sleep in a separate living space

Stigma and discrimination prevent good access to HIV prevention, care, and treatment services for many people. They can also prevent PLHIV and their families from living healthy and productive lives.

Stigma and discrimination around HIV impacts everyone. Stigma and discrimination can:

- Keep people from getting an HIV test
- Make it hard for people to tell their partner(s) their HIV test result
- Make it hard for people to suggest safer sex practices to their partner(s)
- Cause a lot of anxiety, stress, and depression
- Make it hard for parents to disclose to their children
- Make it hard for pregnant women to take ARVs or access other PMTCT services
- Prevent people from caring for PLHIV in their family, in the community, and in clinics
- Make people afraid of knowing their HIV-status, enrolling in care, or getting a CD4 test. This results in fewer people being able to access ART.
- Prevent or delay disclosure, forcing people to keep their status and their ART a secret. This affects the amount of support these people receive.
- Cause people to be isolated from friends and family, which means that they will not be supported to take ART and to adhere to care and treatment
- Result in low quality services at clinics and hospitals, making it less likely that people will access the care they need

Stigma and discrimination has specific effects on ALHIV. Stigma and discrimination can:

- Keep ALHIV from accessing care, treatment, counseling, and community support services because they want to hide their status
- Increase ALHIV's resistance to getting help and contribute to their existing discomfort and fear
- Make adolescents feel isolated and like they don't fit in with their peers
- Make it difficult for adolescents to do well in school
- Can affect caregivers of ALHIV, making it less likely that people will want to care for ALHIV or seek services themselves
- Impact some adolescents more than others. For example, orphans who are HIV-positive may be rejected by their extended families and community, they may be denied access to schooling and health care, and they may be left to take care of themselves

Some common individual strategies for dealing with stigma (in any place):

- Stand up for yourself and speak up.
- Educate people.
- Be strong and prove yourself.
- Talk to people whom you feel comfortable with.
- Try to explain the facts.
- Ignore people who stigmatize you.
- Avoid people who you know will stigmatize you.
- Join a support group.
- Taking and adhering to medicines and ART reduces stigma around HIV, helps normalize HIV, and allows the community to see HIV as a chronic disease. People who openly take ART can reduce stigma around the disease.

Some strategies for dealing with different forms of stigma at a clinic or hospital:

- Make sure young people and ALHIV, such as Peer Educators, are part of the care team. This means they should attend regular staff meetings, trainings, and other events.
- Make sure young people help evaluate the clinical services that are being offered and that feedback is formally reviewed by managers and health care workers.
- Link the clinic with youth groups and ALHIV support groups in the area.
- Talk openly about your own attitudes, feelings, fears, and behaviors with other Peer Educators and health care workers. Support each other to address fears and avoid burnout.
- Share your own experiences as a client with health care workers.
- Encourage health care workers and other Peer Educators to be open about their status. Encourage them to support one another.
- Report any discrimination you see at the clinic toward PLHIV or their families to a manager.
- Listen to clients about their feelings and concerns about stigma and discrimination, and report these back to other health care workers.

Peer Educators and the multidisciplinary care team can work together to identify stigma and discrimination within the clinic. Then they can then work together to make changes!



SESSION 7.4: Identifying and Helping with Crisis (45 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Brainstorming

- Step 1:** Sometimes the psychosocial needs of ALHIV have to do with difficult situations they are facing in life. For example, a person's life may be going along a certain path with a regular routine until there is a difficult situation that disrupts this routine. The person may think: *"I can't believe this is happening. Everything seems crazy! I don't know what to do."* At these moments, the person is in particular need of psychosocial support. This is why it is important that we think about how people are affected by difficult situations.
- Step 2:** Review the definition of a **crisis** using the content below and give some examples (death of a loved one, rape, losing one's job, political unrest, etc.). A difficult situation becomes a crisis when a person thinks he or she has lost the ability to solve their problems. Ask participants to take out a sheet of paper and to write down an example of a crisis that they, a friend, or a family member has had. Ask participants who are willing to share their stories. After each story, ask the participant:
- *What did you/the person do?*
 - *How did you/the person feel?*
 - *What helped you/the person to understand the situation and to find hope for the future?*
- Emphasize that each person reacts to crisis in his or her own way.
- Step 3:** Explain that, even though a crisis may disrupt a person's "world" for some time, we know from experience that it is possible for people to get past difficult times. **Coping skills** are specific ways that individuals and communities help themselves deal with difficult situations. Each individual has his or her own coping skills—what is useful for you may or may not work for someone else. Ask participants to brainstorm both positive and negative coping skills they have used in the past. Write "POSITIVE COPING SKILLS" and "NEGATIVE COPING SKILLS" on two pieces of flip chart and write participant responses under each category. Fill in using the content below.
- Step 4:** Ask participants to brainstorm about the meaning of the following statement:
- *Painful feelings are like a thorn in the foot.*
- After a few minutes of discussion, explain that part of coping is expressing one's feelings, thoughts, and beliefs. After a crisis or a bad event, painful feelings stay inside a person like a thorn in a foot. A person with a thorn in his or her foot will

continue to feel pain unless the thorn is removed. If the thorn stays in too long, the person may become disabled. Similarly, a person in crisis will not start to feel better until he or she has expressed the painful feelings. Only then can the person recover and heal, although he or she may later still have a scar.

Step 5: Brainstorm about the different feelings people may have during a crisis. Explain that listening and reflecting back a client's feelings are the most important communication skills Peer Educators can demonstrate when providing psychosocial support to clients in crisis. Both listening and reflecting back encourage people to tell their stories and to share their problems. Using the content below, discuss the ways that expressing one's thoughts and feelings can be helpful.

Step 6: Explain that Peer Educators can use the Emotions Chart in *Appendix 7A* as a hands-on tool to help younger adolescents explain their feelings during a time of crisis. Also explain that Peer Educators can also use the Talking Tree to help clients talk about a crisis or difficult situation, to identify who will support them during the difficult time, and to decide on possible solutions to the problem.

Step 7: Remind participants that a Peer Educator should never feel alone when helping clients manage a crisis. Remind them that many issues related to crisis are actually beyond a Peer Educator's scope. Emphasize the importance of close supervision and communication with the multidisciplinary care team members and reinforce the importance of a strong referral system.

KEY INFORMATION

What is a crisis?

- A crisis is an event that causes emotional, mental, physical, and behavioral distress or problems.
- A crisis can be any situation in which a person suddenly feels unable to solve or cope with his or her problems.
- Many different events or circumstances can cause a crisis: life-threatening events like natural disasters (e.g. an earthquake), sexual assault or other crimes; physical or mental illness; thoughts of killing yourself or someone else; or big changes in relationships or your life (for example, if a friend or family member dies, if your parents get divorced, if you become homeless, if someone who was supporting you stops giving you money, if you lose your job, or if you are kicked out of school).

Coping skills are specific ways that individuals and communities help themselves deal with difficult situations. Each individual has his or her own coping skills—what is useful for one person may or may not work for another.

Examples of good coping skills that Peer Educators can use themselves and also discuss as options with clients:

- Talk about the problem with someone you trust, such as a friend, family member, counselor, or Peer Educator.
- Join a support group.

- Exercise.
- Change your environment, take a walk, or listen to music.
- Get spiritual help.
- Go to a cultural event, like traditional dancing or singing.
- Join in recreational activities, like sports or youth clubs.
- Return to your daily routine, like household chores (e.g. cooking) or going to school.
- Do something to make yourself feel useful, like helping a sibling with homework.

Because all people are unique, each person reacts differently to crisis. Some reactions and effects of crisis include:

- Shock
- Sadness/crying
- Fear
- Anxiety
- Confusion
- Sleep problems/nightmares
- Loss of appetite
- Withdrawal/isolation
- Anger

Listening breaks people's isolation and encourages them to share their thoughts, feelings, and beliefs.

Expression helps people to:

- Feel relief
- Think more clearly about what has happened
- Feel accepted, cared for, and valued by the person listening
- Develop confidence
- Build self-esteem
- Explore options or solutions to make better decisions
- Prevent bad feelings from coming out as aggressive behavior

Listening and reflecting back a client's feelings are some of the most important communication skills when Peer Educators provide psychosocial support!



SESSION 7.5: Classroom Practicum on Psychosocial Support (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Small Group Work, Case Studies, Role Play

- Step 1:** Ask participants if they remember the 4 phases of a one-on-one Peer Education session and the 7 essential communication skills from *Module 4* and review as needed.
- Step 2:** Review some activities that can be used by Peer Educators to help people express themselves, using the content below. Remind the group that interactive activities like drawing and games work particularly well with younger adolescents who may at first be fearful, embarrassed, or shy sharing their feelings.
- Step 3:** Hand out copies of the Talking Tree (*Appendix 7B*) and the Communication Skills Checklist (*Appendix 7C*) to participants. Remind them of the instructions to use these tools. Divide the participants into groups of 3 and assign each group 1 of the case studies below. The small groups should assign roles: 1 Peer Educator, 1 client, and 1 observer. Give the small groups 20 minutes to role play their case study and tell the Peer Educators they should practice using the Talking Tree with the client. Observers should use the Communication Checklist to write down the communication strategies they saw being used. After the role play, observers should give feedback and suggest other communication strategies that could have been useful. Throughout the activity, trainers should move around the room and give feedback to the small groups.
- Step 4:** Bring the large group back together to debrief the activity. If time allows, ask some of the small groups to perform their role plays for the large group. After each performance facilitate a discussion by asking:
- *What were the main psychosocial issues and needs of the client?*
 - *How did the Peer Educator try to understand the client's psychosocial needs? What was done well? What would you do differently?*
 - *What strategies worked in the role play?*
 - *What were the most difficult aspects of the role play?*
 - *How did the Peer Educator address these challenges?*
- Step 5:** Debrief by reminding the participants that although Peer Educators are not counselors, they can help the multidisciplinary care team address a client's psychosocial needs, even just by listening well, giving emotional support, and using other good communication skills.

KEY INFORMATION

Phases of a Peer Education session (reminder from *Module 4*):

1. Establishing the Relationship
2. Understanding the Problem
4. Creating an Action Plan
5. Ending the Session

There are 7 essential communication skills that Peer Educators should practice and use in their work (reminder from *Module 4*):

- Skill 1: Use helpful non-verbal communication.
- Skill 2: Actively listen and show interest in your client.
- Skill 3: Ask open-ended questions.
- Skill 4: Reflect back what your client is saying.
- Skill 5: Show empathy, not sympathy.
- Skill 6: Avoid judging words.
- Skill 7: Help your client set goals and summarize each Peer Education session.

Tips for Communicating with Younger Adolescents (reminder from *Module 4*):

- They need time to feel safe and to trust. Maybe start the session by doing something together, like playing a game.
- They may feel scared and fear being judged.
- They may feel anxious or embarrassed when asking for help, especially when it's about contraception or other reproductive health issues.
- They need some time to observe you! Do not expect them to talk right away. Allow plenty of time and be patient.
- Explain things in simple terms.
- Just because he or she is not asking questions does not mean that he or she is not thinking about what is being said.
- Do not force him or her to share. Positively reinforce his or her effort to express him- or herself.
- If a youth is rude or aggressive, remember that it may not be directed at you. He or she may be feeling angry with adults for treating him or her badly or for letting him or her down. Be patient and don't take it personally.

Activities for Younger Adolescents (reminder from *Module 4*):

- Reading a book or educational material together
- Drawing about their family, followed by some questions to encourage them to share their feelings:
 - “Tell me about your drawing”
 - “What happened here?”
 - “How did you feel then?”
 - “How do you feel now?”
- Talking while playing a board game
- Making a photo collage about their family
- An “All About Me” Box: use magazines, paper, and markers to decorate a shoe box so that it represents different aspects of their personality and life
- Help them write a letter to a friend or family member about what is happening

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue they are experiencing—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” such as inner strengths, talents, skills, and spiritual resources to help in coping.
6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

Instructions for the Communications Skills Checklist (see Appendix 7C, reminder from Module 4):

1. Pass out copies of the Communication Skills Checklist to participants.
2. Ask the person acting as the “observer” in the group to refer to the checklist while the “Peer Educator” and “client” act out the role play based on one of the case studies.
3. Using the checklist as a guide, the “observer” should take notes about each of the skills and techniques he or she saw used during the role play so he or she can give feedback afterwards.

Case studies to discuss in small groups:

Case Study 1:

N___ is 15 years old and just tested positive for HIV. During adherence counseling, she told the health worker that if the treatment is for life, it will be difficult for her to take because she does not want to disclose her status to anyone. She said she is afraid that her parents would throw her out of the house and not support her. The health care worker told her this was a silly response and that she needs to do what is right. N___ comes to you for help.

What kind of psychosocial support would you give N___?

Suggested responses for Talking Tree:

1. **Main issues for this client:** Disclosure to parents, fear/uncertainty about their response and possible consequences, fears about ART and adherence to medicines; Tell N___ that her fears are normal and justified
2. **Cause of issue:** Lack of support; Talk more with N___ about her feelings/fears related to disclosure and potential problems with her family
3. **Roots:** Talk about who else supports her: friends, teachers, other family members she relies on, people at church, etc.; ask about the people she knows at school
4. **Hope for future/goal:** To disclose to her family, talk about advantages and disadvantages of disclosing to them and her expectations of the process
5. **Branches/options/coping/potential solutions:** Talk about how/when she can disclose to her family, role play some examples how to start the conversation, talk about other positive activities and other forms of support in her life that help her live positively, talk about what has worked well in the past to help her cope with stress and sadness
6. **Next steps:** Suggest a support group for ALHIV, recommend that N___ come back to clinic to talk more with a Peer Educator about preparing for disclosure to her family
7. **Summarize main points:** Give referral to support group, remind N___ of her next appointment at clinic and with the Peer Educator, offer praise and emotional support, tell N___ the you can work together to help prepare for disclosure to her family
8. Review and talk about N___'s situation and "next steps" with the program supervisor or a member of the multidisciplinary care team

Case Study 2:

A 10-year-old boy named V___ has been feeling "down." He comes to you because "he wants to talk to someone" but seems very quiet and embarrassed to say what he wants. He barely speaks in your session. You ask V to draw a picture and in the picture you see a woman drinking from a bottle. V___ tells you it is a picture of his mother.

How do you proceed?

Suggested responses for Talking Tree:

1. **Main issues for this client:** Family problems, mom or family member with drinking problem; be patient and approach the V___ at his level (e.g. sit on the floor, remind him that anything talked about is confidential, remember younger clients may be more shy/embarrassed/scared, do an activity to build trust like reading together or playing a game)
2. **Cause of issue:** Possible problems in V___'s home environment because of his mother's drinking
3. **Roots:** Talk with V___ about who else supports him at home, school, etc. (friends, teachers, other family members?)

4. **Hope for future/goal:** This is up to V___, he might be seeking support and someone to talk to about his mother's drinking problem
5. **Branches/options/coping/potential solutions:** Talk to V___ about what he likes to do (e.g. hobbies, sports) and what makes him feel good/hopeful
6. **Next steps:** Suggest a support group for ALHIV, recommend that V___ come back to the clinic to talk more with a Peer Educator
7. **Summarize main points:** Give referral to the support group, remind V___ about his next appointment at clinic and with the Peer Educator, tell V___ that you can work together to help him cope better with his family problems
8. Review and talk about the client's situation and "next steps" with the program supervisor or a member of the multidisciplinary care team.

Case Study 3:

A 17-year-old woman named B___ tested positive for HIV 6 months ago. She is caring for her 3 younger sisters. She is so busy that she has missed a couple of appointments at the ART clinic. Her partner is the only one who knows she is HIV-positive, and he himself has not been tested. She comes to the clinic because she thinks she might be pregnant and you meet her in the waiting area. She feels a lot of anger.

How would you talk with B___?

Case Study 4:

A 16-year-old boy named D___ has been on ART for many years. Because his mom and dad died he is living with his brother, his brother's wife, and their children. D___ tells you that his brother is worried that D___ will pass HIV to the children when he plays with them or when he eats with them. D___ asks you to talk to his brother, who is at the clinic today.

How do you proceed?

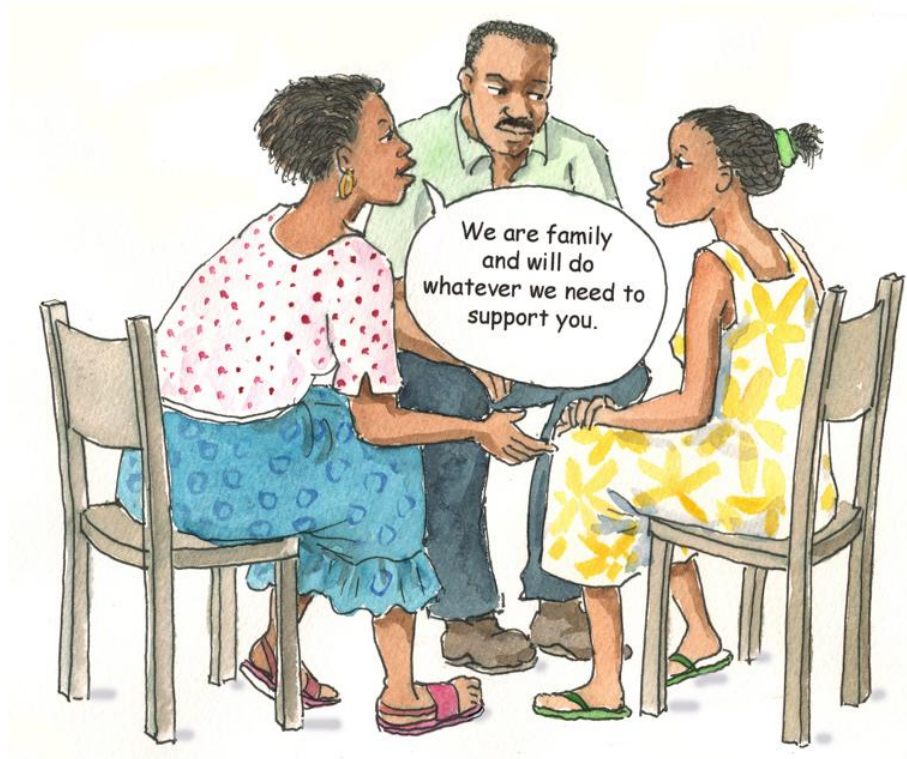
Case Study 5:

You meet with a young 13-year-old girl named T___ whose mother has just died from a HIV-related infection. T___ is enrolled in the ART program and usually comes to all of her appointments and adheres to her medicines. T___ says that she is feeling very sad today and that she has lost hope. She used to be ranked first in her class and now she is ranked last. She feels lonely, confused, and never feels like hanging out with her friends anymore.

How would you support T___?

Peer Educators can use the Talking Tree to help clients problem-solve and cope during times of crisis!





Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

Chiiya, C., Chonta, M., Clay, S., Kidd, R. & Röhr-Rouendaal, P. (2010). *We are all in the same boat: using art and creative approaches to tackle HIV-related stigma*. UNESCO.

Colton, T., Costa, C., Twyman, P., Westra, L., & Abrams E. (2009). *Comprehensive peer educator training curriculum, Trainer manual, Version 1.0*. New York: ICAP.

The CHANGE Project & ICRW. (2003). Understanding and challenging HIV stigma: Toolkit for action. Washington, DC: The CHANGE Project, Academy for Educational Development.

REPSSI. (2007). *Mainstreaming psychosocial care and support: A manual for facilitators*.

Annan, J., Castelli, L., Devreux, A. & Locatelli E. (2003). *Handbook for teachers*. Uganda: AVSI.

SESSION 7.6: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION

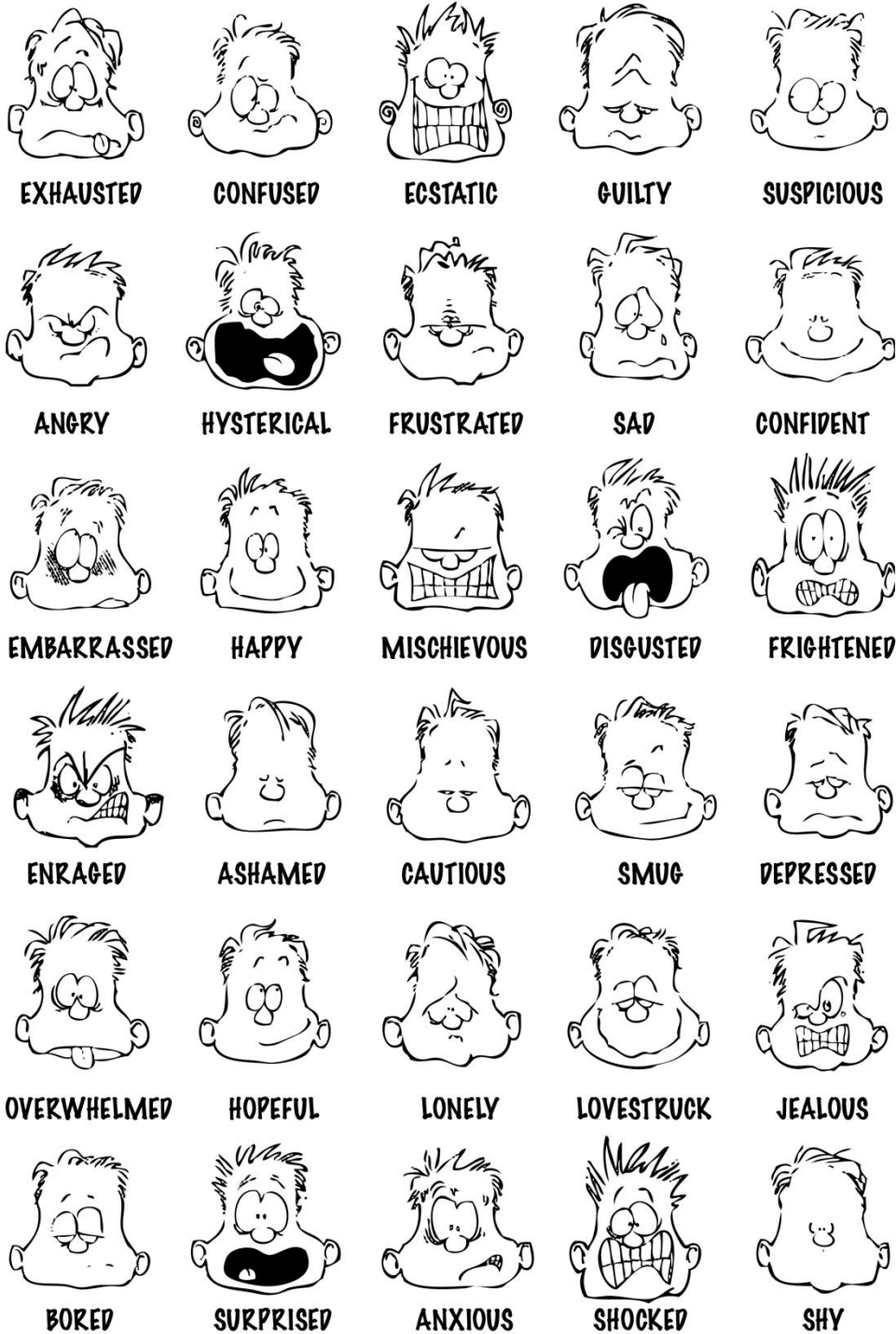


LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Psychosocial support addresses the ongoing emotional, social, and spiritual concerns and needs of people living with HIV, their partners, their family, and their caretakers (in the case of children).
- Younger ALHIV may have many material and psychosocial needs including food, shelter, medical care, parental love, and protection.
- Older ALHIV may have many psychosocial needs as well, including acceptance from peers, a sense of purpose, self-esteem, autonomy, and independence.
- Peer Educators play a key role in helping to address clients’ psychosocial needs over time.
- **Stigma** means having a negative attitude toward people that we think are not “normal” or “right.” For example, stigma can mean not valuing PLHIV or people associated with PLHIV.
- A **crisis** is an event that causes emotional, mental, physical, and behavioral distress or problems.
- **Coping skills** are specific ways that individuals and communities help themselves deal with difficult situations. Each individual has different coping skills.
- Peer Educators can use the Talking Tree to help figure out a client’s psychosocial needs and to support them to come up with their own solutions.
- Helping to manage a client’s crisis is the responsibility of the entire multidisciplinary care team. A Peer Educator should never act alone.

APPENDIX 7A: Feeling Chart

Emotions Vocabulary Chart



Note: This Emotions Vocabulary Chart was borrowed from <http://www.ami-tx.com/Portals/3/EmotionsFlyer.pdf>

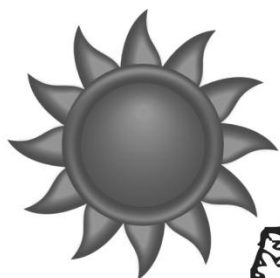
APPENDIX 7B: Talking Tree

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

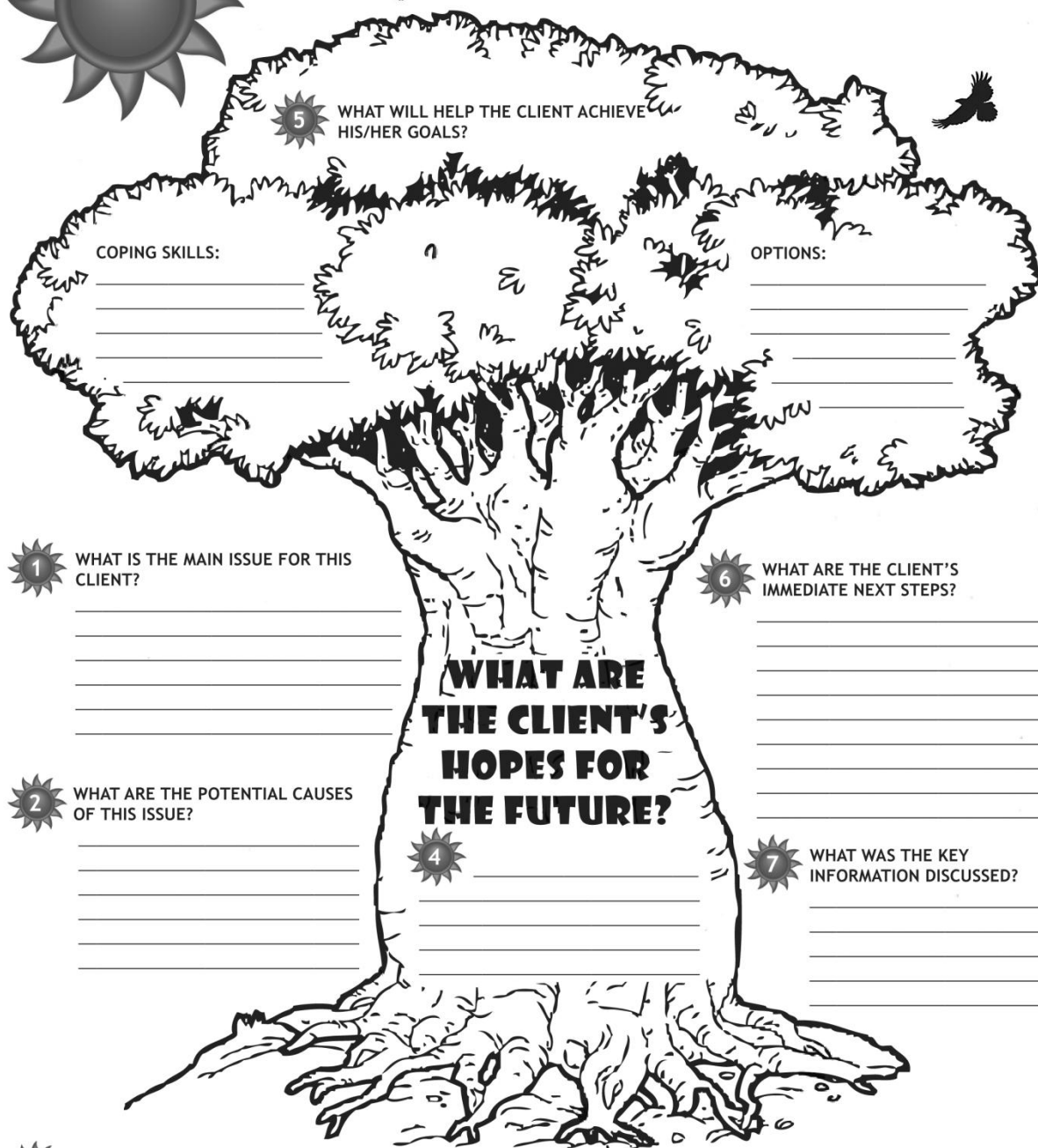
Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue he or she is having—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” like inner strengths, talents, skills, and spiritual resources to help in coping.
6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

TALKING TREE



DATE: _____
 CLIENT NAME: _____
 PEER EDUCATOR NAME: _____
 NAME OF CLINIC: _____



5 WHAT WILL HELP THE CLIENT ACHIEVE HIS/HER GOALS?

COPING SKILLS:

OPTIONS:

1 WHAT IS THE MAIN ISSUE FOR THIS CLIENT?

6 WHAT ARE THE CLIENT'S IMMEDIATE NEXT STEPS?

2 WHAT ARE THE POTENTIAL CAUSES OF THIS ISSUE?

WHAT ARE THE CLIENT'S HOPES FOR THE FUTURE?

4 _____

7 WHAT WAS THE KEY INFORMATION DISCUSSED?

3 WHAT SUPPORT DOES THE CLIENT HAVE?

<p>FAMILY:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>PEERS:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>COMMUNITY:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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APPENDIX 7C: Communication Skills Checklist

		Counseling and Communication Skills	
	Skill	Specific Strategies, Statements, Behaviors	(√)
	Establishing the Relationship	Skill 1: Use helpful non-verbal communication	• Make eye contact.
• Face the person (sit next to her or him) and be relaxed and open with posture.			
• Use good body language (nod, lean forward, etc.).			
• Smile.			
• Do not look at your watch, the clock or anything other than the client.			
• Do not write during the session. • Other (specify)			
Understanding the Client's Needs	Skill 2: Actively listen and show interest in your client	• Nod and smile. Use encouraging responses (such as “yes,” “okay” and “mmm hmm”).	
		• Use a calm tone of voice.	
		• Allow the client to express emotions.	
		• Do not interrupt.	
		• Other (specify)	
	Skill 3: Ask open-ended questions	• Use open-ended questions to get more information.	
		• Ask questions that show interest, care, and concern.	
		• Ask questions to clearly understand the client's problems	
		• Other (specify)	
	Skill 4: Reflect back what your client is saying	• Reflect emotional responses back to the client.	
		• Other (specify)	
	Skill 5: Show empathy, not sympathy	• Demonstrate empathy: show an understanding of how the person feels.	
		• Avoid sympathy.	
		• Other (specify)	
Skill 6: Avoid judging words	• Avoid judging words such as “good,” “bad,” “correct,” “proper,” “right,” “wrong,” etc.		
	• Use words that build confidence and give support (e.g., recognize and praise what a client is doing right).		
	• Other (specify)		
Creating an Action Plan and Ending the Session	Skill 7: Help your client set goals and summarize each session	• Work with the client to come up with realistic “next steps”	
		• Summarize the main points of the Peer Education session.	
		• Other (specify)	

Note: This checklist was adapted from: WHO & CDC. (2008). *Prevention of mother-to-child transmission of HIV generic training package: Trainer manual.*



MODULE 8: Planning and Co-Facilitating Support Groups for ALHIV



DURATION: 270 minutes (4 hours, 30 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Discuss the overall goals and objectives of peer support groups
- List the different types of support groups that may be helpful for ALHIV and their families
- Discuss how to help plan a ALHIV support group meeting
- Discuss how to co-facilitate or help lead a ALHIV support group meeting
- Conduct participatory group activities as part of ALHIV support group meetings



CONTENT:

Session 8.1: Introduction: What Are Support Groups and Why Do We Need Them?

Session 8.2: Practical Tips on Planning and Facilitating Support Group Meetings

Session 8.3: Suggested Activities for ALHIV Support Groups

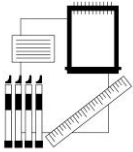
Session 8.4: Classroom Practicum on Planning and Facilitating a Support Group Meeting

Session 8.5: Module Summary



METHODOLOGIES:

- Interactive trainer presentation
- Large group discussion
- Brainstorming
- Game
- Small group work
- Case studies
- Guest Speakers
- Return demonstration
- Role play
- Observation (optional)



MATERIALS NEEDED:

- Flip chart
- Ball for game in *Session 8.1* and in Module Summary
- Markers
- Tape or Bostik
- Flip chart papers with written instructions for activities for *Session 8.3*
- Any materials required for activity practice in *Session 8.3* (this depends on which activities are chosen by the trainers)



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- Read through and select support group activities for *Session 8.3*. Make sure that all trainers and multidisciplinary care team members participating in the Session are able to facilitate the chosen activities.
- Invite multidisciplinary care team members to participate in the interactive training sessions.
- Invite support/youth group leaders and members of the multidisciplinary care team who facilitate support groups at the clinic to participate in Sessions 8.2 and 8.3.
- Organize for participants to attend and observe a ALHIV support group meeting (optional).
- Review the case studies for *Session 8.4* and adapt to the local context as needed.

SESSION 8.1: Introduction: What Are Support Groups and Why Do We Need Them? (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Brainstorming, Game

- Step 1:** Review the Module learning objectives.
- Step 2:** Lead a discussion to introduce the Module and to get a sense of participants' experiences with support groups. Use these questions to guide the group discussion.
- *Have you ever participated in a support group?*
 - *What type of support group was it?*
 - *Who led the support group? Who were the participants in the support group?*
 - *What did the group do and/or talk about?*
 - *What were your experiences with the support group? What was good? What was not good? Did you go back to the group? Why or why not?*
 - *Is/was being a support group member helpful to you? Why or why not?*
- Step 3:** Ask participants to brainstorm and discuss the definition and characteristics of support groups. Fill in as needed, using the content below.
- Step 4:** Ask participants to brainstorm about the different types of people, including youth, who could benefit from support groups as well as the range of topics that could be discussed at a support group meeting. Write answers on flip chart and fill in as needed from the content below.
- Step 5:** Discuss the possible roles of Peer Educators in support groups (as facilitators and as participants). Encourage participants to draw on their own experiences with support groups and fill in using the content below. Stress the important role that Peer Educators play in organizing, co-facilitating, and participating in support groups with other members of the multidisciplinary team.
- Step 6:** Toss a ball around the room. When a person catches the ball, he or she should say one benefit of being in a support group, thinking specifically about ALHIV of different ages. Continue the game until the participants have listed most of the benefits and fill in using the content below.
- Step 7:** Close by reminding participants that while support groups may have many functions and benefits, the most important one is that they provide psychosocial and emotional support to their members.

KEY INFORMATION

What are support groups?

- Peer support groups are groups of people who come together because they share a common situation.
- In peer support groups, members help each other to better manage their situations, to share challenges, and to discuss solutions.
- Members support each other to do the things each has decided will improve his or her psychological, social, physical, and medical well-being.

Support groups can help ALHIV feel less isolated and help them live more fully and positively.



Some of the common characteristics of support groups include:

- They are made up of peers—people who are all directly affected by the same issue, illness, or circumstance (for example, a support group might be for ALHIV, caregivers of children living with HIV, young pregnant women living with HIV, etc.).
- They usually have a discussion leader or facilitator. Peer Educators may be leaders or co-facilitators of support groups.
- They tend to be fairly small in size so that everyone can have a chance to talk.
- Attendance is voluntary—no one should ever be forced to join a support group.
- Information shared within the group is private and confidential. Peer Educators should create a “safe space” for group members and should help make sure that all group members respect and maintain confidentiality. Peer Educators can be role models for confidentiality and make confidentiality the “norm” in the clinic and in support groups.

Support groups come in many shapes and sizes:

- Some support groups may be designed to be ongoing, with members coming and going in and out of the group over time.
- Other support groups may have a specific number of topics to cover, after which members are “graduated” out of the support group.
- Some support groups may be held at health facilities and others may be held in the community (for example, at schools, youth centers, community centers, or even in a person’s home).
- Support groups are most successful when they bring together groups of people who share common circumstances or issues (see below).

Here are some of the different types of support groups that may exist or be needed:

- **Adolescent support groups:** ALHIV face special challenges and may want to form their own support groups. These groups may involve recreational activities (sports, crafts, drama, etc.), as well as time for education, discussion, and mutual support. Also, adolescents who are all starting ART or who are at a similar stage in their treatment (either preparing to begin ART, starting ART, or having been on ART for a long time) may find it helpful to meet each other for mutual support. It is best that they are co-facilitated by a member of the multidisciplinary care team AND a ALHIV, like a trained Peer Educator.

- **Play groups for younger adolescents:** Younger adolescents or children living with HIV and their caregivers may benefit from groups where children of similar ages can play together and where they all have a chance to share and talk. These groups often involve child-friendly activities, like drawing, art, and music.
- **Groups for caregivers of ALHIV:** Family members of ALHIV may benefit from talking with each other or with a health care worker in a support group setting. Often family members need emotional support as well as ongoing educational and practical information to help support children's and adolescent's care and treatment.
- **Young mothers support groups:** Young mothers living with HIV and those caring for HIV-exposed or HIV-infected children may want to have their own support group. Young mothers support groups can provide needed psychosocial and emotional support to members and also help mothers understand and access key HIV and PMTCT services. These groups can also address concerns specific to mothers, such as safer infant feeding, care of HIV-exposed babies, and the importance of adherence to PMTCT and ART services.
- **Adolescent bereavement group:** The death of a loved one is an extremely painful experience, especially if it is the loss of a parent. One way that adolescents can cope with the death of a loved one is to join a bereavement group.
- **Couples support groups:** Young couples may wish to form support groups. This includes couples where both people are living with HIV and couples where only one is (i.e. discordant couples). Couples can share common concerns and challenges and support each other to live positively with HIV and to prevent new HIV infections.
- **Groups for other populations:** Other groups of people with common characteristics may wish to form their own support groups. This could include support groups for sex workers, men who have sex with men, street youth, orphans, or other vulnerable groups. In areas with a diverse population, groups of people that have the same ethnicity or speak the same language may wish to form their own support groups.

What role can Peer Educators play in support groups?

- Depending on the specific program, Peer Educators can work with health care workers and/or youth leaders to start support groups in health facilities or in the community.
- They can help organize support group meetings (such as helping the leader to decide on the location and to work out logistics, etc.)
- They can help recruit support group members from the clinic or the community.
- They can suggest youth-friendly activities or appropriate topics for the group to discuss.
- They can be role models for the group members and help make sure that the group provides a safe, confidential space for participants.
- They can give correct information and facts about HIV and try to dispel any incorrect myths or rumors (refer to *Module 3*).
- They can facilitate or co-facilitate support group meetings, for example with counselors, nurses, or youth group leaders.
- Whatever their exact role, Peer Educators should always work closely with members of the multidisciplinary care team and group leaders to plan, coordinate, and conduct support groups for ALHIV.



Peer Educators can be role models and help make sure that the group is a safe, confidential space for participants! They can also give correct information and facts about HIV and try to dispel any incorrect myths or rumors.

What are the benefits of support groups to the members?

- When a person does not know many (or any) other people who are going through what he or she is coping with, that person can feel isolated and stigmatized. Support groups help people who have a problem or illness feel less alone and more understood.
- Participants in a group can be role models for one another.
- A support group can be a safe place for someone who needs to talk about personal issues, experiences, struggles, and thoughts.
- Adolescents benefit from support groups because they trust information that they get from their peers more than information they get from adults. In a support group, members are equals. This can make people feel much more comfortable talking openly about their problems.
- Support groups can help members understand clinic- and community-based services better, can give members support to seek and adhere to different services, and can engage members' families and peers as supporters.
- Support groups also offer a way to link health facility services and community-based services for their members. For example, health care workers can speak about HIV services as part of community-based support group meetings. Or, leaders of community-based organizations, such as youth groups, can speak about the services they offer at health facility-based support group meetings.
- Support groups may also give income-generating, vocational, or educational assistance, or have savings and loan programs, which can benefit its members.

The main goal of support groups is to offer psychosocial and emotional support to members. While some support groups may decide to do other activities, like income generation projects, there should always still be a focus on psychosocial support.



SESSION 8.2: Practical Tips on Planning and Facilitating Support Group Meetings (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Brainstorming, Small Group Work, Case Study, Guest Speaker

Note: Invite 1-2 multidisciplinary care team members who are responsible for oversight and/or facilitation of support groups at the health facility to participate in this Session (e.g. a social worker, a counselor, a nurse, etc.). In addition, try to invite 1-2 youth group leaders who can give participants practical suggestions about planning and leading group activities.

Step 1: Introduce the Session by explaining that we will talk about 3 main topics: starting a support group, planning a support group meeting, and being a good support group facilitator. Discuss the importance of learning more about the support groups that already exist in the community and at health facilities before starting new support groups. Ask participants what Peer Educators can do to learn more about existing support groups and what specific questions they would ask about existing support groups. Fill in as needed using the information below.

Step 2: Ask participants to brainstorm the key steps to start a support group. Write answers on flip chart and supplement the discussion by reviewing the key steps needed to start a support group. Then ask the group:

- *What can Peer Educators do to help the multidisciplinary care team start a peer support group for ALHIV at the clinic?*

Encourage feedback and responses from the multidisciplinary care team members as well as participants.

Step 3: Ask participants to brainstorm the key steps to plan a support group meeting. Write answers on flip chart and supplement the discussion by reviewing the key steps needed to plan a support group. Then ask the group:

- *What things should you think about when planning a support group meeting for adolescents? What about a support group meeting for younger adolescents?*
- *What are some things you could do or suggest to the group facilitator to help members talk about their feelings?*

Encourage feedback and responses from the multidisciplinary care team members as well as participants.

Step 4: Ask participants to brainstorm about what qualities make a good group facilitator. Break the participants into small groups. Ask each group to draw an outline of a person on a piece of flip chart paper and to then draw body parts, images, and/or phrases to show the necessary characteristics of a good

facilitator (e.g. big heart for caring, big ears for listening skills, etc.). Allow each group to

present their work and facilitate discussion using the following questions:

- *What is the role of a support group facilitator? Of a co-facilitator?*
- *What makes a good support group facilitator?*
- *What things should group facilitators avoid doing?*
- *How should facilitators manage quiet support group members? What about managing very talkative members?*

Remind participants about the 7 essential communication skills and explain that these skills can also be applied to group work. Using the content below, review the tips for speaking in front of a group.

Step 5: Ask participants to get back into their small groups. Assign a multidisciplinary care team member to each small group and give each group a new piece of flip chart. Read the following scenario out loud to participants and ask them to answer the questions with input from the multidisciplinary care team member and to write their answers on the flip chart.

A nurse at the ART clinic where you work asks you to help facilitate this month's ALHIV support group meeting.

- *What questions would you ask the nurse?*
- *How would you prepare for the support group meeting?*
- *What would you do to be a good meeting facilitator?*
- *What would you do after the meeting?*

Step 6: Bring the large group back together. Ask each small group to briefly present their answers to the larger group and ask the support group and/or youth group leaders who were invited to offer feedback. Then, ask each leader to give 3-5 practical suggestions about planning or leading groups, based on his or her own experience.

Step 7: Close by emphasizing that planning and facilitating support groups are difficult tasks that require practice and experience. Working in partnership with other multidisciplinary care team members is necessary to ensure that the support group is productive and well-organized.

KEY INFORMATION

Things to Think About When Starting a Support Group

First, learn what support groups already exist in the community and at health facilities and then try to understand more about what support groups are needed:

- Ask adolescents who attend the clinic what kinds of support groups they are interested in, when they could come to a meeting, where they would like the meeting to be held, and what kinds of things they would like to talk about (e.g. adherence, stigma, relationships, disclosure, etc.).

Decide, mutually with the group facilitator/multidisciplinary care team member, who the support group is for:

- Who will be invited to attend?
- What is the ideal number and type of participants? It is recommended that support groups not have more than 10-15 people in the same meeting so that everyone can participate.
- How will you let people know about the support group?

Work with the group facilitator/multidisciplinary care team member and define the overall goals of the support group:

- What is the purpose of the support group?
- Is the support group meant to go on indefinitely or will it cover a certain number of topics and then come to an end?

Assist the group facilitator/multidisciplinary care team member to decide how often the group will meet and to select a convenient location, days, and times for the meetings:

- Where will the support group be held?
- What time and how often will the groups be held? Do most participants go to school or work during the day or do they have household chores that they need to do at certain times of the day? Is 1 hour enough or is 2 hours better?
- Will the group meet once each month? More often? Less often?

Decide with the group facilitator/multidisciplinary care team member who will lead the support group meetings and who will be invited to speak:

- Who will run the support group and what topics will be discussed? Will there be guest speakers?
- If the Peer Educator helps to facilitate the group, what are his or her exact roles and responsibilities going to be?

Planning and leading support groups are difficult tasks that require a lot of practice and experience. Working together with other multidisciplinary care team members is necessary to make sure that the group meetings are productive and well-organized!



Key Steps to Planning a Successful Support Group Meeting

Work in partnership with the group facilitator/member of the multidisciplinary care team to plan the logistics of the meeting:

- Is it a private space with enough places for people to sit?
- Can the room be arranged so participants are in a semi-circle (instead of in rows)?
- Will someone arrange tea or snacks for the meeting?
- Who will keep attendance and other records related to the support group?

Help plan an agenda and stick to it!

- Most support groups should last between 1-2 hours.

Suggested agenda items for support group meetings:

- Registration/sign-in
- Refreshments (tea, coffee, snacks, etc.)
- Welcome/opening (song, prayer, dance)
- Introductions
- Overview of the agenda
- Reminder about confidentiality and other ground rules
- Main group learning activity (game, health talk, etc.)
- Question and answer session
- Plan for the next meeting
- Closing (song, prayer, dance, etc.)

Make sure to suggest and help plan new learning opportunities and fun activities for support group members:

- Help keep everyone busy and having fun! Decide with the group facilitator which games and participatory activities will be conducted during the meeting (refer to suggestions in *Session 8.3*).
- Consider including a health talk as a part of each support group meeting. Health talks should be kept short and simple (about 15-20 minutes) so that support group members have time to discuss their feelings, questions, and concerns. Ask a nurse or other “expert” to lead the health talk.
- Get feedback from support group members on topics they would like to discuss during the meetings (including topics for the health talks) and incorporate these into the agenda. This can be done through an anonymous questions box.

Make sure the facilitator or co-facilitator reminds the participants about confidentiality and helps establish “ground rules”:

- It is always a good idea to remind support group members at the start of each meeting that what is said during the meeting will not be repeated to anyone. You can say, *“what is said in this room stays in this room.”*
- During the first group meeting, ask the participants to brainstorm possible ground rules. Examples include: not arriving late, what is said in the room stays in the room, not interrupting when another person is talking, respecting the opinions of others, allowing everyone a chance to speak, etc.

Offer ongoing support to participants:

- Encourage participants to speak in private with you or another facilitator (ideally, a member of the multidisciplinary care team) after the meeting if they have concerns they do not want to share with the group.
- Work with the group leader and make sure group members are given any needed referrals to other types of support and services.
- There may be situations where support group members urgently need assistance (for example, if they are mentally distressed, suicidal, violent, or a victim of violence). In these cases, Peer Educators should practice shared confidentiality and tell members of the multidisciplinary care team about these issues right away!
- Participants may also want to keep in touch with one another between support group meetings (e.g. through smaller informal meetings, text messaging, phone calls, etc.).

Keep basic records of the meeting:

- Always keep an attendance record. Remember that this record should be kept confidential.
- Ask someone to take simple notes at the meeting (or you can do this yourself after the meeting has finished). Write down what topics were discussed, key concerns of members, and any next steps.
- Write down the date, time, and location of the next meeting. Remember to remind participants about the time and date of group meetings and follow up with those who miss meetings using text messaging, email, or telephone (make sure to get their consent first).

Key Tips for Facilitators/Co-Facilitators of Support Group Meetings

Important points to remember when speaking in front of a group:

- Be sure to plan the group session ahead of time and practice what you are going to say.
- Do not stand behind a desk or other furniture.
- Encourage participants to sit in a semi-circle to make it feel less like a classroom and more comfortable to talk. The person leading the session should be part of the semi-circle. Make sure you can make eye contact with everyone and that no one is staring at your back.
- Speak loudly enough so everyone can hear you clearly, but not so loud that you are shouting.
- Always remind participants about confidentiality and be sure that you also practice confidentiality.
- Lead an introductory activity (have people introduce themselves or say something about their families) so participants feel more comfortable with one another.
- Interact with participants and get them involved by moving around the room, asking questions, and asking people to share personal stories/concerns, etc.
- Tell participants that they all likely know something about the topic being discussed. Encourage them to share what they know and to use this as an opportunity to identify and correct any misconceptions.
- Make eye contact with all members of the group.
- Check in regularly to make sure participants are engaged and understand the messages.
- Pay attention to participants who seem shy or quiet and emphasize that everyone's personal experiences, questions, and concerns are important.
- Use visual aids and avoid lecturing.
- Only say what you know are the facts. If you are not sure about something, check with a nurse or counselor. Never make up information.
- Encourage participants to speak with you in private after the meeting if they have concerns they do not want to share with the group.
- At the end of the meeting, ask participants to summarize what they have learned and the actions they plan to take.
- Always leave time for questions and re-explain anything that participants did not understand completely.

SESSION 8.3: Suggested Activities for ALHIV Support Groups (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Small Group Work, Return Demonstration, Role Play

Note: Invite 2-3 multidisciplinary care team members who are responsible for oversight and/or facilitation of support groups in the health facility to participate in this Session (e.g. social workers, counselors, nurses, etc.). In addition, try to invite 1-2 youth group leaders who can offer practical suggestions about planning and leading group activities.

Step 1: Start by asking participants the following questions:

- *What activities have you done in groups before that increased learning, discussion, and the sharing of information?*
- *What activities do you think could be done in support groups with older adolescents?*
- *What activities do you think could be done in support groups with younger adolescents?*

Step 2: Groups can have different purposes and can use different methods (e.g. discussion, activities, health talks, etc.). Introduce the concept of activity-based support groups and describe generally how to facilitate such groups, using the content below. Emphasize that using activities as a focus during a group session can encourage better discussion and more open communication, can help with skill building, and can create an environment where group members share information, learn, and support one another. Review some of the suggested activities from the content below and ask participants to suggest others. Allow time for questions.

Step 3: Set up at least 4 different stations around the room. Assign a co-trainer/multidisciplinary care team member to each station. Each station should have the name of a suggested activity and instructions written on a piece of flip chart paper. Break participants up into 4 small groups and assign each group to a station. First, the trainer/multidisciplinary care team member at each station should quickly describe the activity to the small group and demonstrate how it should be conducted at a support group meeting. Then, each group should choose a facilitator who should practice leading the activity with the group. After about 10 minutes, the groups should rotate to a new station and should choose a different participant to be the facilitator of that station's activity. Continue until each group has practiced at all of the activity stations.

Bring the large group back together and debrief by emphasizing the following points:

- *Games can be used to learn! It is very important that you are prepared, that you know the instructions you will give participants, and that you organize any required materials beforehand.*
- *Use good communication skills and group facilitation skills and keep all participants involved.*
- *Remember to always ask debriefing questions at the end of the activity, such as, "What did we learn from this activity?"*

Step 4: Remind participants that they may be asked to facilitate a support group meeting or to support other facilitators. It is important to ALWAYS plan ahead, to be prepared, and to use good communication skills!

KEY INFORMATION

Key Points on Facilitating Activity-Based Support Groups

- Activity-based support groups help group members improve their social and problem-solving skills as well as their ability to work together.
- Learning to facilitate support groups takes time and practice. Using an activity as a focus for the group is a good way to create structure for meetings. Activities help get group members talking, especially in the beginning when they may feel shy or scared.
- The success of activity-based group sessions depends mostly on the preparation of group leaders. Always plan ahead and come to the session prepared!
- After welcoming the group members, making introductions, and deciding on ground rules, the group leaders should introduce the activity and explain that it relates to a particular theme in the lives of ALHIV (e.g. adherence, school, partners, living positively with HIV, stigma, etc.).
- Next, the group leader should carefully explain the rules of the activity. Explain instructions step-by-step and be sure to ask if anyone has questions or is unclear about the instructions. It is also helpful to write out any instructions on a flip chart.
- The role of the group leaders is to help participants have meaningful discussion during the activity. Ask members to share what they observe, think, and feel during the activity, and how they think the activity relates to their life.
- At the end of the activity, always ask group members about the feelings and opinions they had during the activity, what they learned, how this applies to their own lives, and what they liked/disliked about the activity. The trainer can summarize these statements as a way to close the session.

Ideas for support group activities with ALHIV:

Arts and Crafts Games

These games help adolescents think about themes in their lives in new ways. They can be very useful for younger adolescents, who enjoy doing activities that are hands-on, participatory, and creative.

Examples: Painting or drawing a picture of a scene where participants were discriminated against and discussing their feelings; making puppets out of locally-available materials and doing a performance; creating team murals (each team makes a wall drawing showing how they would fight stigma in the community and get everyone to support ALHIV)

Sculpturing

Ask participants to put their whole bodies into a position that communicates an image of an issue or relationship. The resulting “sculpture” is then discussed.

Example: Ask young people to get into groups of 2 and ask each pair to make a sculpture showing how people treat YLHIV. Ask them to decide on roles—one person should be a YLHIV and the other should be a person stigmatizing him or her (i.e. someone in the community, school, or clinic). After all groups have come up with their sculptures, ask some of the pairs to go into the center of the circle and show their sculpture to the others. After each demonstration, ask:

What do you think this person is saying?
How do you think these people are feeling?

Ask the people in the sculpture:

What are you thinking?
Why are you doing that?

Plays/drama/mime/role play

Ask participants to work in small groups to create a play about a specific issue, such as negotiating safer sex, disclosing to a friend, living positively with HIV, or fighting stigma in schools or the community.

Journaling

Ask participants to create an “All About Me” box or journal using magazines, markers, and any other decorative items they can think of. Ask participants to think about the special things (hobbies, traits, talents, strengths, etc.) that make up their identity. Also, ask them to think about their future goals and dreams, including in the box or journal images that show who they want to be as an adult (e.g. having a family, going to university, having a career).

Charades

Players try to act out terms or concepts without speaking.

Materials: A watch or clock; slips of paper (blank or with phrases written on them, like “*good adherence to care and medicines,*” “*poor adherence to care and medicines,*” or phrases about good coping and positive living, like “*eating well*” and “*exercising*”); two baskets, hats, or other containers for the slips; and a piece of paper and pencil to keep score.

Play: Divide the participants into 2 teams and give each team half of the slips of paper. If the slips of paper are blank, give the teams time to come up with an idea to write on each (a term, phrase, or concept related to the material they are learning). Choose a neutral timekeeper/scorekeeper or have the teams take turns keeping score. Review the gestures and hand signals that will be used during the game (e.g. holding up 1 finger will mean first word in the phrase, pointing to your ear will mean “sounds like...”).

To play, teams take turns having 1 player choose a slip from the other team’s basket. Then the player has 3 minutes to, without speaking, use gestures and actions to help his or her team members guess what is written on the slip.

Normally the game continues until every player has had a chance to “act out” a phrase. Scoring may be based on 1 point for every slip correctly guessed. Another scoring option is based on the total time that each team needed for all of the rounds; with this system, the team with the lowest score wins the game.

Note: Some of the preceding activities were adapted from: Program for Appropriate Technology in Health (PATH). (2006). *Games for adolescent reproductive health: An international handbook*. Washington, DC: PATH.

SESSION 8.4: Classroom Practicum on Planning and Facilitating a Support Group Meeting (105 minutes)



TRAINER INSTRUCTIONS

Methodologies: Observation (optional), Small Group Work, Case Studies, Role Play, Large Group Discussion

Note: If possible, take participants to observe a support group meeting, either in the community or in a health facility. Be sure to introduce participants to the support group facilitator and members, and explain why they are observing. After returning to the classroom, debrief on what participants observed at the meeting and what things they would have done the same or differently. If it is not possible to observe an actual support group meeting during the training, arrange for participants to do so after the training has finished or as part of the practicum in *Module 14*.

- Step 1:** Divide participants into groups of 4 and assign a multidisciplinary care team member and/or co-trainer to each group. Assign one of the case studies below to each group. Give each group flip chart and markers. Encourage the groups to find a quiet place where they can sit together away from distraction. Give the groups about 40 minutes to read through their case study and to discuss the questions. The groups should answer the questions, develop a written agenda for the support group meeting, and practice co-facilitating the meeting with their multidisciplinary care team member.
- Step 2:** Bring the large group back together. Give each small group about 15 minutes to present the main points of their discussion and to role play how they would facilitate parts of their specific support group meeting (with other participants acting as support group members). After each role play, discuss what was done well and what the facilitator(s) could have done better. Have participants refer back to the tips on facilitation in *Session 8.3* to guide their feedback.
- Step 3:** Debrief the practicum by asking participants to reflect on their experiences leading the practice support group meetings. Also briefly discuss their specific role in starting and facilitating support groups with the multidisciplinary care team and Peer Educator supervisors.
- Step 4:** Close the Session by reminding participants that support groups are meant to provide psychosocial and emotional support to members and to help them understand, access, and adhere to key health care services, including HIV care and treatment.

KEY INFORMATION

Case studies for small group work

Case Study 1:

You and another Peer Educator are starting a ALHIV support group at your health facility with the help of one of the health care workers. By talking to ALHIV at the clinic, you have learned that most of the younger ALHIV do not belong to a support group and that they would be interested in joining one. The group will meet twice per month.

1. *What is the general goal of the group?*
2. *Make a simple agenda for the first support group meeting, choosing at least one group activity.*
3. *Practice how you would start the support group meeting.*

Case Study 2:

One of the nurses at your health facility notices that many of her older adolescent clients are not coming back to the clinic on time for their appointments and are not taking their ARVs consistently. She is having trouble getting through to her clients about the importance of adherence to care and treatment and is worried that some of her clients are not practicing safer sex with their partners. The nurse comes to you because she wants you to help organize an adherence and positive living support group for older adolescents at the clinic. She says that she will co-facilitate the support group meetings with you.

1. *What is the general goal of the group?*
2. *Make a simple agenda for the first support group meeting, choosing at least one group activity.*
3. *Practice how you would start the support group meeting.*

Case Study 3:

A nurse asks you to help her with a support group for younger adolescents and their caregivers. Most of these clients have not been fully disclosed to by their caregivers—in other words, they may know something about HIV, but they have not yet been told that they are living with HIV for life. About 8 caregivers and the young adolescents they care for are expected to attend the meeting.

1. *What is the general goal of the group?*
2. *Make a simple agenda for the first support group meeting, choosing at least one group activity.*
3. *Practice how you would start the support group meeting.*

Case Study 4:

You, a counselor at your clinic, and another Peer Educator try to learn more about support groups in the community so you can refer your clients to them. You learn that there was a strong support group for ALHIV run by a local church and that this group was mostly for youth who were HIV-infected at birth. The support group had about 30 active members but in the past year the group has not met regularly and members often miss meetings. After talking with other members of the multidisciplinary care team and some of your clients, you decide that you should try to work together and improve this community support group instead of starting a new one. You will work with your colleagues and the local church to plan the next ALHIV support group meeting in 2 weeks.

1. *What is the general goal of the group?*
2. *Make a simple agenda for the support group meeting, choosing at least one group activity.*
3. *Practice how you would facilitate the support group meeting, starting from the beginning.*

Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

The International HIV/AIDS Alliance. (2010). *We are all in the same boat. Using art and creative approaches with young people to tackle HIV-related stigma*. UNESCO.

Morgan, J. (2009). *Hero book manual*. REPSSI.

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SESSION 8.5: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Game, Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants to get up and stand in a large circle. Start with the ball at your feet and state one key point of the module out loud. Kick the ball to one of the participants, who should then state another key point. Continue on until all participants have listed a key point. Fill in as needed using the content below.
- Step 2:** Ask if there are any questions or clarifications.
- Step 3:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 4:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Peer Educators play an important role working with multidisciplinary care team members to start support groups in the health facility or in the community, co-facilitating support group meetings, and helping others organize and recruit members for support groups.
- While there are many different types of support groups, they should all aim to provide psychosocial and emotional support to their members.
- In peer support groups, members help each other to improve, to better manage their situation, to share challenges, and to discuss solutions.
- A support group should be a safe place for people who need to talk about personal issues, experiences, struggles, and thoughts.
- Careful planning is one of the keys to a successful support group. This includes having clear goals and objectives for the groups and an agenda for each meeting. It is important to ask potential support group members questions like what they want to get out of the support group and when/where is convenient for them (this is especially important for youth who are often busy at school or work).
- Including short health talks as part of support group meetings is one way to share information with members and to encourage them to seek health services. This is also a way to get other multidisciplinary care team members involved in the support group.
- Support group meetings should always be participatory and everything that is said during the meetings should be kept confidential.
- Good facilitation skills are important for running successful support group meetings.
- All adolescents can benefit from activity-based support groups, which can incorporate games, music, acting, journaling, and play.

MODULE 9: Understanding and Supporting the Disclosure Process



DURATION: 250 minutes (4 hours, 10 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Reflect on their own values around disclosure
- Discuss why and how disclosure is a process
- Discuss the advantages and disadvantages of disclosure in their own lives and the lives of other ALHIV
- Discuss why it is important for Peer Educators to be open with their own status
- Work with other members of the multidisciplinary care team to provide practical support to adolescents throughout their disclosure process
- Discuss why it is important for younger adolescents and children living with HIV to know their HIV-status
- Work with other members of the multidisciplinary care team to support caregivers in the disclosure process with children and younger adolescents



CONTENT:

Session 9.1: Introduction to Disclosure

Session 9.2: Supporting ALHIV in Their Disclosure Process

Session 9.3: Working with ALHIV Who Have Not Been Fully Disclosed to and Supporting Caregivers in the Disclosure Process

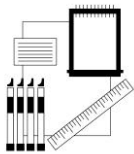
Session 9.4: Classroom Practicum on Disclosure Support

Session 9.5: Module Summary



METHODOLOGIES:

- Reflection
- Small group work
- Large group discussion
- Interactive trainer presentation
- Card storming
- Brainstorming
- Start-stop drama
- Role play
- Case studies



MATERIALS NEEDED:

- Flip chart
- Markers
- Tape or Bostik
- Blank index cards or small pieces of paper for *Session 9.1*
- Drum or object that can be used as a drum (e.g. a bucket or a box) in *Session 9.1*
- Copies of the Talking Tree in *Appendix 9A*



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- For the drumming game in *Session 9.1*, prepare a box containing pieces of paper with a suggested values clarification statement written on each one.
- Make enough copies of the Talking Tree in *Appendix 9A* so that each participant has multiple copies.
- Review the case studies in *Session 9.2* and *9.4* and adapt to the local context as needed.

SESSION 9.1: Introduction to Disclosure (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Game, Large Group Discussion

- Step 1:** Review the Module learning objectives. Explain that in this Module participants will learn many things about disclosure, including:
- Why it is important for Peer Educators to be comfortable disclosing their status to clients
 - How Peer Educators can help other ALHIV disclose to others
 - How Peer Educators can work as part of the multidisciplinary care team to support caregivers throughout the disclosure process to children and adolescents
- Step 2:** Lead the values clarification exercise by first asking participants to get in a circle. Put the box containing the pre-prepared values clarification statements in the middle of the circle. Ask for a volunteer to drum and start the game. This 1st drummer should walk slowly around the circle while drumming. When he or she stops drumming, the person standing closest to the drummer should pick one paper out of the box, read the statement out loud, and then respond to it by saying whether he or she agrees or disagrees with the statement and why. Then, ask at least 2 others to respond as well. The person who read the 1st statement now becomes the drummer. He or she should start drumming again and walk around the circle, etc. Once all the statements have been read out, facilitate a group discussion about the exercise.
- Close the activity by reminding participants that it is important for us to be aware of our own values and attitudes related to disclosure so that we can make sure they do not affect the quality of counseling we provide to clients.
- Step 3:** Next, ask participants what is meant by the terms "*disclose*" and "*disclosure.*" How do these terms translate into the local language? Write responses on a flip chart and fill in using the content below.
- Step 4:** Ask participants what they think is meant by the phrase, "*Disclosure is an ongoing process.*" Write answers on flip chart and fill in using the content below. Emphasize that disclosure is not a one-time event and give the example of a client who spends time talking with her parents and the counselor about disclosure, then discloses her status to her partner, then to some of her close friends, and later to other family members, etc.
- Step 5:** Write the word "**ADVANTAGES**" on one piece of flip chart paper and "**DISADVANTAGES**" on another. Ask participants to brainstorm some potential advantages and disadvantages of disclosure for ALHIV and write down responses on the two flip chart papers. Fill in using the content below, emphasizing that helping a client think about the advantages and disadvantages of disclosure is an

important part of supporting the disclosure process.

Step 6: Tell participants that an important part of being a Peer Educator is being comfortable disclosing one's HIV-status at the clinic, even though some clients may be from the Peer Educator's community. Explain that by "breaking the silence" and openly disclosing their own HIV-status, Peer Educators can help adolescents overcome their fear of disclosure and help them deal with issues like self-stigma. Ask participants to discuss these questions:

- *Why is disclosure among Peer Educators important?*
- *Why might some Peer Educators be hesitant to disclose their status openly at the clinic and in their work as Peer Educators? How can we reduce these barriers?*
- *What are some of your personal concerns about openly disclosing your HIV-status at the clinic?*
- *How can Peer Educators support each other to be disclosure role models for other ALHIV?*

Step 7: End the Session by highlighting the impact of stigma on people's ability to disclose their HIV-status. Explain that as more and more people, including Peer Educators, openly disclose their status, we will eventually reach a tipping point and make HIV "normal." At that point, stigma and discrimination around HIV will start to decrease.

KEY INFORMATION

Statements for the values clarification drumming game:

- If a younger adolescent is taking ARVs, they have a right to know why they are taking these medicines.
- ALHIV should always tell their teachers about their HIV-status.
- ALHIV should be told to keep their HIV-status a secret.
- ALHIV can play an important role in educating other youth about HIV.
- It is wrong for people who are HIV-positive to not tell their sexual partners their HIV-status.
- Young adolescents do not need to know they are HIV-positive—it is better to wait until they are older to tell them.
- Disclosing to a trusted person can help a person adhere to their medicines and live positively.
- It may not be safe for a young woman to tell her partner that she is HIV-positive.
- Parents of an HIV-infected child should be open with the child about HIV as early as possible.
- As a Peer Educator, it is a good idea to convince other ALHIV to be open with their HIV-status.
- Some clients might choose not to tell anyone that they are HIV-positive, and that is okay.
- If parents or caregivers refuse to tell their child that he or she is HIV-infected, it becomes the job of the nurses and doctors to tell the child.
- A child does not really need to know how he or she got HIV.

Disclosure Basics

The word **disclose** means:

- To reveal
- To make known
- To make public
- To share

What is disclosure?

- Disclosure is when someone tells one or more people about his or her HIV-status.
- **Disclosure is an ongoing process**, it is not a one-time event (see below).
- ALHIV need ongoing support and need to talk regularly about disclosure with their family, friends, and the entire multidisciplinary care team (including Peer Educators).

What exactly do we mean by “disclosure is an ongoing process?”

- For children and young adolescents, caregivers should start the disclosure process early. First they may want to “partially disclose” to the child, which means just telling him or her some things about having a sickness and needing to go to the clinic. Over time, caregivers should move to “full disclosure,” which means the child or adolescent knows that he or she is living with HIV and knows exactly what this means.
- Once older children and adolescents know their HIV-status, it takes some time for them to fully understand what this means and to come to terms with their status.
- For adolescents who know their HIV-status, disclosure to others is also a process. At first, young people will likely want to tell only one or a few people they are close with about their HIV-status (like family members, sexual partners, close friends, etc.). Over time, and as they feel more comfortable, adolescents will likely tell more people about their HIV-status.
- All of these processes require ongoing communication and counseling with young people and caregivers. Peer Educators can play an important role in this ongoing process.

Advantages of disclosure may include:

- Avoiding the burden of secrecy and hiding
- Avoiding anxiety about accidental or unwanted disclosure
- Access to emotional and practical support from peers or family members
- The ability to talk about symptoms and concerns
- Easier access to health care
- Improved adherence to care and medicines
- The ability to discuss safer sex and family planning choices with one’s partner(s)
- The ability to refer one’s partner(s) for HIV counseling and testing, and to care and treatment if needed
- For pregnant women, the ability to get support for PMTCT from family members and friends (like giving the baby ARVs and feeding the baby safely)
- The freedom to ask a friend or relative to be a treatment buddy
- Access to patient support groups and community organizations
- Serving as a disclosure role model for other people

Disadvantages of disclosure may include:

- Blame by partner or family for “bringing HIV into the household”
- Distancing, fear, rejection, or abandonment by partner, family, or friends
- Discrimination at school
- Discrimination in the community
- Discrimination at work, including the possible loss of one’s job

- Others making assumptions about one's sexuality, promiscuity, or lifestyle choices
- Rejection in the community
- Partner not wanting to have children
- Physical violence
- Self-stigma
- Loss of economic support from family members or partners.

Part of being a Peer Educator is openly disclosing your status to clients. Peer Educators should be disclosure role models and should also support one another with disclosure!



SESSION 9.2: Supporting ALHIV in Their Disclosure Process (50 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Brainstorming, Case Studies, Role Play

Step 1: Tell participants that in this Session we will focus on how Peer Educators can support other ALHIV to disclose their HIV-status to others.

Step 2: Ask participants to think about disclosure in their own lives. Ask them to think about a time they disclosed their HIV-status to another person and ask them to write down their responses to the following questions on a piece of paper (the paper will not be shared).

- *What were your fears about disclosing to that person?*
- *How did you prepare to disclose to that person?*
- *How did you start the discussion when you disclosed your status to that person?*
- *What was the person's reaction to your disclosure?*
- *What happened in the days and weeks after you disclosed to that person?*
- *What were the advantages of telling them?*
- *What were the disadvantages of telling them?*
- *Did you have any regrets after telling them? Why or why not?*

Facilitate a discussion by encouraging participants who are willing to share their stories and their responses.

Step 3: Ask participants to brainstorm about the role of Peer Educators in giving disclosure support to clients. Ask the following question to facilitate discussion:

- *Based on your personal experience, what do think are some different ways Peer Educators can support ALHIV in their disclosure process?*

Write answers on flip chart and fill in as needed using the content below.

Step 4: Remind participants that, as Peer Educators, one way they can help clients prepare for disclosure is by role playing how to start the disclosure conversation. Ask participants to reflect on their own experiences and brainstorm some different ways a person could start a disclosure conversation with someone they trust. Ask participants to turn to the person next to them and to spend 5 minutes practicing how to start a disclosure conversation with a close friend, family member, or classmate. Ask each person to role play at least 2 practical "conversation starters."

Step 5: Read the case studies below one at a time out loud to the group. For each one, ask participants to discuss how they would talk to the client to help him or her explore the advantages and disadvantages of disclosure. If there is enough time, ask for 2 volunteers to role play the case study in front of the large group (with one participant acting as the Peer Educator and the other acting as the client).

Step 6: Close the session by reminding participants that Peer Educators, in collaboration with the multidisciplinary care team, can play an important role in helping clients prepare to disclose to people they trust and in giving them needed emotional and follow-up support.

Emphasize that disclosing one's HIV-status can be scary but it can also be empowering. Making decisions about disclosure is an important step for ALHIV, who may fear rejection and violence from family, friends, and partners. Some adolescents may have to confront additional stigma because of their sexual orientation and others may be scared to disclose information about their drug use or risky sexual behaviour.

KEY INFORMATION

How can Peer Educators help ALHIV during the disclosure process?

- Adolescents should make their own decisions about disclosure but Peer Educators can support them by answering their questions in an accurate and detailed way.
- Give realistic information and practical suggestions based on your own experience with the disclosure process.
- Remember to give clients ongoing and regular reassurance and emotional support during the disclosure process. Most ALHIV will disclose to one person at first and then more people over time.
- Talk about disclosure in ALHIV support groups.
- Use good communication skills (e.g., use good body language, ask open-ended questions, summarize and reflect, etc.) to talk about the client's fears and feelings around disclosure.
- Discuss the advantages and disadvantages of disclosure specific to each client's life.
- Help people weigh the advantages and disadvantages of disclosing their HIV-status to different people in their lives.
- Identify who supports them (e.g. peers, family, community members, etc.).
- Help clients decide whom to disclose to, when, and where, using the Talking Tree as a tool to guide the conversation.
- Encourage clients to take the time they need to think things through.
- Work with clients to think about a person's possible responses.
- Practice disclosure with clients through role plays, including giving suggestions about how they could start the conversation. For example, you can suggest the following "conversation starters" to clients who are unsure about what to say to family or friends:
 - *"I wanted to talk to you about something because I know you can help and support me."*
 - *"I went to the clinic today for a checkup and they talked to me about how it is important for everyone to get an HIV test because you can't tell if someone has HIV just by looking at them."*
 - *"I want to talk with you about something very important right now. I am talking to you about it because I love you and I trust you."*

– “I need to talk to you about something difficult right now. It is important that I be able tell you even the hard things. We need to support each other.”

- **Never work alone! ALWAYS work together with other members of the multidisciplinary care team—such as nurses, counselors, or social workers—to support clients with disclosure.**

Case Studies for large group discussion:

Case Study 1:

J___ is 16 years old and found out that she is HIV-positive at a VCT clinic 2 months ago. She came back to the ART clinic today for a second visit and says that she has not yet told anyone about her HIV-status because she is too ashamed and scared.

How would you help J___ explore the advantages and disadvantages of disclosure?

Case Study 2:

V___ is a 12-year-old boy who was perinatally infected with HIV. He tells you that he is really worried and stressed out about telling his best friend at school that he has HIV. His family knows his status but none of his friends know.

How would you talk to V___?

Disclosure can be scary for adolescents! Some YLHIV fear rejection and violence from family, friends, and partners. Some adolescents may also be scared to disclose their HIV-status because they are afraid to reveal information about their drug use, sexual behaviors, or sexual orientation.



SESSION 9.3: Working with ALHIV Who Have Not Been Fully Disclosed to and Supporting Caregivers in the Disclosure Process (50 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Case Study

Step 1: Tell participants that in this Session we will talk more about the ways Peer Educators can help support caregivers in the process of disclosing to their children. Begin by asking participants:

- *How is telling a child that he or she has HIV different from an older adolescent or an adult disclosing his or her own HIV-status?*

Step 2: Next, ask participants:

- *What are some reasons that so many adults, including health care workers, do not want to tell children about their HIV-status?*
- *Why might parents or caregivers find it difficult to disclose to their child?*
- *Do you believe that children should be told about their HIV-status? Why or why not? At what age?*

Discuss responses, filling in using the content below. Next, present the reasons why children should know their HIV-status using the content below.

Step 3: Ask participants who feel comfortable sharing their own experiences to talk about when they learned their HIV-status from parents or caregivers.

Step 4: Ask participants what they think the difference is between “partial disclosure” and “full disclosure.” Fill in as needed using the content below.

Remind participants that it is important for parents and caregivers to start the partial disclosure process early, and definitely by the time the child is 5 years old. This will help the disclosure process continue over time. As the child develops, caregivers should move towards full disclosure, which is when the child knows that he or she is HIV-infected. While there is not a “one size fits all” approach, most children should be fully disclosed to between the ages of 7 and 11.

Explain that it often takes time for a child to fully understand and come to terms with his or her status. This is why it is important that we provide an environment where children can keep asking questions and talk about their experiences coming to terms with their HIV-status. Peer Educators can work with other providers to make sure children have this kind of environment at the clinic and to encourage caregivers to talk regularly with their child about his or her status.

Step 5: Explain to participants that Peer Educators can work with other members of the multidisciplinary care team to help caregivers prepare for disclosure to younger adolescents. Discuss how they can work with members of the multidisciplinary care team to support caregivers of young adolescents who may not be fully

disclosed to, filling in using content below.

- *What can Peer Educators do to help the multidisciplinary care team support caregivers in planning for disclosure?*
- *What issues should Peer Educators keep in mind when they are helping to support caregivers (e.g. avoiding accidental disclosure to the child)?*
- *What group activities are good to use with younger adolescents that may not be fully disclosed to?*

Step 6: Debrief by explaining that disclosure is a complicated process for adolescents. The Peer Educator's role is to work with the multidisciplinary care team when talking to caregivers, to give emotional support, and to offer their perspective and practical suggestions based on their personal experience.

KEY INFORMATION

What are some of the reasons adults (including health care workers) do not want to tell children or younger adolescents about their HIV-status?

- Sometimes they do not know where to start.
- If there are other children who are not HIV-infected in the home, there may be concerns about how the other children will react or how the HIV-infected child will feel.
- They fear that disclosing will cause psychological harm to the child.
 - They fear that disclosing will reduce the child's will to live.
 - They fear that disclosing will make the child think he or she is not normal.
 - They have the belief that children are supposed to be happy, and that knowing they have HIV will make them no longer enjoy their childhood.
- They are afraid that the child's or family member's HIV-status will be revealed by accident.
 - Children are not always good at keeping secrets.
 - Children may not understand the stigma attached to HIV.
- They want to protect the child from social stigma, discrimination, and rejection.
- They feel guilty that the child is HIV-infected.
- They are not comfortable talking about taboo subjects (such as sex) with children.
- They believe that children are too young to understand complicated health issues.

Why might parents or caregivers find disclosing to their child difficult?

- They may have a hard time coping with their own illness or the illness of other loved ones.
- Families have different ways of coping. Some use silence, have limited communication, or deny that the child has HIV.
- Some caregivers believe that the child will not understand.

What are the reasons to disclose a young person's HIV-status?

- All youth have a right to know about their own health.
- Youth who have not been disclosed to may:
 - Have frightening or incorrect ideas about their illness
 - Feel isolated and alone
 - Learn their HIV-status by mistake

- Have poor adherence
- Youth often want and ask to know what is wrong. Youth are observant, smart, and curious. They often know much more than adults think they do.
 - Younger adolescents may already suspect their HIV-status but are keeping it a secret or waiting for an adult to talk to them about it.
 - Younger adolescents may have fears about their HIV-status, especially if one or both of their parents has died.
- The later a young person is told about their status, the more difficult it will be for the young person to accept.
- When youth learn about their status directly from their caregivers, it can provide comfort and reassurance. Too often, younger adolescents overhear health care workers and caregivers talking about their health as if they were not in the room.
- Younger adolescents who know their HIV-status can take an active role in their own care and treatment plan and, when old enough, can take steps to live positively and prevent new infections.
- Orphaned or other vulnerable adolescents may wonder why they have lost a parent or been rejected by the family. They need to know the truth. This will also help adolescents get the services they need, especially those who do not have regular caregivers.

Partial and full disclosure

Partial disclosure:

- Means giving a child information about his or her illness without using the actual words “HIV” or “AIDS”
- Should start at an early age (and definitely by age 5)
- Helps move the disclosure process forward and prepares the child for full disclosure later on
- Is an effective strategy to help caregivers who do not yet feel ready for full disclosure
- Is part of a process in which caregivers move little by little toward full disclosure

Full disclosure:

- Means telling a child specifically that he or she is HIV-infected and giving him or her information about what this means (including that the child will need lifelong HIV care and treatment)
- Is easier for the child if they have been partially disclosed to over time, understand some basics about their health and their care and medicines, and have been supported throughout the disclosure process
- It often takes time for young people to understand and come to terms with their HIV diagnosis, so the disclosure process requires ongoing communication (at the clinic and at home) even after the young person knows his or her status.
- Remember that disclosure is an ongoing process and not a one-time event. Clients and caregivers both need ongoing and regular disclosure support from the entire multidisciplinary team, including Peer Educators.

Peer Educators can help adolescents and their caregivers with the disclosure process by:

- Helping provide an environment where children can keep asking questions and talk about their experiences coming to terms with their HIV-status
- Being an ongoing source of information and support throughout the disclosure process, both for caregivers and adolescents
- Working with members of the multidisciplinary care team to encourage caregivers to talk regularly with their child about his or her status and to encourage open communication at home

- Helping a nurse, counselor, or social worker talk with the parents or caregiver at follow-up appointments to see how the child is handling knowing his or her status
- Talking about their personal experiences with disclosure
- Offering support and understanding to the family to cope with their emotions and feelings during the disclosure process
- Suggesting (and leading) a ALHIV support group



Peer Educators can work with the multidisciplinary care team to help support clients and caregivers with the disclosure process. They can offer ongoing emotional support and can also refer the client and caregiver to a support group. Most importantly, they can give information and answer questions based on their personal experience!

SESSION 9.4: Classroom Practicum on Disclosure Support (75 minutes)



TRAINER INSTRUCTIONS

Methodologies: Small Group Work, Case Studies, Role Play, Large Group Discussion

- Step 1:** Divide participants into groups of 3 and assign each group one of the case studies below. Ask participants to role play the case study, with one person playing the Peer Educator giving disclosure support, the second playing the client, and the third acting as an observer. Remind participants of the Talking Tree (*Appendix 9A*), emphasizing that Peer Educators can use this as a tool to help guide their conversations about disclosure with ALHIV. Each group should use the Talking Tree during the role play of at least their first case study. Throughout the activity, trainers should move around the room and give feedback to the small groups. If time allows, groups may move onto a second case study.
- Step 2:** After about 30 minutes, bring the large group back together. As time allows, ask the small groups to perform their role play. After each role play, ask the other participants to give feedback using these questions:
- *What did the Peer Educator do well?*
 - *What other points do you think the Peer Educator could have discussed with the client about disclosing his or her HIV-status?*
- Step 3:** Close the Session by stating that, for Peer Educators, part of helping clients means being open about their own HIV-status. Helping clients during the disclosure process does NOT mean putting pressure on them to disclose. Instead, Peer Educators should focus on helping the multidisciplinary care team support clients to work through issues related to disclosure, allowing them to talk about their concerns and, if they have decided they want to disclose their status to someone, working with them to make a plan.

KEY INFORMATION

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue they are experiencing—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in

finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.

2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” such as inner strengths, talents, skills, and spiritual resources to help in coping.
6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

Peer Educators can use the Talking Tree to help guide their conversations with clients about disclosure.



Case studies for role play:

Case Study 1:

H___ is 16 years old and tested positive for HIV about 2 years ago. H___ got tested because his girlfriend at that time found out she was HIV-positive. He now has a different girlfriend and he has not told her about his HIV-status. He takes good care of himself and feels fine. Today, he has come to the clinic for his regular appointment and wants to talk with you about how to tell his girlfriend that he is living with HIV. He does not like using condoms and is afraid that if he starts using them with her, she will know he has HIV.

What would you say to H___ in order to support him in the disclosure process?

Suggested responses for Talking Tree:

1. **Main issues for this client:** Disclosing to his girlfriend, risk reduction/using condoms with his girlfriend, partner testing
2. **Cause of issue:** Fears related to disclosure, potential problems/conflict with his girlfriend if he discloses
3. **Roots:** Talk with H___ about who else supports him in his life: friends, family, teachers, people at church?
4. **Hope for future/goal:** Disclosing to his girlfriend; talk about advantages and disadvantages of disclosing to his girlfriend, what he thinks his girlfriend's reaction will be, etc.
5. **Branches/options/coping/potential solutions:** Talk to H___ about how and when he can disclose to his girlfriend; role play some examples of how to start the conversation; ask H___ if he has disclosed to other people and talk about that experience; offer H___ practical suggestions based on your own personal experience; talk about how he can start practicing safer sex with his partner, including using condoms
6. **Next steps:** Suggest a support group for ALHIV, recommend that H___ come back to the clinic to talk more with a Peer Educator about preparing for disclosure to his girlfriend; talk with H___ about the importance of using condoms with his partner; give H___ condoms and show him how to use them
7. **Summarize main points:** Give H___ a referral to the support group, remind H___ about his next appointment at the clinic and with the Peer Educator, offer praise and emotional support, tell H___ you can work together to help him prepare to disclose to his partner and to start practicing safer sex
8. **Review and discuss the H___'s situation and "next steps" with the program supervisor or a member of the multidisciplinary care team.**

Case Study 2:

S___ is a 14-year-old girl who was perinatally infected with HIV. S___ really wants to disclose to one of her male friends at school. S___ likes her friend very much and she knows that he likes her, but S___ is nervous about her friend's reaction. They have been arguing recently because S___ has been avoiding him. S___ has come today to ask your help to decide what to do.

What would you say to S___ to support her in the disclosure process?

Suggested responses for Talking Tree:

1. **Main issues for this client:** Disclosing to her friend
2. **Cause of issue:** Fears related to disclosure, potential problems/conflict with her friend
3. **Roots:** Talk with S___ about who else supports her in her life: friends, family, teachers, people at church?

4. **Hope for future/goal:** Disclosing to her friend and possibly others; talk about advantages and disadvantages of disclosing to her friend, ask S___ what she thinks her friend's reaction will be
5. **Branches/options/coping/potential solutions:** Talk to S___ about how and when she can disclose to her friend; role play some examples of how to start the conversation; ask S___ if she has disclosed to other people and talk to her about that experience; offer S___ practical suggestions based on your own personal experience
6. **Next steps:** Suggest a support group for ALHIV, encourage S___ to come back to the clinic to talk more with a Peer Educator about preparing for disclosure to her friend, talk about safer sex and using condoms
7. **Summarize main points:** Give S___ a referral to the support group, remind S___ about her next appointment at the clinic and with the Peer Educator, offer encouragement and emotional support
8. **Review and discuss the S___'s situation and "next steps" with the program supervisor or a member of the multidisciplinary care team.**

Case Study 3:

D___ is a 10-year-old girl who has been living with HIV since she was a baby. Her mother died 5 years ago and since then she has lived with her grandmother. D___ and her grandmother have come to the clinic today for D___'s monthly visit. When the nurse asks her about missed doses, D___'s grandmother says that D___ does not want to take her medicines anymore. She says that D___ was a "good" girl in the past and took them without complaining but now she keeps asking why she has to take these pills. She says D___ wants to know when she will finally be done taking them. When the nurse asks the grandmother what D___ knows about her health she becomes quiet. The nurse decides to speak with D___'s grandmother and asks you to help her with the counseling session.

Is there any support you can offer to D___'s caregiver to help with the disclosure process?

Case Study 4:

L___ is a 12-year-old boy living with HIV who is taking ART. He lives with his mother, his uncle, and 5 older half-siblings and cousins. Each time L___ comes to the clinic he becomes upset when he gets blood drawn and he has recently been asking, "why do I need to take medicines" and "why am I always sick"? Today, L___ seems mad that he had to come to the doctor instead of playing with his cousins. When you ask his mother, she says she has not told L___ anything about his HIV-status or the reasons he has to come to the clinic so much. She asks your advice about what to do. The nurse decides to have a conversation with L___'s mother about disclosure and asks that you help her with the conversation.

Is there any support you can offer to L___'s mother to help with the disclosure process?



Helping clients during the disclosure process does NOT mean putting pressure on them to disclose. Instead, it means helping the multidisciplinary care team support clients to work through issues related to disclosure, allowing them to talk about their concerns and, if they have decided they want to disclose their status to others, working with them to make a plan.



Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

The CHANGE Project & ICRW. (2003). *Understanding and challenging HIV stigma: Toolkit for action*. Washington, DC: The CHANGE Project, Academy for Educational Development.

The International HIV/AIDS Alliance. (2006). *Trainer's manual: Community engagement for antiretroviral treatment. Participatory tools and activities for civil society organizations working with people with HIV*. International HIV/AIDS Alliance.

Joint United Nations Programme on HIV/AIDS. (2003). *Fact sheet: Stigma and discrimination*. Geneva, Switzerland: UNAIDS.

The International HIV/AIDS Alliance. (2008). *Building Blocks: Africa-wide briefing note on 'Young Children and HIV.'* International HIV/AIDS Alliance.

Joint United Nations Programme on HIV/AIDS. (2007). *Reducing HIV stigma and discrimination: A critical part of national AIDS programmes. A resource for national stakeholders in the HIV response*. Geneva, Switzerland: UNAIDS.

Adherence Networking Group. (2006). *Kids count: Children's ART adherence resource pack*. Centre for the Study of AIDS, University of Pretoria and the Perinatal HIV Research Unit, South Africa.

SESSION 9.5: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- When Peer Educators are very open about their own HIV-status, it helps to reduce stigma and discrimination.
- Peer Educators can work with ALHIV to help them understand why disclosure is important.
- Disclosure can:
 - Help a person access prevention, care, treatment, and support
 - Improve adherence
 - Help reduce stigma and discrimination by bringing HIV out into the open
 - Slow the spread of HIV by helping people protect themselves and their partners
- Peer Educators can help adolescents weigh the advantages and disadvantages of disclosure and they can be supportive counselors throughout the disclosure process. They can help prepare clients for disclosure and give follow-up support after disclosure.
- Disclosure is an ongoing process, not a one-time event.
- It is important for all adolescents to know about their HIV-status.
- ALHIV who have not been disclosed to may:
 - Have frightening or incorrect ideas about their illness
 - Feel isolated and alone
 - Find out about their HIV-status by mistake
 - Have poor adherence
- **Partial disclosure** means giving a child information about his or her illness without using the actual words “HIV” or “AIDS.”

- **Full disclosure** means telling a child that he or she is HIV-infected and giving him or her information about what this means. This includes telling the child that he or she will need lifelong HIV care and treatment.
- When to say “HIV” varies with the child and the family, but most children should know they have HIV as soon as they have developed the emotional maturity to understand what this means.
- Many children who are told their HIV-status want to continue to talk about it, so it is important that they are given ongoing support and opportunities both at home and at the clinic to talk and ask questions.
- Peer Educators can use the Talking Tree and role playing to help prepare ALHIV for the disclosure process.



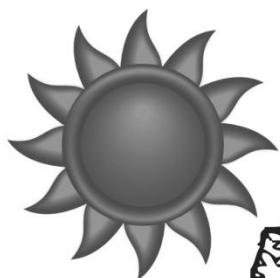
APPENDIX 9A: Talking Tree

Instructions for the Talking Tree: Each instruction below goes with a number on the Talking Tree. The Peer Educator should follow these instructions in order.

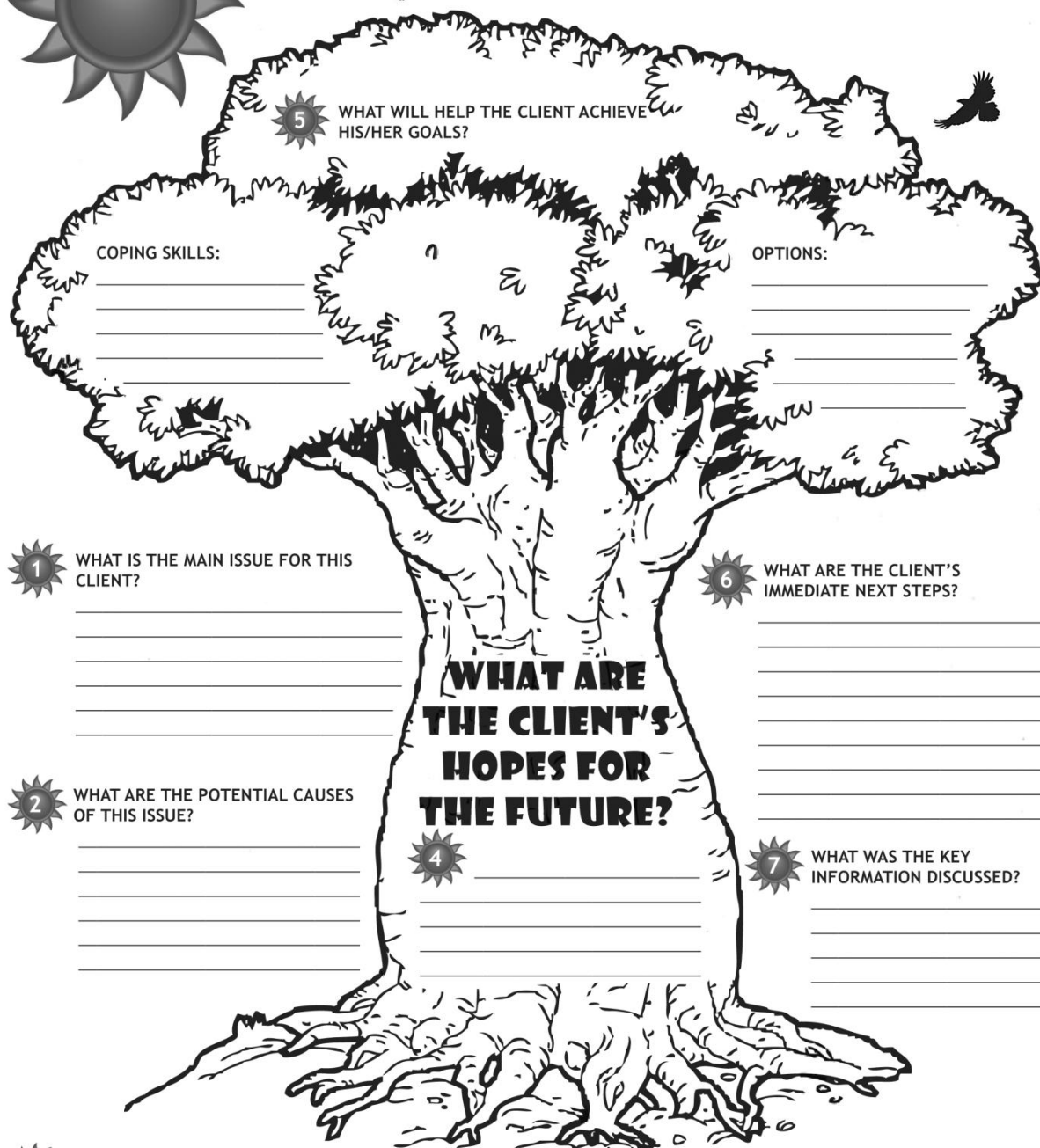
Begin by explaining that the African Baobab tree is one of the longest-living and largest trees on Earth. It symbolizes survival and life because it sometimes grows in harsh conditions. It also symbolizes protection and sharing because it can be used as shelter and a place for people to gather and meet. Talk about the various parts of the tree: the trunk, roots, branches, leaves, fruits, nuts, or birds living in the trees.

1. Allow some time for the client to describe what is currently happening in his or her life (i.e. why he or she came here today to talk with you). Ask the person to tell you about the main problem or issue he or she is having—when it started, how it developed, and how he or she feels about it. Let the person know you would like to work together in finding something that he or she can do to make the situation better. Write a brief description of what is happening under “What is the main issue for this client” on the left-hand side of the tree.
2. Ask the client what he or she thinks is causing the problem/issue and write this under “What is the cause of this issue?”
3. Ask the client to imagine him- or herself as a tree—the roots are “*where you come from, your home, your family, and your community.*” The roots are “*what supports and grounds you.*” Ask the client who provides him or her with the most support in life and who can help him or her resolve this issue. Write this information under “family, peers, and community” in the roots of the tree.
4. Next move to the trunk. The trunk is the client’s “*hope for the future, a future goal, or dream.*” Write the goal on the trunk of the tree. Encourage the client to close his or her eyes and think about him- or herself in the future, achieving her goal. Ask: “*What are you doing in that picture?*”
5. The branches are the client’s options, the ways he or she copes, and potential solutions (i.e. things he or she can do to achieve the hope or goal). Talk about the benefits and consequences of each option. Encourage the person to think about strategies that have worked in the past. Write these on the branches. Then talk about all the person's resources—the “*things you have going for you,*” like inner strengths, talents, skills, and spiritual resources to help in coping.
6. Then ask: “*What is the next step in achieving your goal or hope for the future?*” Help the client form an action plan of immediate next steps.
7. Lastly, summarize the main points that were discussed during the Peer Education session (example: disclosure to partner) and, if necessary, talk about any referrals or arrange another time to talk
8. Review and discuss the client’s situation and “next steps” with the program supervisor or a member of the multidisciplinary care team.

TALKING TREE



DATE: _____
CLIENT NAME: _____
PEER EDUCATOR NAME: _____
NAME OF CLINIC: _____



5 WHAT WILL HELP THE CLIENT ACHIEVE HIS/HER GOALS?

COPING SKILLS:

OPTIONS:

1 WHAT IS THE MAIN ISSUE FOR THIS CLIENT?

6 WHAT ARE THE CLIENT'S IMMEDIATE NEXT STEPS?

2 WHAT ARE THE POTENTIAL CAUSES OF THIS ISSUE?

WHAT ARE THE CLIENT'S HOPES FOR THE FUTURE?

4

7 WHAT WAS THE KEY INFORMATION DISCUSSED?

3 WHAT SUPPORT DOES THE CLIENT HAVE?

FAMILY:

PEERS:

COMMUNITY:

MODULE 10: Sexual and Reproductive Health



DURATION: 295 minutes (4 hours, 55 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Define the terms sex and sexuality
- Discuss different forms of sexual behavior and expression
- Reflect on their attitudes and values about different sexual behaviors
- Understand the importance of being non-judgmental when talking with adolescents about sexual and reproductive health
- Describe the basic functions of sexual and reproductive body parts in men and women
- Provide basic information about ways to practice safer sex, contraception, and dual protection
- Demonstrate male and female condom use
- Review basic information about the prevention and treatment of common STIs
- Provide basic information on PMTCT to adolescent clients
- Discuss the needs of adolescent clients who have experienced sexual abuse and gender-based violence



CONTENT:

Session 10.1: Introduction: Let's Talk About Sex

Session 10.2: Parts of the Body Involved in Sex and Reproduction

Session 10.3: Safer Sex and Contraception

Session 10.4: Preventing and Treating Sexually Transmitted Infections (STIs)

Session 10.5: Preventing Mother-to-Child Transmission of HIV (PMTCT)

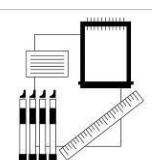
Session 10.6: Sexual Abuse and Gender-Based Violence

Session 10.7: Module Summary



METHODOLOGIES:

- Brainstorming
 - Large group discussion
 - Interactive trainer presentation
 - Game
 - Small group work
 - Role play
 - Case studies
 - Homework assignment
-



MATERIALS NEEDED:

- Flip chart
 - Markers (different colors if possible)
 - Tape or Bostik
 - Sexual behavior cards for *Session 10.1*
 - Male and female anatomical models, if available
 - Female and male condoms
-



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
 - Prepare sexual behavior cards for *Session 10.1*.
 - Review the case studies for *Sessions 10.3 and 10.5* and adapt to the local context as needed.
-

SESSION 10.1: Introduction: Let's Talk About Sex (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Brainstorming, Large Group Discussion, Interactive Trainer Presentation, Game

- Step 1:** Review the Module learning objectives.
- Step 2:** Post blank flip chart pages along one side of the training room, creating a “wall” of paper. Give markers out to participants and ask them to write all the words or phrases they can think of that have to do with sex along the “graffiti wall.” This can include body parts, sexual activities, and anything else they think of. Encourage the group to use local languages and slang. Give participants about 5 minutes to write on the wall.
- Step 3:** Ask participants to take turns reading out the words on the “graffiti wall.”
- Step 4:** Debrief the activity by asking participants to discuss these questions:
- *How did you feel saying these words out loud?*
 - *Why do you think so many people find it hard to talk about sex?*
 - *How can we become more comfortable talking about sex?*
- Step 5:** Next, lead a discussion using the following questions and fill in as needed using the content below:
- *What is sex?*
 - *What is sexuality?*
 - *What is the difference between sexuality and sexual intercourse?*
 - *Name some ways that adolescents express their sexuality.*
 - *What challenges do you think adolescents face in terms of expressing their sexuality?*

Note: Before the training, trainers should have prepared pieces of A4 or letter-sized paper, each listing one of the sexual behaviors from the list in the content below. Trainers can leave out some behaviors on the list or add others depending on the local context. It is important to include some behaviors that are considered “outside of the mainstream” or taboo in your setting. On each piece of paper, write the behavior in large letters. Underneath, in smaller letters, write, “OK for me,” “Not OK for me, but OK for others,” and “Not OK.” Here is a sample of what each piece of paper should look like:

VAGINAL SEX		
OK for me	Not OK for me, but OK for others	Not OK

Step 6: Now prepare 3 large pieces of paper, each with one of the following labels: “OK FOR ME,” “NOT OK FOR ME, BUT OK FOR OTHERS,” and “NOT OK.” If possible, use different colored paper or different colored markers. Post them next to each other high on a wall in the training room. Leave enough space for the sexual behavior cards to be posted under them.

Step 7: Introduce the exercise by telling participants that we will be exploring a range of sexual behaviors people practice and our own attitudes and values about these behaviors. Tell participants that their opinions will be kept confidential and encourage them to be honest.

Step 8: Give each participant the same number of pre-prepared sexual behavior cards (as many as there are to go around). Ask participants to:

- Read the sexual behavior on the card to themselves.
- Decide how they feel about this behavior and circle one option on the card:
- “OK for me” means this is a behavior I would do.
- “OK for others, but not for me” means this is a behavior that I would personally not do, but I have no problem with other people doing it.
- “Not OK” means that no one should do this behavior because it is wrong.

Remind participants that they should not share their answers with others and that their answers will be kept confidential. Also remind participants that this exercise is NOT about HIV risk, but about our values related to sexual behaviors.

Give participants about 10 minutes to circle their answer on each of their cards and then ask them to place all of the cards face down in a pile in the center of the room.

Step 9: Mix up the cards and redistribute them to participants. Note that participants may or may not have some of their own cards, but that all responses should remain confidential.

Ask participants, one by one, to read the behavior on a card and then to post it on the wall under the “OK FOR ME,” “OK FOR OTHERS, BUT NOT FOR ME,” or “NOT OK” sign, according to what is circled on the card.

Step 10: Once all of the cards have been posted, ask participants to gather around the wall and to review the placement of the cards. Lead a group discussion using some of the following questions as a guide:

- *Are you surprised by where some of the cards have been posted? Which ones surprise you?*
- *Does the placement of the cards suggest that some sexual behaviors are “right” and some are “wrong?” How do you feel about that?*
- *Are there behaviors that are “not OK” under any circumstances? (possible responses could include rape, incest, etc.)*
- *What does this activity tell us about how adolescent clients might feel when we ask them about their sexual practices?*

- *How can we make clients feel more comfortable talking about sex and sexual behaviors?*

Step 11: Discuss the increased risks of certain sexual behaviors with participants. For example, “dry sex” can increase the chances that a person will get HIV because it often causes cuts and irritation in the woman’s vagina.

Step 12: End the session by explaining how important it is that Peer Educators be able to accept and talk about sex and sexuality openly and comfortably in their communities. Telling the truth about sexuality could make it easier for young people to talk with parents, teachers, and religious leaders.

KEY INFORMATION

Sex:

- Sex is a normal part of life for some older adolescents and adults.
- Sex means different things to different people and there are many different types of sexual behaviors.
- It is very important for Peer Educators to be comfortable talking about sex and reproduction with their clients.
- HIV is mainly spread to adolescents and adults through unsafe sex.
- Unsafe sex is any kind of sex that puts people or their sexual partners at risk of getting a sexually transmitted infection, including HIV, or of unwanted pregnancy.
- In order to help people protect themselves and their families, we must make sure people know the facts about sex.

Sex means different things to different people. People have different sexual behaviors, including:

- Vaginal sex (when the penis or fingers go into the vagina)
- Anal sex (when the penis or fingers go into the anus)
- Oral sex (when a person kisses or licks their partner’s penis, vagina, or anus)
- Inserting fingers or objects into the vagina or anus
- Masturbation (alone or with a partner)
- Having sex with men, women, or both men and women

Note: we will learn more about the parts of the body mentioned here in the next Session

Sexuality:

- Is more than sex and sexual feelings
- Includes all the feelings, thoughts, and behaviors of being a girl, boy, woman, or man, including feeling attractive, being in love, and being in relationships that include sexual intimacy and physical sexual activity
- Is an experience involving the whole mind and body
- Is constantly evolving as we grow and develop
- Is a part of us from birth until death

The following are some aspects of sexuality. Each of these aspects is connected to the others and makes a person who he or she is.

- Body image: How we look and feel about ourselves, and how we appear to others
- Gender roles: The way we express being either male or female, and the expectations people have for us based on whether we are male or female
- Relationships: The ways we interact with others and express our feelings for others
- Intimacy: Sharing thoughts or feelings in a close relationship, with or without physical closeness
- Love: Feelings of affection and how we express those feelings for others
- Sexual arousal: The different things that excite us sexually
- Social roles: How we contribute to and fit into society
- Genitals: The parts of our bodies that define our sex (male or female). They are part of sexual pleasure and reproduction.
- Ways we can express sexuality: dancing, flirting, wearing attractive clothes, having wet dreams, masturbation, daydreams, and others.

Remember:

- In many places, “sex” is usually thought to mean only penis-vagina sex between a man and a woman. However, sexual behaviors actually include much more than penis-vagina sex.
- If Peer Educators do not talk about sex and sexual behaviors with clients, clients may not get the information, skills, and supplies they need to protect themselves and their partners and to reduce their risk of HIV, STIs, sexual violence, discrimination, and unwanted pregnancy.
- While Peer Educators can have their own opinions about different sexual behaviors, they should not put their values on clients. Clients should feel comfortable talking about their sexual behaviors with Peer Educators no matter what.

Adolescence is an important stage of sexual development:

- Adolescence is a time of change, sexual experimentation, and risk taking.
- Adolescents are defining their sexual identity and exploring their sexuality.
- Adolescents may fear that they will be judged or that their sexual orientation will be disclosed to others, so listen and support them in a nonjudgmental way.

It's important for Peer Educators to always be open and honest about sexuality. This will make it easier for young people to feel comfortable talking with parents, teachers, and religious leaders!



Different types of sexual behaviors (adapt to the local context as needed):

Hugging	Kissing	Giving oral sex	Receiving oral sex
Group sex	Penis-vagina sex	Anal sex	Oral-anal sex
Two women having sex	Two men having sex	Getting paid for sex	Sex in a public place
Being faithful to one partner	Having many sex partners	Sex with a person who is much younger	Sex with a person who is much older
Masturbation	Masturbating your partner with your hand	Watching pornographic movies	Sex with people you do not know well
Sex with your spouse	Sex between a teacher and a student	Having “dry sex”	Hurting someone during sex
Sex between relatives	Sex with children	Sex before marriage	Sex with someone other than a boyfriend or girlfriend
Rape	Paying for sex	Sex with animals	Having sex without feeling pleasure
Swallowing cum (semen)	Telling someone a lie just to have sex	Sex with someone of a different race	Sex with someone of a different ethnic group
Forcing your partner to have sex	Sex with someone who is married	Sex with a disabled person	Sex after drinking alcohol
Sex after using drugs	Watching other people have sex	Having sexual desires about other people	Being celibate (not having sex), even if you are older
Having sex because it is your duty	Placing objects in the rectum/anus	Placing objects in the vagina	Using toys or vibrators for sexual pleasure

SESSION 10.2: Parts of the Body Involved in Sex and Reproduction (40 minutes)



TRAINER INSTRUCTIONS

Methodologies: Brainstorming, Small Group Work, Interactive Trainer Presentation

- Step 1:** Start by asking the group to brainstorm some of the changes that happen in the adolescent body during puberty. Write responses on flip chart and fill in using the content below.
- Step 2:** Refer participants to the drawings of body parts in the Participant Manual and, if available, also pass out anatomical models. Ask participants to brainstorm all of the body parts involved in sex and reproduction for older adolescents and adult men and women. Write responses on flip chart, filling in using the content below, and encourage participants to think about all of the parts of the body where people may experience sexual pleasure (e.g., breasts, anus, clitoris, etc.).
- Step 3:** Break participants into 4 small groups. Ask each team to work together to create a sculpture of the male and/or female reproductive system using the anatomical models as a reference (if available). Any or all of these materials can be used: felt, clay or modeling dough, fruits, vegetables, “found objects” (silverware, bottles, boxes, paper plates), scissors, tape, glue, paper, and pictures of reproductive systems. Tell the groups that they should discuss the name and location of each body part as well as what each body part does. Give the small groups about 20 minutes to create their sculptures.
- Step 4:** Ask each small group to present their sculpture to the art gallery (the large group). Be sure that participants understand the function of each body part in sex and reproduction.
- Step 5:** Debrief the activity by discussing these questions:
- *Do you think most young people in your community understand the changes happening in their bodies as they go through puberty? Why or why not?*
 - *Do you think most young people in your community understand how their own sexual and reproductive body parts work? Why or why not?*
 - *What can Peer Educators do to help ALHIV learn about and feel comfortable talking about their bodies and their sexual health?*
- Step 6:** Close by emphasizing that it is important for Peer Educators to understand the parts of the body involved in sex, sexuality, and reproduction in women and men so they can help clients understand the changes taking place in their bodies. It is important to give adolescent clients accurate information to make sure they have the facts!

KEY INFORMATION

Because HIV is most often spread through unsafe sex, it is very important that Peer Educators understand the parts of the body involved in sex and reproduction. By making sure that young people have the facts, we can help them protect themselves!

Adolescents go through many physical, emotional, and sexual changes before becoming adult men and women:

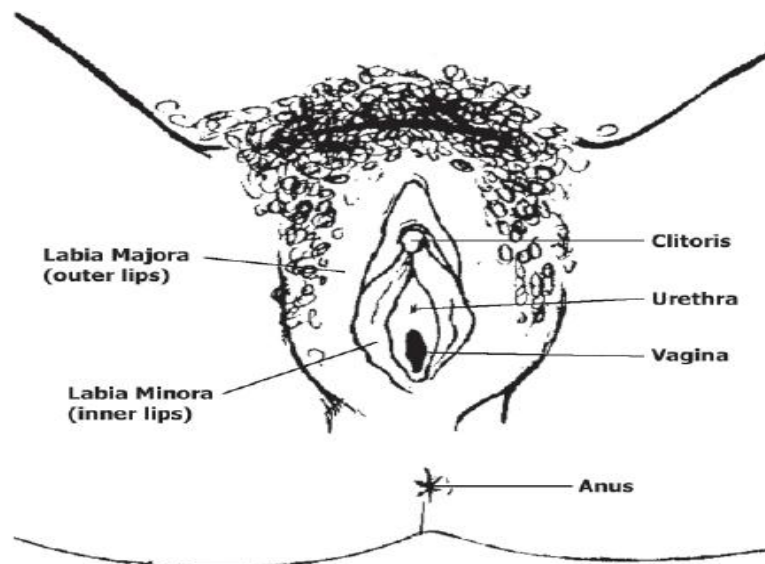
Changes in women	Changes in men	Changes in both sexes
<ul style="list-style-type: none">• Menstruation• Development of breasts• Widening of hips• Appearance of body hair (pubic hair, leg, and underarm hair)• Development of vulva and pelvis	<ul style="list-style-type: none">• Growth of penis, scrotum, and testicles• Morning erections• Development of muscles• Appearance of body hair (pubic area, underarms, chest, and facial hair)	<ul style="list-style-type: none">• Growth• Acne• Change in tone of voice• Interest in physical changes, sex, and sexuality• Sexual experimentation• Hormonal changes

Female sexual and reproductive body parts:

External female body parts (parts you can see):

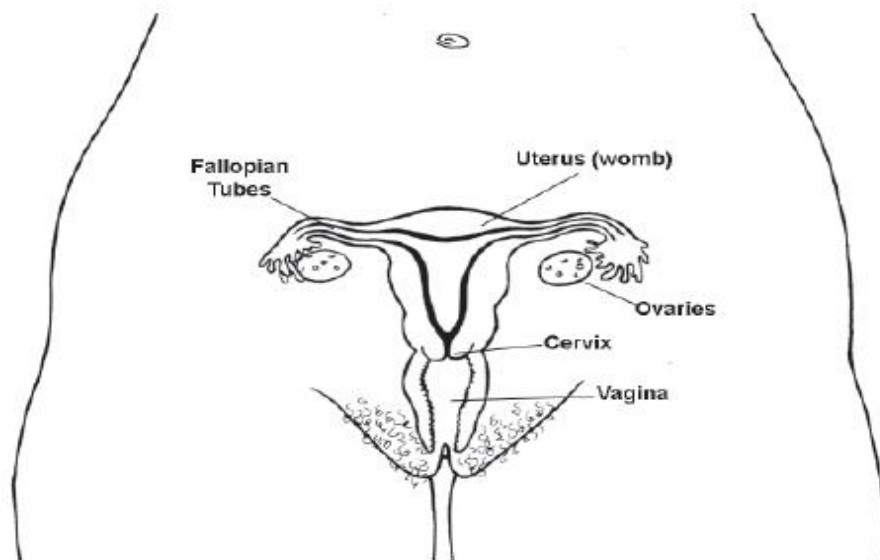
- **Urethra:** where urine (pee) comes out of the body
- **Vagina:** where the penis or fingers enter during sex and also where a baby comes out. The vagina is the opening to the cervix and the uterus, which is where babies grow.
- **Anus:** where stool (poop) comes out of the body and where the penis or fingers enter the body during anal sex
- **Labia minora** and **labia majora:** sometimes called the “lips” around the vagina and urethra
- **Clitoris:** where women can have strong pleasure leading to orgasm

Some girls and women may have experienced genital cutting, where the clitoris and labia may have been partially or completely removed. Some girls and women may also have had parts of their vaginas sewn up. It is important not to judge clients who have or have not undergone these procedures.



Internal female body parts (parts you cannot see):

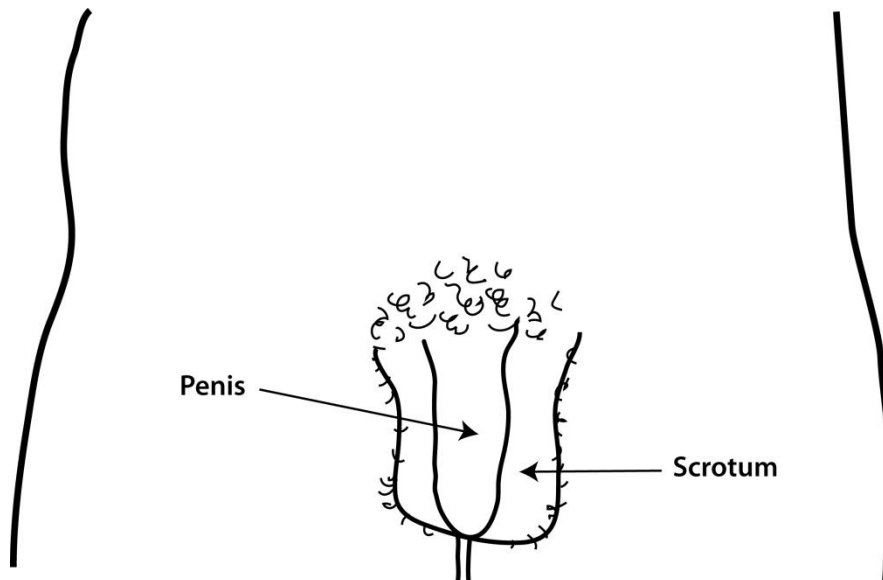
- **Uterus or womb:** where a baby grows and where monthly bleeding comes from
- **Ovaries:** where the eggs are stored
- **Fallopian tubes:** attached to the uterus. The eggs travel through the fallopian tubes to get from the ovaries to the uterus.
- **Cervix:** “mouth” of the uterus. Sperm enters the uterus through the cervix and the baby comes out of the uterus through the cervix.
- **Vagina:** where the penis or fingers enter during sex and also where a baby comes out. The vagina is the opening to the cervix and the uterus, which is where babies grow.



Male sexual and reproductive body parts

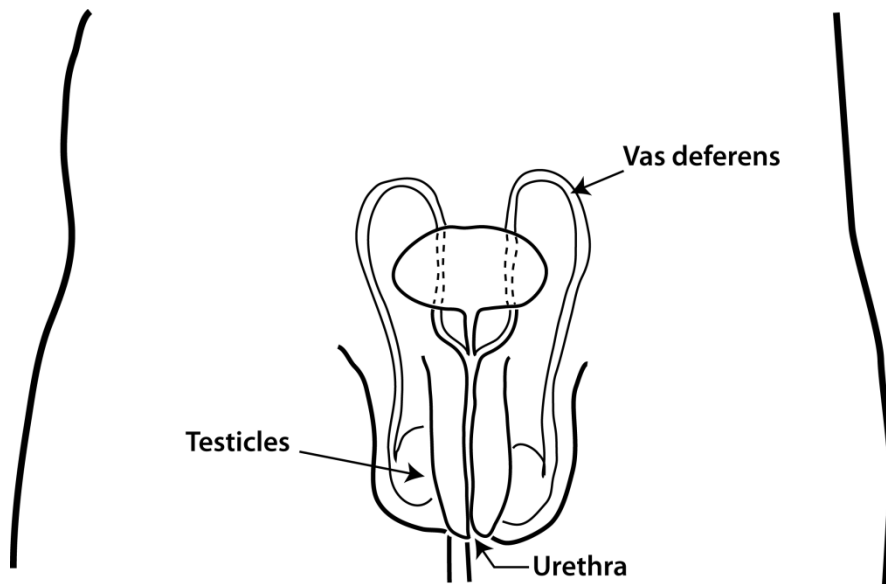
External male body parts (parts you can see):

- **Penis:** the main body part for sex and pleasure. The penis delivers the sperm that can make a woman pregnant during sex. The tip of the penis may have foreskin or, if the man has been circumcised, there will be no foreskin.
- **Scrotum:** sack that holds the testicles (balls)
- **Anus:** where stool (poop) comes out of the body and where the penis or fingers enter the body during anal sex. Note that the anus is not shown in the diagram below, but is located in the same place as in females.



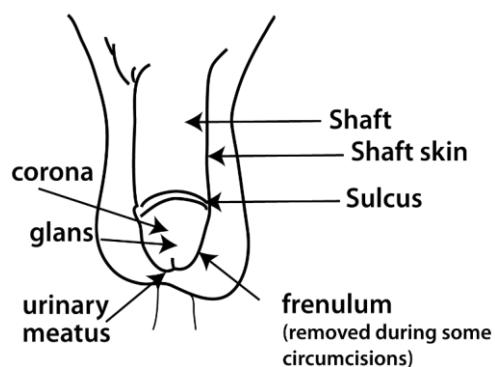
Internal male body parts (parts you cannot see):

- **Testicles or balls:** where sperm are made and stored. Sperm live in a fluid called semen (cum), which is what comes out when a man ejaculates. Semen can contain STIs and HIV.
- **Vas deferens:** attached to the testicles. Sperm travel through these tubes to get to the urethra.
- **Urethra:** the opening on the end of the penis where urine (pee) and semen (cum) containing sperm come out. Note that urine and semen do NOT come out at the same time.



Uncircumcised Penis

Circumcised Penis



Note: A **circumcised penis** is one that has had the foreskin cut off.
An **uncircumcised penis** is one with foreskin. This is how all boys are born.

SESSION 10.3: Safer Sex and Contraception (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Small Group Work, Case Study, Role Play, Brainstorming

Note: Male and female condoms and penis and vagina anatomical models are needed for this Session. If models are not available, you can use other objects, like a broom handle or banana. Some participants may be uncomfortable touching and talking about condoms, but it is important that all Peer Educators know about condoms and can tell and show people how to use them.

- Step 1:** Remind the group that adolescents often do not have access to sexual and reproductive health information and services. This lack of access can result in their inability to make responsible and appropriate decisions about protecting themselves from disease and pregnancy. Peer Educators and the multidisciplinary care team have an important role to play in both educating young people and helping them with responsible decision-making.
- Step 2:** Ask participants what is meant by the term safer sex, and then ask them to brainstorm ways to practice safer sex (including but not limited to condoms). Then facilitate discussion by asking participants to brainstorm reasons adolescents may not practice safe sex. Write responses on a flip chart and fill in using the content below.
- Step 3:** Facilitate a general discussion on condoms. Ask the group:
- *Why don't people use condoms?*
 - *What are the things that make it difficult for people to use condoms? What about for adolescents?*
 - *Why is it important ALHIV use condoms, even if both partners are HIV-infected?*
 - *Do you know of other ways, other than using condoms, that ALHIV can reduce the risk of transmitting HIV to their partners?*
- Write answers on flip chart and fill in using the content below.
- Step 4:** Now introduce the penis model and ask if anyone in the class can show how male condoms are used. Ask the participant to describe the steps out loud. Make corrections as needed according to the steps described in the box below.
- Repeat with the female condom.
- Step 5:** Ask participants to break into groups of 3 and to practice showing how male and female condoms are used, making sure to explain each step along the way.
- Step 6:** Ask participants what they think the term “*dual protection*” means. Write on flip chart and fill in using the content below. Remind participants that using condoms is an effective ways to prevent HIV, STIs, and unwanted pregnancies. Then ask the group to brainstorm what makes negotiating safer sex difficult for adolescents and how Peer Educators can help.

Step 7: Ask participants if there are any other ways (besides using condoms and practicing safer sex) to reduce the risk of passing HIV to a sexual partner. Probe if participants have heard about new studies on microbicides and “treatment as prevention.” Fill in using the content below and review the information in the “Future HIV Prevention Options with ARVs” box, making sure that participants understand the terms and facts about “treatment as prevention,” PrEP, and microbicides. Emphasize the point that PrEP and microbicides are not yet available for use in the general population.

Step 8: Next, use the content below to describe the risks of adolescent pregnancy. Then review the main categories of family planning methods listed in the content below, focusing on those that are available in your setting. Explain that all modern methods of family planning are generally safe and work well for people living with HIV, but that condoms are the only method that effectively prevents HIV. Pass around samples of each method and discuss:

- *What are some of the things you have heard about adolescents and contraception?*
- *What challenges do young people have if they want to use contraception?*
- *What are the most common methods of contraception among adolescents that you know (e.g. withdrawal method)?*
- *What are the risks or disadvantages of the withdrawal method as a form of contraception?*
- *Which methods are most suitable for young people if they do not abstain from sex? Why?*
- *Which methods protect us from HIV?*
- *How can Peer Educators help clients who would like to prevent getting pregnant?*

Write answers on flip chart and fill in using the content below.

Step 9: Read the case studies below to the entire group. Briefly discuss how a Peer Educator could respond to the clients and write responses on a flip chart.

Step 10: Debrief by reinforcing the following points:

- *ALHIV can use contraception—it is completely safe.*
- *Clients' choices about current and future child bearing should be respected.*
- *If a ALHIV wishes to become or is pregnant, the Peer Educator should work with the multidisciplinary care team to refer her to the appropriate PMTCT, care, and treatment services.*
- *Sometimes talking about sex can be embarrassing and uncomfortable for an adolescent. The more comfortable and open YOU are, the more comfortable the client will be.*

Step 11: Close the discussion by reminding participants that Peer Educators play a very important role in helping ALHIV to understand and practice safer sex and to avoid unwanted pregnancy.

KEY INFORMATION

What do we mean by safer sex?:

Safer sex is anything that sexual partners do to lower their HIV, other STI, and pregnancy risk. Safer sex involves choosing sexual practices and protection methods that do not allow body fluids to pass from one person to the other.

Some ways to have safer sex are:

- Using a condom for all types of sexual intercourse (oral sex, anal sex, vaginal sex)
- Masturbating one's partner, as long as males do not ejaculate near any opening or broken skin on their partner
- Mutual masturbation
- Rubbing against each other with clothes on
- Sharing fantasies
- Massaging
- Hugging
- Kissing

Reasons why adolescents may not practice safer sex:

- They think they are not vulnerable to pregnancy or HIV. They think: *"It can't happen to me"* or *"I don't have sex often enough to get pregnant or contract a STI/HIV."*
- They do not have access to youth-friendly reproductive health services.
- They do not have access to accurate information at home, in school, in the community, or from media sources (television, radio, etc.).
- Contraceptive methods are not available or they are too expensive.
- Denial: *"My partner would never expose me to any risk."*
- They feel pressure from their boyfriend or family to get pregnant.
- They are scared their partner will reject them.
- They are scared of side effects.
- They feel embarrassed.
- The doctor or nurse at the clinic has a judgmental attitude.
- They do not know how to negotiate condom use with their partner.
- They have inaccurate information, like thinking that a girl cannot get pregnant if she is menstruating or that a girl cannot get pregnant if when she has sex for the first time.

Condoms:

- Not having sex at all is one way to be completely safe, but this is not practical or enjoyable for most people.
- Using condoms is one reliable way to practice safer sex and to prevent transmission of HIV to your partner. Condoms also prevent other STIs and unwanted pregnancy.
- There are a lot of myths about condoms, like that they are only for sex workers or that married people do not use them. Peer Educators should spread the truth about condoms, promoting them as a way for young people to protect themselves and their partners from HIV and other STIs.
- Some people feel that condoms make sex less enjoyable. We should respect everyone's personal experiences with condoms, but remember that even if it does change the way sex feels, it is still worth it to protect ourselves and our partner(s).

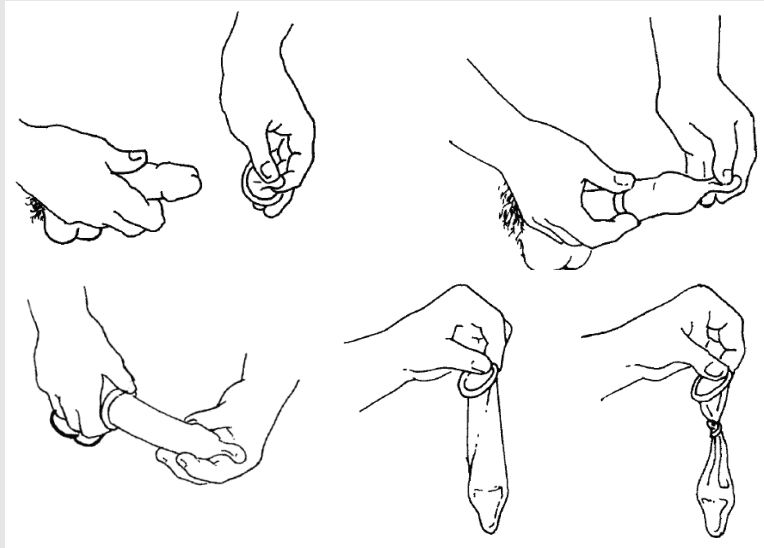
- Some people think that if both partners are living with HIV, then they do not need to use condoms. It is important for Peer Educators to explain that even if both partners are living with HIV, using condoms is still a good idea. This is because there may be some chance of passing different types of HIV from one partner to the other, which may lead to drug resistance. Condoms can also prevent the spread of other STIs between partners. Peer Educators can help explain the facts so people and couples can then make up their mind about using condoms with their partners.

Part of the Peer Educator's job is to spread the truth about condoms, to give out condoms, and to help YLHIV learn how to use them. This is so they can protect themselves and their partners from HIV, STIs, and unwanted pregnancy.



How to use a Male Condom

These are the basic steps you should know for using, and showing others how to use, a male condom. If penis models are not available, you can use a bottle, banana, or corn. Only condoms made out of latex protect against HIV.



Steps to use a male condom:

- Look at the condom package and check the date to make sure it is still good and that the package does not have any damage.
- Open the packet on one side and take the condom out. Do not use your teeth to open the package.
- Pinch the tip of the condom to keep a little space at the tip. This will hold the semen and prevent the condom from breaking.
- Hold the condom so that the tip is facing up and it can be rolled down the penis.
- Put it on the tip of an erect (hard) penis (only use condoms on an erect penis) and unroll it down to the bottom of the penis.
- After ejaculation (coming), hold the rim of the condom while the man removes his penis without spilling the semen. The penis must be removed while it is still hard to make sure the condom does not fall off.
- Remove the condom and tie it in a knot to avoid spilling. Throw it away in a latrine or bury it.
- Use a new condom every time!

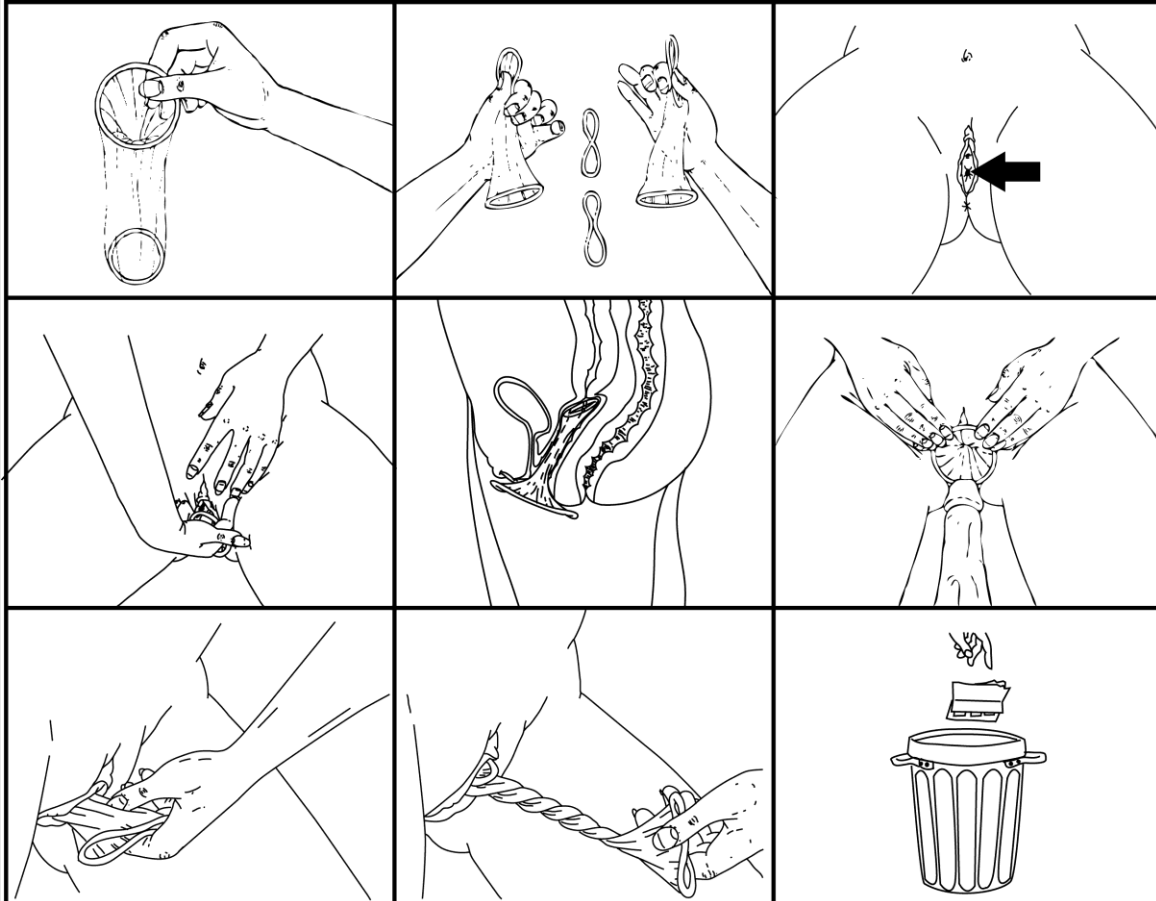
Also, it is important to:

- Use only lubricants made out of water (not oils).
- Store condoms in a cool, dry place, out of the sun. Do not keep them in a wallet.
- Do not use condoms that seem to be sticky, a strange color, or damaged in any way—throw them away.

Note: These instructions were adapted from: Burns, A.A., Lovich, R., Maxwell, J., & Shapiro, K. (1997). *Where women have no doctor: A health guide for women*. Berkeley, CA: Hesperian Foundation.

How to Use a Female Condom

Some women really like the female condom because it gives them more control over their own bodies and over sex. Some men like it too because they do not have to use a male condom. The female condom is becoming more affordable and available to women in many countries. These are the main steps for using a female condom. If no vaginal model is available to show people how to use it, you can use a box with a round hole cut in it or your hand.



Steps to use a female condom:

- Look at the condom package and check the expiration date to make sure it is still good and that the package does not have any damage.
- Open the packet. Do not use your teeth.
- Find the inner ring at the bottom, closed end of the condom. The inner ring is not attached to the condom.
- Squeeze the inner ring between your thumb and middle finger.
- Guide the inner ring all the way into the vagina with your fingers. The outer ring stays outside the vagina and covers the lips of the vagina.
- When you have sex, guide the penis through the outer ring. It has to be **INSIDE** the ring.
- After the man ejaculates (comes), before the woman stands up, squeeze and twist the outer ring to keep the semen inside the pouch and pull the pouch out.
- Put the used condom in a latrine or bury it. Do not put it in a flush toilet.

Note: These instructions were adapted from: Burns, A.A., Lovich, R., Maxwell, J., & Shapiro, K. (1997). *Where women have no doctor: A health guide for women*. Berkeley, CA: Hesperian Foundation.

Dual protection:

Dual protection means preventing STIs/HIV and unwanted pregnancy at the same time. Dual protection includes:

- Using male or female condoms together with another contraceptive method
- Using male or female condoms alone
- Abstinence (not having sex at all)
- Avoiding all forms of penetrative sex

Using condoms plus a hormonal or long-term contraceptive method is one of the best ways to prevent HIV and unwanted pregnancy in male-female sexual relationships.

**Reasons adolescents may not be able to negotiate safer sex:**

- They may not have the right communication skills to talk about protection with their partners.
- Young women may not have control over when and how they have sex because men often make those decisions.
- Adolescents may believe that if they suggest having safer sex, their partners will think they don't trust them.
- Adolescents may be scared or embarrassed to bring up the topic of protection.
- Adolescents may want to get pregnant: For young women, it may be a way to keep a relationship. For young men, getting a girlfriend pregnant may be a way to prove their manhood.

In addition to using condoms and practicing safer sex, there are other ways to reduce the risk of HIV transmission to a sexual partner. These include:

- Making sure your partner gets an HIV test and repeats the test every 3 months if he or she is negative
- Making sure that you (and your partner if he or she is also living with HIV) are taking ART if eligible
- Taking your ART the right way, at the same time, every day to keep your viral load low and to reduce your risk of transmitting HIV to your partner (see the “treatment as prevention” section in the box below)
- Checking to make sure your partner is taking his or her medicines if he or she is also living with HIV and is on ART
- Preventing sexually transmitted infections (or STIs) and getting yourself and your partner treated right away if either person has an STI (there is more about STIs later in this Module)

Future HIV Prevention Options with ARVs

Treatment as Prevention

- **"Treatment as prevention"** is a term describing the use of ART by an HIV-positive person to reduce the risk of passing HIV to others.
- **The goal of “treatment as prevention” is to reduce an HIV-positive person’s viral load.** When the amount of virus in the blood is very low (or undetectable), the person is less likely to pass on the virus.
 - Findings from an important study, known as **HPTN 052**, were released in 2011. The study assessed HIV transmission in nearly 900 discordant couples (where 1 partner is HIV-positive and the other is not). To enroll in the study, the HIV-positive person had to be relatively healthy and not yet eligible for ART. Half of the HIV-positive participants started ART immediately (at a CD4 between 350 and 550) and half waited or ‘deferred’ ART until they met eligibility criteria (CD4 <250). All of the couples received condoms and counselling on safer sex.
 - The results showed that when ART was started immediately, the HIV-negative partners in the couples were much less likely to acquire HIV compared with couples where ART was deferred.
 - The study showed a 96% reduction in risk of HIV transmission when comparing the ‘immediate’ ART group (when ART was started at a higher CD4 count) with the ‘deferred’ group (when ART was initiated at the lower CD4 count).
- **PLHIV on ART should always practice safer sex, but now there is good proof that taking ART can prevent transmission to sexual partners. Therefore, this is another important reason to start ART as soon as eligible and to adhere to it: to protect sexual partners from HIV.**

(Continued on next page)

PrEP

- **Pre-exposure prophylaxis, or PrEP**, is an experimental approach that uses ARVs to reduce the risk of HIV infection in HIV-negative people.
 - Results announced in 2011 by the **Partners PrEP study** demonstrated that HIV infection among discordant heterosexual couples can be prevented by taking PrEP daily. The study showed that when an HIV-negative person takes a daily tablet of the ARV tenofovir (TDF), alone or in combination with another ARV called emtricitabine, also known as Truvada (TDF/FTC), his or her risk of acquiring HIV infection is reduced. In this study, both HIV-negative men and women (who had HIV-positive partners) were protected against new infections when they took this medication every day.
 - Similar to the Partners PrEP study, the **CDC TDF2 study** in Botswana found that when HIV-negative heterosexual men and women took a once-daily tablet containing TDF/FTC (Truvada), it reduced their risk of acquiring HIV infection by roughly 63%.
 - The **iPrEx study** results released in 2010 also showed that in HIV-negative men and transgender women who have sex with men, taking a daily tablet containing TDF or TDF/FTC (Truvada) reduced the risk of acquiring HIV by 44%.
- **It is important to remember that PrEP is not yet recommended for use. More research studies are currently being carried out to determine how well PrEP works in other populations.**

Microbicides

- **Microbicides** are products that can be applied inside the vagina or rectum to protect against HIV and other STIs. They can be in the form of gels, creams, films, and vaginal rings.
- **Microbicides are still being tested in clinical trials and are not for sale yet.**
- **How microbicides work:** Different microbicides work in different ways. Most of the newer microbicides currently being studied to prevent HIV infection have an ARV in the product, which stops the HIV from copying itself or, in other cases, prevents the HIV virus from attaching to or entering our cells.
- **Why microbicides are important:** Vaginal microbicides would greatly empower women to protect themselves. Unlike male or female condoms, microbicides are a potential prevention option that women can easily control and that do not require the cooperation, consent, or even knowledge of their partner.
- In 2010, a study conducted in South African and known as the **CAPRISA 004 study**, showed that a microbicide containing the ARV tenofovir (TDF) was almost 40% effective at preventing sexual transmission of HIV to women during sex with an HIV-infected partner. It was also shown to be effective at lowering the risk of acquiring new herpes infections. The tenofovir vaginal microbicide is still being studied by researchers and is not available for use yet.

Sources (for box above):

HIV Prevention Trials Network (HPTN). (2011). Initiation of antiretroviral treatment protects uninfected sexual partners from HIV Infection (HPTN Study 052) [Press Release]. Retrieved from http://www.hptn.org/web%20documents/PressReleases/HPTN052PressReleaseFINAL5_12_118am.pdf

University of Washington International Clinical Research Center (ICRC). (2011). Pivotal study finds that HIV medications as highly effective as prophylaxis against HIV infection against men and women in Africa [Press Release]. Retrieved from http://depts.washington.edu/astda/resources/PrEP_PressRelease-UW_13Jul2011.pdf

Centers for Disease Control and Prevention (CDC). (2011). CDC trial and another major study find PrEP can reduce risk of HIV infection among heterosexuals [Press Release]. Retrieved from <http://www.cdc.gov/nchstp/newsroom/PrEPHeterosexuals.html>

Grant RM, Lama JR, Anderson PL, McMahan V, Liu AY, Vargas L, et al. (2010). *Pre-exposure chemoprophylaxis for HIV prevention in men who have sex with men*. *New England Journal of Medicine*. 363(27):2587-99.

CAPRISA. (2010). Study of microbicide gel shows reduced risk of HIV & Herpes infections in women [Press Release]. Retrieved from <http://www.caprisa.org/joomla/Micro/CAPRISA%20004%20Press%20Release%20for%2020%20July%202010.pdf>

Risks of adolescent pregnancy:

- Young girls are at higher risk for complications because they are not fully developed and their bodies may not be well prepared to handle pregnancy and to give birth.
 - Young mothers may face problems such as: obstructed labor, long labor, anemia, pre-eclampsia or hypertension during pregnancy, consequences of unsafe abortion, spontaneous abortion, still birth, and pre-mature birth. Adolescents younger than 17 often have not reached physical maturity and their pelvises may be too narrow to accommodate the baby's head.
- Pregnancy often means the end of formal education because girls are sometimes kicked out of school when they become pregnant.
- Adolescent pregnancy changes a girl's choice of career, her opportunities, and may limit her future marriage options. Unmarried mothers sometimes have to take low paying and risky jobs or become sex workers to support their children.
- Sometimes the adolescent's partner refuses to take responsibility for the pregnancy, which can make things much harder for the mother and child.
- Young parents are often not prepared to raise a child, which in extreme cases can lead to problems like child abuse or neglect.
- Early marriages that happen because of an unplanned pregnancy are often unhappy and unstable.



Peer Educators can work with the multidisciplinary care team to help ALHIV make responsible and appropriate decisions about protecting themselves from disease and pregnancy.

Contraception and Family Planning

There are ways that people can prevent unwanted pregnancy and plan when they will have a baby. These are called **contraceptives** or **family planning methods**.

Key terms:

- **Contraception:** The use of a method or more than one method to prevent a woman from becoming pregnant.
- **Family planning:** When a woman plans the number of children she wants and when she wants them. Often this includes using a contraceptive or family planning method to prevent pregnancy or space births.
- **Birth spacing:** When a woman plans her births far enough apart so she and her baby are not at risk of the health problems that can occur when babies are born too close together. It is recommended that women wait at least 2 years after giving birth before becoming pregnant again.

The main types of contraceptives:

- **Barrier methods** prevent sperm from getting inside the woman. These include male and female condoms and the diaphragm.
- **Hormonal methods** are those that prevent eggs from being released inside the woman's uterus. These include pills, injectables, emergency contraception, and implants.
- **Long-term methods** have to be provided at a health clinic by a trained nurse or doctor. These include IUDs (intra-uterine devices) and implants.
- **Permanent methods**, like male and female sterilization, require surgery. These methods are not usually recommended for adolescents, who may change their mind about wanting to have children in the future. Permanent methods are best for adults who have already had children and know that they do not want to have any more.
- **Natural methods** do not require any materials (i.e. withdrawal and the "rhythm method," which is when the woman learns to recognize when she is fertile and avoids having sex during this time.). In general, natural methods do not work as well as the "modern" methods listed above.
- In some places, there are **traditional methods** that people use. These are mostly traditional herbs that are given to prevent pregnancy. They are not reliable because the dosage is not controlled and they have not been scientifically proven to work.

Common issues adolescents have with contraceptives:

- Some adolescents may experience side effects from contraceptive methods (i.e. weight gain, spotting, menstrual changes). However, these side effects are generally not major health risks to adolescent clients.
- Adolescents who are taking the ARV called efavirenz may need a second method of birth control, as efavirenz may change how well some birth control pills work.

For clients who want to prevent pregnancy or space births, Peer Educators can provide information and referrals:

- Refer clients to a nurse for family planning information and counseling.
- Talk about the importance of dual protection to protect against both pregnancy and HIV/STIs.
- Give clients condoms and show them how they are used.

- Remind clients to come to the clinic if they have any side effects or questions about their contraceptives. Just like with ARVs, it is important to adhere to contraception (e.g. taking pills at the same time, every day) and to never make the decision alone to stop—clients should always talk with the nurse first.
- Remind clients of the importance of long-term adherence to care and treatment so that they can stay healthy for their own well-being and that of their future child/children.

Case studies for role play and discussion:

1. K___ is a 17-year-old young woman living with HIV. She is on ART and is feeling very well. She does not have a regular partner, but does have a couple of different boyfriends. She does not want children right now, but she may want them in the future. Her family is pressuring her to never have kids because of the risk the children could be HIV infected. What would you say to K___?

2. A noisy group of young boys is standing at the clinic door laughing and talking loudly. They push one of the boys towards you and say: “He needs some condoms.” The boy looks embarrassed and doesn’t say anything. What do you say to him and how do you proceed?

Peer Educators can play a very important role in helping ALHIV to understand and practice safer sex and to avoid unwanted pregnancy.



SESSION 10.4: Preventing and Treating Sexually Transmitted Infections (STIs) (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Game, Interactive Trainer Presentation

- Step 1:** Ask participants what they think the definition is of a sexually transmitted infection (STI) and how they think STIs and HIV are connected. Fill in as needed from the content below, making sure to explain that having an STI increases the chances that a person will become infected with HIV.
- Step 2:** Tape 2-3 pieces of flip chart paper (depending on the size of the group) on the wall and pass out markers to participants. Ask participants to write on the “graffiti wall” any local or slang terms for or related to STIs that exist in their community. Debrief by reviewing the common names of STIs as well as some common signs of STIs, referring to the content below.
- Step 3:** Ask participants what basic advice or information they can give to clients on preventing STIs. Write responses on flip chart and fill in using the content below. Remind participants that preventing STIs should be a part of Peer Education for YLIHIV, their partners, and their family members.
- Step 4:** Ask participants what advice or information they can give to clients who think they have an STI. Write responses on flip chart and fill in using the content below. Stress the importance of getting partners treated at the same time.
- Step 5:** Close the session by reminding participants that Peer Educators play a big role in helping the multidisciplinary care team provide ALHIV with basic information about STIs because youth may be more comfortable talking about these sensitive issues and getting advice from their peers. It is important for Peer Educators to provide honest and accurate information, and that they always consult with the multidisciplinary care teams if they don’t have the answers!

KEY INFORMATION

Sexually transmitted infections, or STIs, are infections passed from one person to another during sex. Any type of sex—vaginal, anal, or oral—can cause an STI. STIs can also be passed from a pregnant woman to her baby before it is born or during the delivery.

It is very important for clients and their partners to understand the importance of rapid diagnosis and treatment of genital problems and STIs. **When a person has an STI, especially one with sores, it is much easier to spread HIV.**

Unless STIs are treated, they can cause:

- HIV to spread more easily
- Infertility (when a person is not able to have children)
- Premature or unhealthy babies

- Very bad pain in the abdomen
- Cancer of the cervix (the entrance to a woman’s uterus)
- Death from a bad infection

Both young men and women can get STIs, but a young woman gets infected from a young man more easily than a young man gets infected from a young woman. Often people, especially young women, will have an STI and not know it because they have not had any symptoms. If a person does have symptoms, it is always best to practice safer sex with condoms and to go to the doctor.

The most common signs of STIs include:

- Unusual discharge from the vagina (some discharge is normal and normal discharge is usually white and thin. If a person has more discharge than usual or if it smells bad; is green, yellow, or has white clumps; or looks different than usual, he or she may have an STI or another type of infection.)
- A strange discharge from the urethra, the place where pee comes out (in a man, this is at the end of his penis and in a woman it is just above her vaginal opening)
- Pain or bleeding when peeing or during sex
- A rash, bump, or sore on or around the penis, vagina, or anus
- A red and itchy genital area or anus (itching may also be caused by scabies or lice)
- Warts or bumps in the genital area or around the anus
- Swollen glands around the genital and thigh areas
- For men, swollen or painful testicles (balls)
- For women, pain in the lower belly
- High fever

- | |
|---|
| <p>Names of Common STIs:</p> <ul style="list-style-type: none"> • Trichomonas • Gonorrhea (“clap,” VD) • Chlamydia • Genital warts • Syphilis • Chancroid • Genital herpes • HIV • Hepatitis B • Pelvic Inflammatory Disease (PID) |
|---|

How to prevent STIs:

- Always practice safer sex.
- Use condoms every time you have sex.
- Keep the genital and anal areas clean.
- Do not douche or use herbs or powders in the vagina.
- If you or your partner(s) have an STI, do not have sex until it is cured. This will prevent the STI from spreading to others.

What to tell clients if they may have an STI:

- Always go to the clinic right away! Treat the STI early—usually with pills or creams—and do not wait until you are very ill.
- Help your partner to get checked by a doctor or nurse and to get treated.
- Make sure to take ALL of the medicine, even if you feel better.
- It is best to not have sex until your and your partner’s STI signs have gone away AND you both have finished all of your medicines.
- Practice safer sex with condoms when you do have sex again.

SESSION 10.5: Preventing Mother-to-Child Transmission of HIV (PMTCT) (40 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Small Group Work, Role Play

Step 1: Begin the Session by leading a discussion using the following questions as a guide:

- *Do you think that people living with HIV should have children?*
- *What are some of the risks of having children when you are living with HIV?*
- *What are some of the risks of having children when a woman is very young?*
- *Why might a young person living with HIV want to have children despite these risks (now or in the future)?*

Emphasize that all people, including PLHIV, have the right to decide if they want to have children or not.

Step 2: Ask participants what they know about “PMTCT.” Review the definitions of MTCT and PMTCT using the content below.

Step 3: Ask if any of the participants have gotten PMTCT services or if they know someone who has. Ask participants to discuss the following questions and fill in content as needed:

- *What types of PMTCT services did you or someone you know receive? What other services does PMTCT include?*
- *Why are PMTCT services important for all pregnant ALHIV?*

Step 4: Review the key PMTCT messages using the content below. Make sure participants understand that ALL pregnant women living with HIV and all babies exposed to HIV need to take ARVs and get other PMTCT services.

Step 5: Ask participants to think about ways Peer Educators and the multidisciplinary care team can make sure young women understand the importance of PMTCT services for themselves and for their unborn children. Read the case study in the content below out loud to participants. Ask for 2 volunteers—1 to act as a client and 1 to act as a Peer Educator—and have them perform a brief role play in front of the large group. The trainer should stop (“freeze”) the actors from time to time and the group should discuss what is going on. After the discussion, the role play should continue. Continue the start-stop drama for about 10 minutes.

Step 6: Close the session by reminding participants that many ALHIV have concerns or fears about their future, including getting married and/or having children. Peer Educators can help them understand that there are ways to safely have children in the future, including by using PMTCT services.

KEY INFORMATION

Future childbearing choices:

All people, including people living with HIV, have the right to decide if they want to have children or not and, if they do, how many children they want to have.

It is very important that Peer Educators are never judgmental of a young person's decisions about having children. Peer Educators can work with doctors, nurses, counselors, and other members of the multidisciplinary care team to help young people understand their choices about having children and help them make healthy, informed decisions. Peer Educators can help support adolescents, who often experience double stigma because they are young, pregnant, and have HIV.

Mother-to-child transmission (MTCT) is the transmission of HIV from a woman living with HIV to her baby during pregnancy, labor, delivery, or after birth during breastfeeding.

PMTCT stands for Prevention of Mother-to-Child Transmission (of HIV).



ALHIV may have concerns or fears about their future, including getting married and having children. Peer Educators can help them understand that there are ways to safely have children in the future, including using PMTCT services.

PMTCT services are important for ALHIV because:

- Without PMTCT and HIV care and treatment services, babies born to mothers living with HIV can become HIV-infected during pregnancy, labor, delivery, or breastfeeding.
- PMTCT services help young mothers have a safe pregnancy and delivery.
- Young pregnant women may have many fears and misconceptions about taking medicine during pregnancy. That is why they may need extra support to make sure they continue with appropriate care and treatment.

Key PMTCT Messages:

- Moms need to stay healthy!
 - The healthier the mom (meaning the less HIV she has in her blood and the higher her CD4 cell count), the less likely it is that her baby will become HIV-infected.
 - The sicker the mother (meaning she has a lot of virus in her blood and a low CD4 cell count), the more likely it is that her baby will become HIV-infected. A healthy mom is able to take care of herself and love and take care of her baby and the rest of her family.
 - Without healthy moms, we will not have healthy families or communities!
- All pregnant women need to take ARVs. Most ARVs will not hurt the baby and this is one of the best ways to prevent MTCT.
- All babies exposed to HIV also need to take ARVs.
- Mothers and their babies should keep coming back to the clinic for care and treatment and child health services.
- All HIV-exposed babies should get follow-up care at the clinic.

Case study for role play:

E___ is 16 years old, HIV-positive, and pregnant. She is terrified to tell her family that she is pregnant and doesn't really know what to do next. She is afraid that her baby will also have HIV. She is also scared that the ARVs she is taking might harm the baby and thinks she should stop taking them.

What would you talk about with E___?

ALL pregnant women living with HIV and all babies exposed to HIV need to take ARVs and need to get other PMTCT services!



SESSION 10.6: Sexual Abuse and Gender-Based Violence (45 minutes)



TRAINER INSTRUCTIONS

Methodologies: Game, Interactive Trainer Presentation, Large Group Discussion, Case Studies, Role Play

- Step 1:** Start by reading the statements from the list in the content below. After each statement, ask participants to raise their hands if they think the statement is a truth and to leave them down if the statement is a myth. Discuss the responses.
- Step 2:** Discuss the definitions of the following terms: sexual abuse, rape, date rape, incest, and gender-based violence.
- Step 3:** Next, facilitate discussion by asking the participants the following questions:
- *What types of laws, practices, and cultural norms make some people more vulnerable to sexual abuse?*
 - *Is sexual violence a problem in your community? If so, for whom?*
 - *What types of violence do adolescents experience?*
 - *Which adolescents may be more vulnerable to sexual abuse?*
 - *Can men or boys be raped?*
 - *Can a boyfriend rape his girlfriend?*
- Step 4:** Emphasize that as long as one person is unwilling to have sexual intercourse, it is rape no matter if the person committing the act is a husband, boy, girl, wife, acquaintance, relative, neighbor, or stranger. Reinforce the following points:
- *Many young girls are forced or tricked into their first sexual experience.*
 - *Any act of sexual violence is a crime punishable by law. There are legal consequences for this crime and referrals should be made to the proper authorities.*
 - *Nothing a young woman does--a including using drugs or alcohol, going to "risky" places, wearing certain clothes, kissing and sexually touching someone, or even having previously had sex with a person—gives a man the right to force her to have intercourse against her will.*
 - *However, being drunk or high makes women less able to set clear boundaries and it also makes men less likely to listen to those boundaries.*
 - *Sexual abuse is a complex problem with many legal and psychosocial factors that need to be addressed.*
- Step 5:** Ask participants to discuss what a Peer Educator should do if a client experiences sexual abuse or gender-based violence. Brainstorm what services a client may need if she experiences sexual abuse, filling in using the content below. Write responses on flip chart.

Step 6: Reinforce that sexual abuse and gender-based violence are very complex problems that require immediate referrals to clinical and psychological services. Peer Educators can only do so much and should work very closely with their supervisor and other members of the multidisciplinary care team if they know or think someone has experienced sexual abuse.

INFORMATION

Statements for Truth or Myth Game

1. Rape happens only to females. (*Myth*)
2. Sexual abuse only means rape. (*Myth*)
3. Rape is an act of uncontrollable sexual desire. (*Myth*)
4. Sexual abuse mostly happens among poor people. (*Myth*)
5. Once a person realizes that he or she is being sexually violated by a boyfriend or a husband, it is easy to leave the relationship. (*Myth*)
6. Most rapes are committed by strangers. (*Myth*)
7. A person can change another person's sexually violent behavior by changing some of his or her own behaviors. (*Myth*)
8. It is rape if someone puts his or her fingers inside a woman's vagina against her will. (*Truth*)
9. An adolescent is less likely to be sexually violated if his or her parents know his or her boyfriend or girlfriend. (*Myth*)
10. People who are sexually abused as a child or adolescent are more likely to become sexual abusers as adults. (*Truth*)
11. Rape can occur within marriage. (*Truth*)
12. Women ask to be raped when they wear short skirts or act flirtatious. (*Myth*)
13. Alcohol can contribute to sexual assault. (*Truth*)
14. If a young woman did not fight back, she was not really assaulted. (*Myth*)

Key Terms:

- **Sexual abuse** includes all forms of sexual violence or exploitation (emotional, physical, and economic) against a person. It may or may not include rape. Any type of unwanted sexual contact is considered sexual abuse.
- **Rape** is when a person uses force, coercion, intimidation, or any kind of threat to have sexual intercourse with an unwilling male or female. Every country has an age of consent to take part in a sexual relationship (when a person is legally old enough to say “yes” to sex). In most countries this is between 16 and 18 years old. Some adolescents are forced to have sex, feel pressured to have sex in exchange for good grades or pocket money, are assaulted if they refuse to have sex, or sell sex in order to survive.
- **Date or acquaintance rape** is rape that happens between people who are dating or who know each other.
- Sometimes young children are the victims of **incest** (when a young person is forced to touch, kiss, or feel the sex organs of a relative or have sexual intercourse with a relative). Because of the older person's position in the family, he or she may be able to pressure the child into doing sexual things without actually having to use force. These crimes, including rape, are the fault of the perpetrator or older person and not the fault of the victim or child.

- **Gender-based violence** is any act done to a woman with the aim of hurting her because she is a woman. This may be physical or psychological harm, including threats and intimidation in public or private.

The practice of rape and sexual abuse is made worse by laws and practices that make women the property of men. Such laws and practices deny women the right to make their own decisions and keep them dependent on men. They also make it more difficult for women to report sexual abuse and rape to the police and, if they do, to get justice. Cultural attitudes toward women often result in women being unjustly blamed for sexual abuse and rape.

Certain adolescents are at increased risk of sexual abuse, including rape:

- Adolescents who live in extreme economic poverty (forced into sex for money or forced to become street hawkers, who may be assaulted while working)
- Adolescents who live separately from their parents
- Adolescents with a physical or mental disability
- Adolescents with a mental illness
- Adolescents who abuse drugs or alcohol
- Adolescents who have family members who abuse drugs or alcohol
- Orphans
- Neglected adolescents
- Adolescents whose parent(s) was physically or sexually abused as a child
- Adolescents who live in a home with other forms of abuse, with sex work going on, or with transient adults
- Adolescents who are in a juvenile home or in jail
- Homosexual adolescents, who may be at greater risk because they are often socially marginalized

What to do if you think someone has experienced sexual abuse:

- Refer the person **immediately** to your supervisor or a clinical staff member of the multidisciplinary care team.
- Sexual abuse can have health consequences that need to be addressed urgently by a doctor. Work with the multidisciplinary care team to refer the adolescent to the necessary clinical, legal, and social services.
- If the person discloses and wants to talk, offer support, understanding, and compassion.
- Tell the person that it is not his or her fault.
- Help the person identify someone who could be a source of support.

What services might adolescents need who have experienced sexual abuse?

- A clinical checkup and clinical services
- ARVs, if they may have been exposed to HIV (and aren't already on ARVs)
- Legal or advocacy services, if the perpetrator is prosecuted by the police
- Immediate and ongoing psychological counseling
- Social support (support groups for survivors of abuse, etc.)
- Emergency shelter, if they are unsafe at home

Sexual abuse is a serious and complicated issue! Peer Educators should work very closely with their supervisor and other members of the multidisciplinary care team if they know or think someone has experienced sexual abuse.



Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

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Colton, T., Costa, C., Twyman, P., Westra, L., & Abrams E. (2009). *Comprehensive peer educator training curriculum, Trainer manual, Version 1.0*. New York: ICAP.

Colton, T., Dillow, A., Hainsworth, G., Israel, E., & Kane, M. (2006). *Community home-based care for people and communities affected by HIV/AIDS: A comprehensive training course for community health workers*. Watertown, MA: Pathfinder International.

EngenderHealth. (2002). *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York, NY: EngenderHealth.

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Senderowitz, J., Solter, C., & Hainsworth, G. (2004). *Comprehensive reproductive health and family planning training curriculum. Module 16: Reproductive health services for adolescents*. Watertown, MA: Pathfinder International.

World Health Organization. (2010). *IMAI one-day orientation on adolescents living with HIV. Facilitator guide*. Geneva, Switzerland: WHO Press.

SESSION 10.7: Module Summary (20 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Scavenger Hunt (optional)

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.
- Step 6:** Ask the group what questions they would like answered about sex, sexuality, or sexual activity. Tell them to write their questions on a piece of paper and to hand them in anonymously (or to place them in the Question Box). Then, answer all of the questions one by one.
- Step 7:** Tell participants that as a homework assignment (optional), they will be doing a Condom Scavenger Hunt. Ask participants to go out into the community and to try and bring in samples of the types of condoms that are available for free in the community. Also ask participants to think of answers to the following questions for the next morning:
- *Where are condoms available in the community?*
 - *How much do the condoms cost?*
 - *Which condoms do people in the community like? Which condoms don't they like?*
 - *How hard or easy was it to find free condoms?*
 - *How did you feel asking for condoms?*
 - *Why don't some people in the community use condoms?*
 - *Are these reasons different for youth and adults? Are they different for married and unmarried people?*

Questions for optional homework activity, Condom Scavenger Hunt:

- Where are condoms available in the community?
- How much do the condoms cost?
- Which condoms do people in the community like? Which condoms don't they like?
- How hard or easy was it to find free condoms?
- How did you feel asking for condoms?
- Why don't some people in the community use condoms?
- Are these reasons different for youth and adults? Are they different for married and unmarried people?



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- We all have our own attitudes and values when it comes to sex and sexual behaviors. To be good Peer Educators, however, we must not put our values on our clients.
 - Peer Educators need to talk openly and non-judgmentally with young people to help them practice safer sex, understand reproduction, and make informed choices about having children.
- Adolescence is a time of sexual experimentation. Everyone has sexual behaviors that are “OK for them.”
- It is important for Peer Educators to know all of the body parts involved in sex and reproduction in women and men so that they can help clients understand the changes taking place in their bodies.
- **Safer sex** is anything that sexual partners do to lower their HIV, other STI, and pregnancy risk. Safer sex involves choosing sexual practices and protection methods that do not allow body fluids to pass from one person to the other her. Peer Educators can talk about and help adolescents choose safer sex methods.
- Part of the Peer Educator’s job is to spread the truth about condoms, to give out condoms, and to help people learn how to use them to protect themselves and their partners from HIV, STIs, and unwanted pregnancy.
- There are many reasons adolescents may not be able to negotiate safer sex with their partners, including lack of good communication skills and/or fear or embarrassment about bringing up the topic of protection.
- In addition to practicing safer sex and using condoms, taking ART the right way, at the same time, every day can also lower the chances of passing/getting HIV through sexual contact. This is sometimes called “treatment as prevention.”
- Microbicides and “PrEP” are new interventions that can protect HIV-uninfected individuals when they are exposed to HIV. We know from research studies that these interventions work to prevent HIV, but we are waiting to see how they can best be used in the general population. For now, microbicides and PrEP are not available for use in the general population.
- There are many physical, social, and economic risks of adolescent pregnancy, including spontaneous abortion, stillbirths, health complications for the mother (like high blood pressure), loss of education, and parents being unprepared to raise a child.
- Peer Educators are not trained family planning providers, but they can provide basic information on contraceptive methods and referrals to ALHIV. Peer Educators should always consult with doctors, nurses, counselors, and other members of the multidisciplinary care team when providing clients with information on getting pregnant,

having children, and contraception.

- Dual protection means preventing STIs/HIV and unwanted pregnancy at the same time. The key to practicing dual protection is to use condoms, either alone or with another contraceptive method.
- When a person has a STI, especially one with sores, it is much easier to spread HIV.
- Peer Educators should always encourage clients to go to the clinic right away if they think they have a STI. They should also tell them to get their partners checked and treated as well.
- **Mother-to-child transmission (MTCT)** is the transmission of HIV from a woman living with HIV to her baby during pregnancy, labor, delivery, or after birth during breastfeeding.
- **PMTCT** stands for prevention of mother-to-child transmission.
- PMTCT services during pregnancy, labor and delivery, and after the baby is born help young mothers reduce the chance that their baby will become HIV-infected. Peer Educators should help educate young women about the importance of enrolling in PMTCT services and of adhering to their own and their baby's care and medicines.
- **Sexual abuse** includes all forms of sexual violence or exploitation (emotional, physical, and economic) against a person. Any type of unwanted sexual contact is considered sexual abuse.
- If a client discloses sexual abuse, Peer Educators should always believe the person and offer emotional support and understanding. The Peer Educator should consult immediately with his or her supervisor or a clinical staff member of the multidisciplinary care team. The client will need both clinical care and emotional support.



MODULE 11: Positive Living



DURATION: 190 minutes (3 hours, 10 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Support clients to have a healthy mind
- Recognize serious signs of anxiety and depression, which require a referral to the multidisciplinary care team
- Support ALHIV to keep their bodies healthy
- Work with ALHIV to actively participate in their own care and advocate for themselves as part of positive living
- Support adolescents who are transitioning into adult care



CONTENT:

Session 11.1: Introduction: The Recipe for Positive Living

Session 11.2: Healthy Mind

Session 11.3: Healthy Body

Session 11.4: Taking Responsibility for Your Care and the Transition to Adult Care

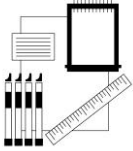
Session 11.5: Classroom Practicum on Positive Living

Session 11.6: Module Summary



METHODOLOGIES:

- Brainstorming
- Small group work
- Interactive trainer presentation
- Large group discussion
- Snowballing
- Case studies



MATERIALS NEEDED:

- Flip chart
- Markers
- Tape or Bostik



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- Review the case studies for *Session 11.5* and adapt to the local context as needed.



SESSION 11.1: Introduction: The Recipe for Positive Living (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Brainstorming, Small Group Work, Interactive Trainer Presentation

- Step 1:** Review the Module learning objectives.
- Step 2:** Ask participants to think about whether or not they have heard the term “positive living” and to think about what living positively with HIV means to them.
- Step 3:** Write the “recipe for positive living” on flip chart.

KNOWLEDGE + DETERMINATION

with actions for a

HEALTHY MIND + HEALTHY BODY + HEALTHY SOUL

= A LONG, HEALTHY LIFE

- Step 4:** Ask participants to discuss what the different “ingredients” in the “recipe” mean and fill in using the content below. Debrief by reminding participants that Peer Educators can be strong role models to help adolescent clients live positively with HIV.

KEY INFORMATION

- Positive living means having a positive outlook on living and life. It also means living responsibly with HIV and preventing new infections.
- ALHIV can live full and healthy lives if they take care of themselves, access care and treatment, and feel supported to make healthy choices.
- Families can also live positively with HIV by supporting and taking care of each other.
- Positive living includes:
 - Keeping the mind healthy
 - Keeping the body healthy
 - Keeping the soul and spirit healthy (e.g. things we do to be happy on the “inside” and to feel a sense of peace and happiness)
 - Preventing new HIV infections

- Peer Educators play a key role in helping other ALHIV live positively and follow the “**recipe for positive living**”:

KNOWLEDGE + DETERMINATION TO LIVE

with actions for a

HEALTHY MIND + HEALTHY BODY + HEALTHY SOUL

= A LONG, HEALTHY LIFE

Peer Educators can help ALHIV
live positive lives!



SESSION 11.2: Healthy Mind (40 minutes)



TRAINER INSTRUCTIONS

Methodologies: Brainstorming, Interactive Trainer Presentation, Large Group Discussion, Small Group Work

- Step 1:** Ask participants to brainstorm times when clients may need extra support to cope with their feelings, like the difficult times or times of crisis that were discussed in *Module 7*. Write responses on flip chart. Then ask participants to brainstorm ways that people living with HIV can keep their minds healthy and be happy, even during difficult times. Write responses on flip chart.
- Step 2:** Write the words “STRESS” and “SADNESS” on two separate pieces of flip chart (or use local words that make more sense). Ask participants the following questions:
- *What do you or people you know do when they are very stressed about something?*
 - *What happens if they are stressed for a long period of time?*
 - *What do you or others do when they are very sad?*
 - *What happens if people are very sad for a long period of time?*
 - *What do you think helps people cope? What has helped you cope during times of stress or sadness?*
- Step 3:** Ask participants to turn to the person sitting next to them. Ask each pair to spend about 10 minutes talking about a time when each of them felt very stressed and another time when they felt very sad. The pairs can answer these questions:
- *How did you feel during that time?*
 - *What were the signs that you were stressed or sad?*
 - *What helped you to feel better?*
- Step 4:** Bring the large group back together and lead a discussion about the signs of stress and sadness. Use the content below to fill in as needed. Explain that when stress goes on for a long time and interrupts a person’s normal routine, it can be very serious and could mean that the person is experiencing something called “anxiety.” When a person is very sad for a long time and this sadness disrupts their world and keeps him or her from enjoying normal activities, this could mean that the person is experiencing “depression.”
- Step 5:** Explain that ALHIV may experience other mental health issues besides anxiety and depression, such as changes in their behavior, acting out, being violent, and many other serious problems. Review some of the common mental health problems and disorders. Then, use the content below to discuss drug and alcohol use among adolescents and how Peer Educators can help prevent their peers from using and abusing drugs and alcohol.
- Step 6:** Ask participants when they think ALHIV need a lot of support and what they

think Peer Educators can do to help them have a healthy mind and live positively with HIV. Fill in using the content below.

Step 7: Remind participants that Peer Educators are not trained counselors and that if they think a client needs additional support, is anxious or depressed, is hopeless, or is thinking about taking his or her own life, they should always talk with a member of the multidisciplinary care team immediately, especially a counselor or social worker. Review when a client needs professional help and support using the content below.

KEY INFORMATION

Mental Health Issues in ALHIV

Many mental health problems develop in late childhood and early adolescence. ALHIV are especially at risk of developing many mental health problems and challenges. There is information below on two common mental health issues, anxiety and depression.

Key Definitions: Anxiety and Depression

Anxiety is when you feel nervous, have a lot of fear, or do not want to do things that you normally enjoy. Sometimes people also use the word “stress” to describe their feelings of anxiety.

Depression is when you feel very sad and hopeless for a long period of time and cannot go about your normal routine or do things that you enjoy.

Anxiety and depression

Almost everyone, especially adolescents, feel sad and stressed sometimes. Sadness and stress can come and go, and are normal parts of adolescence and even adulthood. But, if they last a long time and if they negatively affect how a person functions, copes, and maintains his or her normal routine, this stress and sadness may lead to anxiety and/or depression, which are much more serious.

Anxiety and depression are common reactions to living with HIV, especially when people are not feeling well and do not get the support they need from family, friends, health care providers, and their community. Our mental health and our physical health are closely related—this is why helping people deal with anxiety and depression can help with positive living.

Being depressed and anxious can cause symptoms that are very much like a physical illness or infection. When a person is very stressed for a long period of time, he or she may have anxiety. Symptoms may include:

- Not being able to eat
- Not being able to breathe
- Shaking and sweating
- Heart pounding fast
- Tingling in the hands or feet

- Not being able to sleep
- Not being able to concentrate on anything
- Feeling “jumpy” or “stressed”
- Feeling worried about many things

When a person is very sad for a long period of time, he or she may be depressed.

Symptoms may include:

- Feeling like you just do not know what to do (helpless or hopeless)
- Feeling really tired with no energy
- Not being able to find good in anything
- Not enjoying the things the person used to
- Sleeping too much or not enough
- Getting angry for no reason
- Not being able to eat or eating too much
- Not feeling like being social with friends or family
- Not feeling like having sex
- Talking about running away
- Thinking about suicide (killing oneself)

If Peer Educators think that a client is experiencing serious stress (anxiety) or sadness for a long period of time (depression), they should talk with a clinic doctor, nurse, or social worker IMMEDIATELY. Remember the principles of shared confidentiality when doing this.

If a client’s problems and symptoms are mild, then Peer Educators can help in the following ways:

- Give him or her a referral to meet with a counselor, social worker, or other member of the multidisciplinary care team.
- Listen well and give him or her emotional support. Use good communication skills, such as reflection.
- Encourage the person to join a ALHIV association and a support group to meet other people living positively with HIV, to share his or her worries and feelings, and to find solutions.
- Link him or her with community support services, like groups that provide spiritual support, counseling, home care, or nutritional support.
- Remind him or her not to use alcohol or drugs because this will only make things worse.
- Encourage him or her to stay in school and to participate in school-related activities like sports or after-school clubs.
- Encourage the person to continue any religious or spiritual practices that make him or her feel peaceful.
- Remind the person that his or her feelings are normal and that he or she will feel better.
- Encourage him or her to have a good cry because this can help relieve stress and sadness.
- Encourage him or her to laugh, play, and socialize with friends because relaxation helps to lower stress.
- Encourage the person to do something that he or she enjoys at least once every day, like dancing, singing, writing in a journal, or reading.

Other mental health problems and disorders that ALHIV may face:

In addition to anxiety and depression, ALHIV may have:

- Behavioral problems, such as violence, aggression, and being very impulsive
- Eating disorders, such as eating too much, not eating enough, dieting to the point of starvation, or eating a lot and then vomiting
- Diseases in the brain and central nervous system that can result in a person having problems talking and expressing him- or herself, taking a long time to understand what another person is trying to say, having memory loss, not being able to pay attention, and not developing well
- Thoughts about suicide
- Problems with drugs and alcohol (see below)
- Problems coping with HIV, including social withdrawal, loneliness, anger, confusion, fear, and guilt

Drugs and alcohol: A part of everyday life for many adolescents

- Many adolescents face a lot of challenges and temptations with drugs and alcohol.
- People sometimes drink or use drugs to take away their worries. However, using drugs or drinking alcohol to cope with sadness or stress will only make people feel physically and emotionally worse in the long term, even if it makes them feel better at first.
- When people take drugs or alcohol, they may become addicted, which means that their bodies start to need the substance and that they feel unwell if they do not get it.
- People who are addicted to drugs and alcohol often do not eat well because they spend most of their money on drugs and alcohol instead of on food. Also, drugs and alcohol can affect a person's appetite.
- Helping your peers learn about the risks of drugs, alcohol, and cigarettes before they start using them helps prevent addiction and harmful effects. This can be done through individual counseling or group health education sessions with adolescents (and caregivers).
- Talking with your peers about alcohol and drug use and providing counseling and referrals to adolescents who abuse drugs or alcohol are key components of adolescent HIV care and treatment. They are also important aspects of supporting ALHIV to live positively.

Peer Educators should get help from other members of the multidisciplinary care team IMMEDIATELY when:

- Clients might hurt themselves or another person or if they say that they are going to do so
- Clients' depression or anxiety is so bad that they are thinking about hurting or killing themselves
- Clients' families seem like they cannot cope with them anymore and want to throw them out of the house
- Clients have unusual behaviors (e.g. they are violent or are acting out in other ways)
- Clients talk about running away from home
- Clients cannot eat or sleep
- Clients are abusing drugs or alcohol

Peer Educators can help people deal with their feelings about HIV. Clients will often need extra support in dealing with their feelings:

- When they feel rejected or like they do not fit in with their peers
- When they feel upset, frustrated, or angry about living with HIV every day (e.g. having to take medicines every day, coming to the clinic instead of being with their friends)
- After learning that they or a family member is HIV-positive
- When preparing to disclose to friends or family members
- When they worry about dating, having sex, or one day having children
- When starting ART
- When they are having problems with personal relationships, like with friends or partners
- When a friend or family member is close to death or has just died
- When they face stigma, discrimination, or violence in school, at home, or in the community
- When they are sick
- When they have new symptoms or when the HIV disease progresses, like when there is a major drop in CD4 cells
- When they are hospitalized (particularly the first hospitalization)
- And many other times

These are all important times for Peer Educators to give clients emotional support. Ongoing support is also needed to help people live positively with HIV in the long term.

Peer Educators can also help adolescent have healthy minds by doing the following:

- Make sure that clients have access to adolescent-specific support groups and peer support.
- Make sure psychosocial support services are part of comprehensive HIV care and treatment.
- Make sure adolescent clients and caregivers have disclosure support.
- Make sure that adolescent clients (and caregivers) get ongoing adherence support.
- Encourage adolescents to go to and stay in school. Adolescents who stay in school will have more opportunities in the future. In addition to building academic skills, school also gives adolescents the chance to make more friends and to develop life skills.
- Talk with adolescents about their spiritual and/or religious beliefs and practices.

SESSION 11.3: Healthy Body (40 minutes)



TRAINER INSTRUCTIONS

Methodologies: Snowballing, Large Group Discussion

- Step 1:** Introduce the Session by telling participants that next we will do an activity about keeping our bodies healthy. Break participants into pairs.
- Give each pair 2 pieces of flip chart and a marker. Ask each pair to write “HEALTHY” on one flip chart and “UNHEALTHY” on the other. Ask the pairs to list as many behaviors they can think of that ALHIV can do to keep their bodies healthy on the “HEALTHY” flip chart and to list all the behaviors that ALHIV should avoid on the “UNHEALTHY” flip chart. Give the pairs 5-7 minutes to do this.
- Step 2:** Next, have each pair join another pair, forming groups of 4. Ask the groups to review and combine their lists onto 2 new pieces of flip chart (with the same titles). Participants should not write down the same answer more than once.
- Step 3:** Then have the groups of 4 join another group of 4 and to combine their lists as before. Keep going until there is one large group and a final list of healthy and unhealthy behaviors. Ask for a participant to read through each list out loud. Fill in as needed from the content about healthy and unhealthy behaviors below.
- Step 4:** Ask Peer Educators what challenges they have faced keeping their own bodies healthy and practicing healthy behaviors. Discuss how Peer Educators can help clients keep their bodies healthy.

KEY INFORMATION

Healthy behaviors:

Peer Educators should actively encourage ALHIV to live healthy, positive lives. Some of the many things ALHIV can do to keep their bodies healthy and to live positively with HIV are listed below.

“Living positively” with HIV includes...

Health care

- Going to the hospital or clinic for checkups, lab tests, and to pick up medicines (and never missing an appointment)
- Taking medicines the right way (at the right time, the right number, etc.)
- Telling health care workers if taking any traditional remedies or supplements
- Telling a nurse or doctor if there have been any health-related changes, even small ones

Sexual health

- If sexually active, using condoms and practicing safer sex every time; using a contraceptive method in addition to condoms (dual protection)
- Getting tested for STIs and, if infected, getting treatment immediately and also referring partners for treatment

Staying active and socially engaged
<ul style="list-style-type: none"> • Doing physical exercise (walking, jogging, doing household chores) to build muscles, reduce stress, and improve appetite
<ul style="list-style-type: none"> • Staying socially engaged: making new friends and getting peer support through youth clubs, sports teams, and/or after-school clubs; joining an ALHIV association; talking about things openly
<ul style="list-style-type: none"> • Staying in school/at work and prioritizing education/career
Rest
<ul style="list-style-type: none"> • Getting enough rest
<ul style="list-style-type: none"> • Sleeping and resting under an insecticide-treated mosquito net if in a malarial area
Personal hygiene
<ul style="list-style-type: none"> • Washing hands with soap often, especially: <ul style="list-style-type: none"> – After using the toilet, touching the genitals, or touching any body fluid – Before preparing food or eating – After sneezing or coughing – After touching garbage – After touching animals
<ul style="list-style-type: none"> • Bathing regularly
<ul style="list-style-type: none"> • Practicing good hygiene during the menstrual period: <ul style="list-style-type: none"> – Changing sanitary pads or cloths regularly – Washing hands before and after changing sanitary products – Bathing daily during the monthly period (note: there is never a need to clean inside the vagina, not even during the monthly period) – Safely disposing (by putting into a pit latrine or burning) or washing used sanitary pads/cloths
Oral health
<ul style="list-style-type: none"> • Keeping your mouth clean by brushing teeth, mouth, and tongue at least twice a day
<ul style="list-style-type: none"> • Treating severe oral lesions with gauze soaked in salt water to clean the mouth
Nutrition
<ul style="list-style-type: none"> • Eating enough healthy food and taking multivitamins
<ul style="list-style-type: none"> • Avoiding junk foods and processed foods. Fresh foods are better!
<ul style="list-style-type: none"> • Drinking at least 8 glasses of clean water each day; always drink water that has been boiled, that has been put in a plastic bottle in the sun for a day, or that has been treated with chlorine liquid or tablets (for example, “WaterGuard”)
Food hygiene
<ul style="list-style-type: none"> • Washing food preparation, cooking, eating, and storage utensils with soap and hot water
<ul style="list-style-type: none"> • Washing raw fruits and vegetables well with clean water
<ul style="list-style-type: none"> • Covering food to prevent both flies and dust from contaminating it; not storing raw and cooked foods together
<ul style="list-style-type: none"> • Eating food as soon as it is cooked; not storing leftovers unless they can be kept in a refrigerator or a cool place
<ul style="list-style-type: none"> • Cooking food thoroughly, particularly meat, poultry, and fish (meat should have no red juices), but remember that overcooking vegetables decreases their nutritional value
<ul style="list-style-type: none"> • Keeping the house and compound clean—getting rid of any still water, keeping garbage covered and disposing of it at least once per day
<ul style="list-style-type: none"> • Keeping all food preparation surfaces clean. Use a germ-killing bleach solution (like Jik or Gentian Violet) diluted with water to keep household surfaces clean. If using Jik for home disinfecting, mix 1 part Jik to 10 parts water. When using Jik in health care settings (for example, disinfecting instruments such as blades and needles), use 1 part Jik to 6 parts water and soak at least 10 minutes

Unhealthy behaviors:

Peer Educators should talk with clients about avoiding practices or behaviors that are not healthy. These include:

- Drinking alcohol
- Using drugs
- Smoking cigarettes
- Having unsafe sex
- Avoiding social contact and staying alone too much
- Sharing medicines, stopping medicines without talking to the doctor, or missing medicine doses
- Missing appointments at the clinic
- Taking traditional medicines that have not been discussed with the doctor or nurse
- Not eating enough healthy foods or eating too many sugary or fatty foods

**A HEALTHY BODY
+ A HEALTHY MIND
= A HEALTHY LIFE!**



SESSION 11.4: Taking Responsibility for Your Care and the Transition to Adult Care (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Brainstorming, Interactive Trainer Presentation

Step 1: Begin by explaining that as a natural part of growing up and becoming adults, adolescents must become responsible for their health care. Taking responsibility for their own health care is part of becoming independent from their families and finding a place in the adult community.

Ask participants to discuss why it is important to be an advocate for yourself and to be an active participant in your own HIV care and treatment, filling in using the content below. Ask participants to think about how much they have been involved in their own care and treatment decisions. Use these questions to guide the discussion and fill in using the content below:

- *What do you have to know in order to independently manage your own care and treatment?*
- *What have been your experiences as a participant in your own care at the clinic? What challenges have you faced managing your own care as a young person?*
- *What can Peer Educators do to advocate for themselves and to help other clients advocate for themselves at the clinic?*

Step 2: Explain that in some places adolescents attend pediatric clinics where they may have been getting services since birth or for many years. After a certain age, however, they may have to transition to adult services or to the adult ART clinic. Ask the following question to facilitate discussion:

- *How do you think transitioning to adult care affects adolescents?*
- *Based on your personal experience, what fears or concerns do you think ALHIV may have about transitioning to adult care? For example, what expectations, fears, or concerns do you think ALHIV might have about self-care and/or managing in the new clinic?*
- *What do you think adolescents might ideally want in an adult clinic?*
- *How can Peer Educators, together with the multidisciplinary care team, support ALHIV during the transition process? What types of activities could Peer Educators do with or suggest to the client to assist with his or her transition to adult care?*

Fill in using the content below.

Step 3: ALHIV need support from the entire multidisciplinary care team, including Peer Educators, when they transition from the pediatric to the adult clinic. Peer Educators can help adolescents prepare and feel comfortable with this transition!

KEY INFORMATION

Why be involved in your own care?

We all know a lot about our own bodies and our own health. The more we know, the more we can find the services we need, understand the care plan, and follow up at home and at the clinic. Sometimes, and especially in very busy clinics, we need to help clients advocate for themselves, ask questions, and be involved in their own care.

How can Peer Educators help older ALHIV be more involved in their own HIV care and treatment and help prepare them to transition to adult care? Peer Educators can encourage older adolescents to:

- **Be involved:** Be a part of every decision that is made about your health.
- **Think ahead:** If you talk to your health care workers about your health BEFORE problems happen, you will get the best possible care.
- **Ask questions:** If you do not understand something that the doctor, nurse, counselor, or pharmacist tells you, always ask questions. If you do not understand the answer, ask your question again.
- **Learn more about your health and treatment:** Get as much information as you can about your diagnosis, care, and treatment. Ask your health care worker about the tests and treatment you need and how to get them.
- **Join a ALHIV association and a support group:** This will help you talk to others in similar situations and will help you deal with specific challenges (like adherence or side effects).
- **Understand which medicines you are taking:** Make a list of all the prescription medicine, traditional medicine, and anything else you are taking or doing for your treatment. Make sure you write down if you are allergic to any drugs. Before you take any medicines, make sure you ask a health care worker about:
 - How to use the medicine
 - How you might feel when you are on the medicine (side effects)
 - What other medicines you should NOT take when using the medicine
 - How long you will need to take the medicine
- **Get the results of every test:** Ask for the results of the tests you get. Ask what the results mean.
- **Ask for more information about referrals:** Ask the doctor, nurse, social worker, or Peer Educator:
 - Why am I being referred? Is it necessary?
 - How quickly do I need to go to the clinic/hospital? Will I have to wait a long time?
 - Will they be familiar with my case so I do not have to explain everything?
 - Will they know I am HIV-positive or will I need to tell them?
 - Is there a referral form to take?
 - What will happen to me if I do NOT go?
 - Will I have to pay for treatment? How much will it cost?
- **Understand the treatment plan:** Before you leave the clinic, ask your health care worker to explain the treatment plan you will use at home. Know what you need to bring back to your health care worker the next time. Also make sure you understand your follow-up care plan and what medicines you must continue to take. Remember that Peer Educators are always available to help and that they can give you useful tools, such as a copy of your Adherence Support Tree as a reminder of your adherence plan.
- **Follow up with a community health worker or Peer Educator:** This can help you remember things you may have forgotten and help you follow your care and treatment plan.

Transitioning to Adult HIV Care:

- In some places, adolescents attend pediatric clinics where they may have been getting services since birth or for many years. After a certain age, these clinics may no longer be able to provide them with care and they may have to transition to adult services or to the adult ART clinic.
- This can be difficult for many reasons. Adolescents may have concerns about dealing with new providers or an unfamiliar environment, they may fear stigma, they may worry about the care they will receive, etc.
- The transition to adult care can affect clinic staff, adolescents, and their caregivers because at this point adolescents have to start taking more responsibility for their own treatment and adherence.
- Depending on the understanding and attitudes of the multidisciplinary care team, adolescents may be able to receive adolescent-friendly services at the adult clinic.
- Adolescents need to be educated, motivated, and supported to take care of themselves and to tell health care workers what services they need and the concerns they have. Being able to do so gives them a better sense of control, makes them feel better about their situation, and helps them be more successful in caring for themselves in the long term.
- Peer Educators can work with the multidisciplinary care team to help prepare and support older ALHIV who will transition to adult HIV clinic/services.
- Peer Educators can help adolescents transition to adult care through:
 - Discussion
 - Journaling activities, such as creating a Transition Workbook about the adolescent's health, future goals, sources of support, etc.
 - Peer support, for example linking them to specific support groups for transitioning and transitioned youth and accompanying them to the adult clinic for an orientation, to meet the clinic's health care workers (including the adult Peer Educators and other lay counselors), and to talk about their specific concerns and questions
- Remember, Peer Educators are a resource for other health care workers and they can provide information about individual clients. They can also represent youth and their needs to the multidisciplinary care teams at both pediatric and adult HIV clinics.



Peer Educators can help the multidisciplinary care team prepare and support older adolescents who are transitioning to adult care by helping to address some of their concerns and by helping them be active participants in

SESSION 11.5: Classroom Practicum on Positive Living (50 minutes)



TRAINER INSTRUCTIONS

Methodologies: Small Group Work, Case Studies, Large Group Discussion

- Step 1:** Give participants a quick review of the content covered in the Module so far and ask if there are questions or areas where participants do not yet feel comfortable and need more help.
- Step 2:** Divide participants into small groups and pass out flip chart paper and markers to each group. Ask the groups to spend 15 minutes discussing 2-3 of the case studies below, writing on a flip chart how they would support the client in each case. The trainers should move around the room and provide feedback to the small groups during the activity.
- Step 3:** As time allows, ask some of the small groups to present to the large group or even role play their case study and to give a summary of the next steps they would take as Peer Educators.
- Step 4:** Then, keep participants in their small groups. Ask them to brainstorm how they or people they know live positively with HIV. Based on their answers and what was discussed during this Module, ask each group to develop a poem, rap, or song about what it means for young people to live positively with HIV. After about 20 minutes, ask each group to perform in front of the large group.
- Step 5:** Remind participants that one of the most powerful roles a Peer Educator has is that of a role model. As both recipients and providers of HIV services, Peer Educators play a big part in teaching adolescents how to live positively with HIV!

KEY INFORMATION

Case Study 1:

A 16-year-old young woman named L___ tells you that she is very stressed about school and all of the school she misses because of her appointments at the clinic. She also says that her boyfriend has been acting strange lately. She says she feels like her heart might jump out of her body and that she is having trouble eating and sleeping.

How would you support her?

Case Study 2:

A young woman named N___, who is 16 years old, just started coming to the ART clinic. Her mother died when she was 3 years old and she now lives at home with her younger sister and aunt. She tells you that she feels worried all the time that she might get sick or die and not be able to take care of her sister.

What would you tell her about living positively with HIV?

Case Study 3:

You learn that a client of yours can often be found at the local bar drinking and smoking pot/marijuana all night. You worry that he may be hurting himself and missing doses because he stays out so late and is drunk when he gets home.

What would you say to him about positive living and adherence?

Case Study 4:

K___ is an ALHIV who is 19 years old. Soon he has to start getting care and treatment at the adult clinic instead of at the pediatric clinic. He is nervous about this change because he doesn't know the staff there and because the clinic is so big. Work with the nurse to support him with this transition.

What would you say to K___?

As both recipients and providers of HIV services, Peer Educators play a big part in teaching adolescents how to live positively with HIV! If we can think and talk of "living with HIV infection" instead of "being sick or dying of AIDS," it helps to reduce fear and makes all of us feel more hopeful about the future!



Note: Some of the preceding information in this Module was borrowed and/or adapted from the following sources:

International HIV/AIDS Alliance. (2007). *Our future: Sexuality and life skills education for young people, grades 8 to 9*. International HIV/AIDS Alliance.

Burns, A.A., Lovich, R., Maxwell, J., & Shapiro, K. (1997). *Where women have no doctor: A health guide for women*. Berkeley, CA: Hesperian Foundation.

Colton, T., Dillow, A., Hainsworth, G., Israel, E., & Kane, M. (2006). *Community home-based care for people and communities affected by HIV/AIDS: A comprehensive training course for community health workers*. Watertown, MA: Pathfinder International.

Life Skills Subgroup of the AETC Adolescent HIV/AIDS Workgroup. (2006). *Adolescent transition workbook*. AIDS Education and Training Center.

Orr, N. (2004). *Positive health*. Cape Town, South Africa: Double Story Books.

WHO. (2005). *Participant manual for the WHO basic ART clinical training course, based on chronic HIV care with ARV therapy module* (draft). Addis Ababa, Ethiopia: WHO.

SESSION 11.6: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- People with HIV can live full and healthy lives if they take care of themselves, access treatment and support, and feel supported to make healthy choices.
- Peer Educators play a key role in helping other ALHIV and their families live positively and follow the “recipe for positive living”:

KNOWLEDGE + DETERMINATION TO LIVE

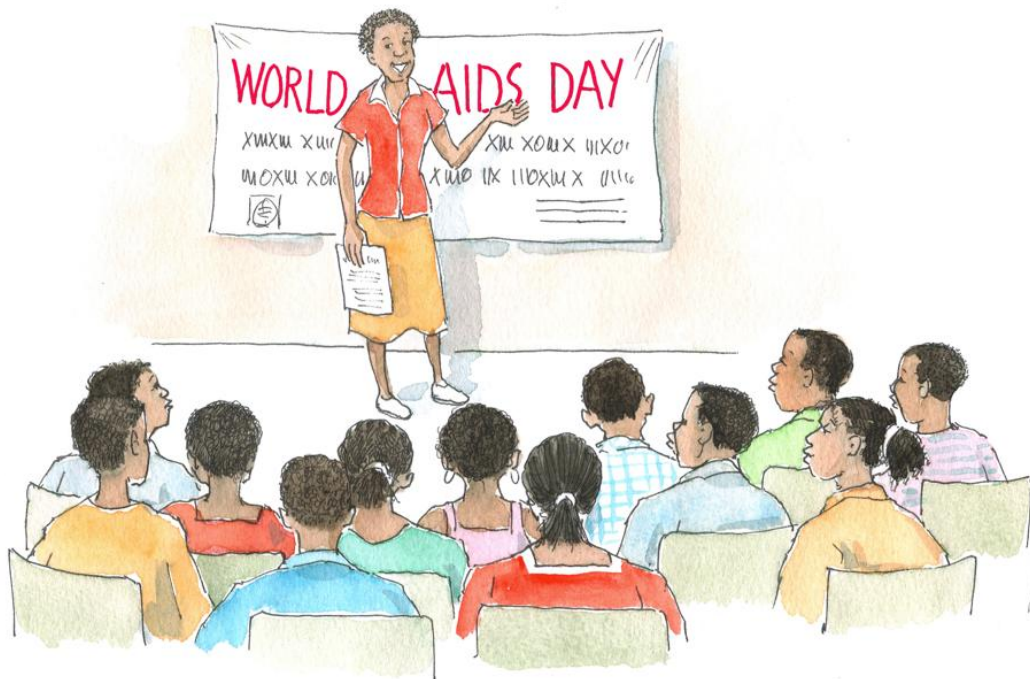
with actions for a

HEALTHY MIND + HEALTHY BODY + HEALTHY SOUL

= A LONG, HEALTHY LIFE

- Peer Educators can help clients keep their minds healthy by making sure they speak with a counselor, social worker, or other member of the multidisciplinary care team; by offering emotional support; and by referring them to peer support groups, spiritual counselors, and other groups for ALHIV.
- Peer Educators should tell the clinical team if they think a client is showing serious signs of depression, anxiety, or of being very troubled.
- Peer Educators can help people keep their bodies healthy by practicing safer sex, eating well, staying clean, and keeping active (among other things).

- Peer Educators should help people stay away from unhealthy things like alcohol, smoking, unsafe sex, eating sugary and fatty foods, and being isolated from other people.
- Older adolescents living with HIV need support and help from the entire multidisciplinary care team, including Peer Educators, to prepare for the transition from the pediatric clinic to the adult clinic.
- Peer Educators can help ALHIV advocate for themselves, be involved and understand their treatment, ask questions, and understand referrals and other aspects of their care as they transition to adult care.



MODULE 12: Community Outreach, Education, and Linkages



DURATION: 215 minutes (3 hours, 35 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Describe community-based support services that ALHIV and their families may need and the importance of each
- Describe the Peer Educator's role in linking clients with community-based support services
- Create a community treasure map and an inventory of community services for ALHIV
- Discuss how Peer Educators can serve as community HIV educators and advocates



CONTENT:

Session 12.1: Introduction: What Services Do ALHIV Need in Their Communities?

Session 12.2: Linking ALHIV to Community Support Services

Session 12.3: Community Resource Mapping

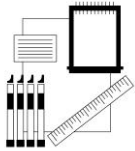
Session 12.4: Being a Community Educator and Advocate

Session 12.5: Module Summary



METHODOLOGIES:

- Guest speaker
- Interactive trainer presentation
- Brainstorming
- Small group work
- Large group discussion
- Role play



MATERIALS NEEDED:

- Flip chart
 - Markers
 - Tape or Bostik
 - Any existing community resource directories, maps, or brochures about available services for PLHIV and their families
 - Locally-available art materials for the Treasure Maps in *Session 12.3* (like glue, colored paper, old magazines, etc.)
 - Copies of *Appendix 12A: Sample Community Resource Map*
-



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
 - Trainers may want to invite guest speakers from the community, such as support-group leaders, youth group leaders, vocational training program managers, home-based care workers, food support organizations, and legal service organizations. Be sure to prepare the guest speakers in advance by briefing them on the Adolescent Peer Education program and the training.
 - Collect copies of any existing community HIV and/or youth support resource directories or materials that are available. In many places, district HIV teams or local NGOs will have created these directories. Try to get enough copies for each participant.
 - Collect a variety of locally-available art materials for the Treasure Maps in *Session 12.3* (like glue, colored paper, old magazines, etc.)
 - Copies of *Appendix 12A: Sample Community Resource Map* for each participant
-

SESSION 12.1: Introduction: What Services Do ALHIV Need in Their Communities? (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Brainstorming

Note: If possible, trainers may want to invite guest speakers to this Session. This could include peer support group leaders, income-generation or community banking leaders, food support organizations, home-based care organizations, legal service organizations, or other youth organizations. Be sure to prepare the guest speakers in advance and ask each to spend about 5 minutes at the end of the session discussing his or her program.

Step 1: Review the Module learning objectives.

Step 2: Remind participants that a key part of being a Peer Educator is encouraging strong linkages between health facilities and the community. In order to help the multidisciplinary care team give enough care and support to ALHIV and their caregivers, we must actively help ALHIV get the services they need at the health facility, in the community, at school, and at home.

Step 3: Ask participants to brainstorm common support needs of ALHIV that could be provided in the community, at school, or in the home. Write responses on flip chart and fill in using the content below.

Ask participants to pick the top 5 most important community support needs for ALHIV from the list. Circle these on the flip chart and tell participants that you will come back to these in the next session.

Step 4: Ask the invited guests to discuss their programs, briefly describing the activities and services they offer for ALHIV and how their programs meet some of the community support needs that were just discussed with participants. Allow time for questions.

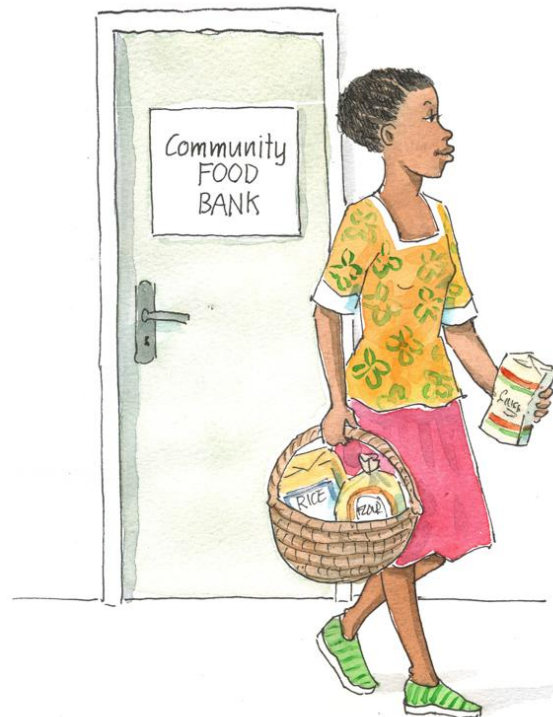
Step 5: Close by emphasizing that Peer Educators are an important source of information for ALHIV about services and activities that exist in their communities. It is important for Peer Educators to stay updated and to always have current knowledge about all of these organizations and groups so they can give informed referrals to ALHIV.

KEY INFORMATION

Common support needs of ALHIV and their caregivers in the community, home, and school:

- Peer support groups
- Youth clubs and organizations
- Income-generating activities

- Vocational /skills training/apprenticeships
- Educational assistance/help with accessing education
- Recreational and sports activities
- “Chill” clubs where young people can get together, talk, and share
- Education and counseling for family members
- Nutritional and food support
- Legal advice and support
- Spiritual guidance and support
- Disclosure support
- Transportation to get to the clinic
- Social welfare for young mothers (e.g. child grants)
- Others



SESSION 12.2: Linking ALHIV to Community Support Services (50 minutes)



TRAINER INSTRUCTIONS

Methodologies: Small Group Work, Large Group Discussion, Interactive Trainer Presentation

Step 1: Break participants into 5 small groups. Assign each small group one of the 5 support needs that participants prioritized in *Session 12.1*. Give each small group flip chart paper and markers.

Give the small groups about 20 minutes to discuss the following questions (you may want to write these on flip chart):

- *Why is this type of support important to ALHIV?*
- *What are your own experiences with this type of support?*
- *Which organizations provide this support in your community?*
- *How can Peer Educators help link clients with this support? Be specific!*

Step 2: Ask each group to give a 5-minute presentation back to the large group. Encourage participants to share their own experiences giving or receiving the various services.

Step 3: Close the Session by reminding participants that Peer Educators should think about all of the comprehensive support needs clients and their caregivers may have and work to help link them to available community- and home-based services.

KEY INFORMATION



No one person or organization can provide all of the services and support ALHIV need. We must work together to provide a continuum of ongoing care and support in the health facility, in the community, at school, and at home!

SESSION 12.3: Community Resource Mapping (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Small Group Work, Large Group Discussion

Step 1: Start by telling participants that one of the important ways Peer Educators can help improve facility-community linkages is by knowing what types of services exist in the community and where. If available, hand out and review any existing community resource directories for PLHIV or youth that you were able to collect before the training.

Step 2: Break participants into small groups. Participants who will be working at the same health facility should work together. Give each group flip chart paper, markers, and tape or Bostik.

Explain that each small group should create a Community Treasure Map on flip chart, showing where a client can go to access some of the services discussed in *Session 12.2*. Encourage participants to be creative and to use color, collage, etc. to decorate their resource maps. They should label any health facilities as well as any community organizations available in the surrounding areas for ALHIV and their families. They should also list a description of the “treasure” at each location (e.g. the activities and/or services each one offers). Make sure participants draw roads or pathways on their treasure maps to indicate how a client would get to each organization from the clinic.

After creating their Treasure Map, each group should hang it on the wall. Ask each group to present their map and to answer the following questions:

- *What community services for ALHIV are good/strong in the area?*
- *Which are lacking?*
- *How are these community services linked to the health facility now?*
- *How could Peer Educators help improve these linkages?*

Encourage the Peer Educators to keep working on their Treasure Maps and to hang them at the clinic, keep them updated, and refer to them when speaking with clients.

Step 3: Refer participants to *Appendix 12A: Sample Community Resources Inventory* in their Participant Manual. This is a form that all multidisciplinary care teams, including Peer Educators, should fill in together and update often. Once it is filled in, the form is an “inventory” of all of the community-based resources available to ALHIV and their families. Ideally, different members of the multidisciplinary care team should be involved in learning about community resources, developing an inventory, and referring clients.

Walk participants through the form and, if time allows, start filling in the inventory based on the treasure mapping activity. If there is no time, encourage participants to fill in the inventory with other Peer Educators and members of the multidisciplinary care team within 2 months.

Note that this type of inventory could also be used to list the different services, dates, and times of clinics where ALHIV may need to go within a large health facility.

KEY INFORMATION

Community resource maps and inventories:

- As a first step, Peer Educators can work together with community organizations and community health workers to map resources available in the community for people and families affected by HIV. In some places, resource lists may already exist, so check in with your local PLHIV and youth associations, district HIV teams, regional health bureaus, or other coordinating organizations.
- Peer Educators should carry an updated inventory of community support services at all times and should hang one up at the clinic for easy reference and referral.
- Remember, it especially important to map and partner with programs that focus on food distribution (e.g. community food banks), income generation, and education and vocational training support because these are all services needed by many ALHIV.

Peer Educators should keep updated inventories or Treasure Maps in the clinic to use as helpful resources when speaking to clients about community-based services!



SESSION 12.4: Being a Community Educator and Advocate (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation, Small Group Work, Role Play

Note: The content of this Session should be adapted based on the anticipated role of Peer Educators in the community. In some programs, it is likely that Peer Educators will be based mainly in facilities, with limited activities in the community. In others, Peer Educators will be expected to share their time between facility- and community-based activities. Within the same program, these roles and responsibilities may change over time, so trainers should adjust this Session accordingly.

- Step 1:** Lead a discussion on the role Peer Educators will play in community education and advocacy within your specific program. Specifically, ask participants how Peer Educators can mobilize the community around HIV, filling in from the content below.
- Step 2:** Ask participants if they remember any of the key points about speaking in front of a group from *Module 8*. Add to the conversation as needed using the list of key points below.
- Step 3:** Break participants into 4 small groups. Assign each group one of the following scenarios to role play:
- *You have been asked to speak about HIV and youth at your school's World AIDS Day event.*
 - *You have been asked to speak to an after-school youth club about HIV prevention, care, and treatment.*
 - *You have been asked by your church (or mosque, temple, etc.) to talk to a small group of people about the support ALHIV need in the community.*
 - *You are going to talk to a local NGO that focuses on vocational training for adolescents about creating a referral system for ALHIV enrolled in care and treatment at the clinic where you work.*
- Step 4:** Give the small groups about 20 minutes to prepare an outline of what they would talk about given the scenario.
- Step 5:** Ask each group to spend about 7-8 minutes performing their role play in front of the large group. Allow the large group to give comments and constructive feedback on content and the way Peer Educators presented the information.
- Step 6:** Remind participants that as trained, respected Peer Educators, they may be asked to speak to community groups and at community gatherings. This is a good opportunity to educate the community about HIV, to advocate for the needs of ALHIV and their families, and to help reduce stigma and discrimination facing ALHIV.

KEY INFORMATION

How can Peer Educators mobilize the community around HIV?

- Use your position as a Peer Educator to speak at your school; at youth clubs and organizations; at community gatherings and group meetings; at religious services; and at other community events.
- Talk with community members and your peers about HIV, about how to prevent HIV, and what prevention, care, and treatment services are available for youth in the community.
- Talk to your peers and young people about how to protect themselves from HIV, STIs, and unwanted pregnancy. Help ALHIV get the care and treatment they need.
- Involve other community members in the fight against HIV. Talk with teachers and leaders of youth groups and organizations in the community about what they can do to help ALHIV and their caregivers.
- Get involved in community events, such as World AIDS Day activities and HIV testing campaigns, especially those focused on youth.

Reminder from *Module 8*

Important points to remember when speaking in front of a group:

- Be respectful of everyone, even if their ideas and values are different from your own.
- Be sure to plan the group session ahead of time with the group leader, decide on what your role will be, and practice what you are going to say.
- Do not stand behind a desk or other furniture.
- Encourage participants to sit in a semi-circle to make it feel less like a classroom and more comfortable to talk.
- Speak loudly enough so everyone can hear you clearly, but not so loud that you are shouting.
- Interact with participants, asking questions and asking people to share personal stories/concerns, etc.
- Make eye contact with all members of the group.
- Check in regularly to make sure participants are engaged and understand the messages.
- Use visual aids and avoid lecturing.
- Offer your opinion and offer practical suggestions based on your personal experience.
- Use the 7 essential communication skills.
- Pay attention to people who seem shy or quiet and emphasize that everyone's personal experiences, questions, and concerns are important.
- Encourage participants to speak with you or the group leader in private afterward if they have concerns they do not want to share with the group.
- Work with the group leader to plan and lead youth-friendly games and activities.

Peer Educators are important community educators and advocates! They may be asked to speak to community groups and at community gatherings. This is a good opportunity to educate the community about HIV, to advocate for the needs of ALHIV and their families, and to help reduce stigma and discrimination!



SESSION 12.5: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Some common needs of ALHIV and their caregivers at the community and home levels include access to education, legal support, adherence support, poverty reduction and income-generating activities, peer support groups, nutritional support, and many other services.
- There are many community-based services in most places, but often groups and organizations do not know about each other or do not make formal plans to work together. A key part of Peer Education is advocating for strong linkages between health facilities and these community-based services for ALHIV.
- There are many ways to strengthen facility-community linkages, such as knowing what youth-friendly community services are available, participating in community meetings, keeping an updated resource map or list of services available, working with the multidisciplinary care team to meet with community leaders, and helping the multidisciplinary care team develop a strong two-way referral system between the health facility and community organizations for ALHIV.
- Peer Educators should stay up-to-date on which services are available for ALHIV and work with the multidisciplinary care team to make referrals.
- Peer Educators may be asked to speak to community groups or at community gatherings. Use your respected position to educate and mobilize the community and to advocate for the needs of ALHIV and their families. Speaking in the community can also help reduce stigma and discrimination.
- Be sure to plan ahead when speaking in the community and use good group communication skills.

APPENDIX 12A: Sample Community Resources Inventory

Name of District or Community: _____

Name of Organization	Services Provided and Schedule (days/hours)	Catchment Area	Contact Person, Telephone Number, and Address
1.			
2.			
3.			
4.			
5.			
6.			

MODULE 13: Record-keeping and Reporting



DURATION: 80 minutes (1 hour, 20 minutes)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Explain the importance of record-keeping
- Understand how information collected and reported by Peer Educators can be used to make program improvements
- Fill in basic daily and monthly reporting forms for Peer Education sessions, group sessions, and referrals



CONTENT:

Session 13.1: Introduction: Why Do We Need Records?

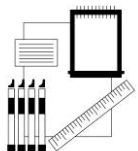
Session 13.2: Peer Educator Recording and Reporting Forms

Session 13.3: Module Summary



METHODOLOGIES:

- Interactive trainer presentation
- Large group discussion
- Small group work



MATERIALS NEEDED:

- Flip chart
- Markers
- Tape or Bostik
- Copies of all Peer Educator recording and reporting forms and registers, including (but not limited to) the Peer Educator Daily Recording Form (*Appendix 13A*) and the Peer Educator Monthly Reporting Form (*Appendix 13B*), adapted as needed



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- Adapt the content of the Module to your specific Peer Education Program, including the recording and reporting systems and forms used.
- It may be useful to invite multidisciplinary care team members and/or data officers from the clinic to explain the recording and reporting systems and forms in use.
- Adapt the Peer Educator Daily Recording Form (*Appendix 13A*) and the Peer Educator Monthly Reporting Form (*Appendix 13B*) as needed and photocopy for each participant.
- Collect any other recording and reporting forms and registers that Peer Educators will be using. Make copies for each participant.



SESSION 13.1: Introduction: Why Do We Need Records? (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion

- Step 1:** Review the Module learning objectives.
- Step 2:** Ask participants if they can list all of the people they talked to in the last 3 weeks. Since most will not be able to remember, make the point that if we do not write things down, we often do not remember them.
- Step 3:** Ask participants what kind of records they keep in their daily lives (e.g., a diary; medical records; a calendar of appointments, social events, and times they have to be at the clinic to work as Peer Educators; etc.). Ask participants why they keep these records.
- Step 4:** Discuss why it is important for Peer Educators to keep daily records and to complete monthly reports. Using the content below, give some examples of how Peer Educators and their supervisors can use different kinds of information for program decision-making and improvement.

KEY INFORMATION

Records are important because they can help us:

- Remember things we have done or need to do
- Plan what we need to do
- See what we have done
- See what we could do better
- Report to other people (such as our supervisor) what we have done
- See what the gaps are in our services and fill them

It is important for Peer Educators to fill in daily registers and to prepare reports each month because they will:

- Be a record of general activities and time spent at the clinic (e.g., how many people you have provided education and information to, how many group education sessions you have helped lead, how many clients you have referred to peer support groups, etc.)
- Show your supervisor what you have done
- Help you plan for the next month
- Show how effective Peer Educators can be in helping ALHIV

Peer Educators should keep good records to show what they have accomplished and they should use the information to help improve the overall program.



SESSION 13.2: Peer Educator Recording and Reporting Forms (50 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Small Group Work

Note: Adapt the content in this Session to your specific Peer Education program. Use the actual forms that Peer Educators will be using in their day-to-day work.

Step 1: Pass out copies of the register(s) that Peer Educators will be using in their work. Orient participants on the different information they are expected to collect using the content below and the forms as guides.

At minimum, Peer Educators should complete:

- Daily registers for Peer Education sessions, group sessions, and referrals
- Monthly reports showing the totals of their daily activities (from the Daily Recording Form)

Step 2: Go through the 2 forms with participants: the Peer Educator Daily Recording Form (*Appendix 13A*) and the Peer Educator Monthly Reporting Form (*Appendix 13B*). Be sure to make this activity participatory (for example, stopping to ask participants why we would need to know each specific piece of information). Also review the points in the “Record-keeping Basics” box below.

Discuss how the reports will be collected, reviewed, and used to make program improvements by Peer Educators, supervisors, and the multidisciplinary care team (for example, through monthly meetings).

Step 3: Break participants into small groups of 4. Give locally realistic scenarios for participants to practice filling out each form. The trainers should assist the small groups as needed.

Step 4: Bring the large group back together. Ask participants what they think will be most challenging about keeping good records. Then ask participants to think of ways to support each other in filling out daily and monthly forms. Write on flip chart and emphasize again the importance of good record-keeping.

KEY INFORMATION

There are at least 2 types of forms that Peer Educators should fill in:

- A daily register for Peer Education sessions, group sessions, and referrals
- A monthly report showing the totals of their daily activities

Depending on the program, Peer Educators may also need to fill in forms related to:

- Adherence and psychosocial support assessments (e.g. Talking and Adherence Tree tools can become part of the client's record)
- Attendance
- Others

Peer Educator Daily Recording Form (see *Appendix 13A* for a sample and adapt to your own setting):

Peer Educators can write down all Peer Education and group sessions on this form. Every day a Peer Educator works at the clinic, he or she should use this form to record the following information:

- Peer Educator's name, clinic name, reporting week/year, and supervisor's name
- Daily total of Peer Education sessions, by gender
- Number of referrals made and the gender of the client being referred (for example, a client was taken to the ART clinic, a client was referred to a support group, etc.)
- Number and type of group sessions conducted (for example, adherence, disclosure, positive living) and the total number of young people who attended the sessions

Peer Educator Monthly Reporting Form (see *Appendix 13B* for a sample and adapt to your own setting):

At the end of each month, each Peer Educator should add up the information from their Daily Recording Forms to complete a monthly report. The Monthly Reporting Form includes the following information:

- Peer Educator's name, clinic name, reporting month/year, and supervisor's name
- Monthly total of individual sessions (total with female clients and total with male clients)
- Monthly total of referrals made (total with female clients and total with male clients)
- Monthly total of group sessions and the approximate number of participants who attended
- A brief description of any achievements or challenges the Peer Educator had during the month
- Peer Educators should sign and date their monthly reporting forms and give them to their Supervisor.

All Peer Educator monthly reports should be reviewed by supervisors and shared and discussed with the multidisciplinary care team, including Peer Educators, to see what is going well and what improvements could be made based on the information. A summary of Peer Educator activities should also be presented to the entire multidisciplinary care team and discussed on a regular basis (e.g. during monthly team meetings). Remember, there is no point in collecting information if we do not use it to improve our program!

Record-keeping Basics

- Keep records and reports confidential.
- Write neatly.
- Write in blue or black ink.
- Cross-out mistakes neatly.
- Write corrections clearly.
- Keep forms and registers in a clean, dry place.
- If you have to hand in a report, always make a photocopy for your records.
- If you are unsure about something, ask another Peer Educator, a supervisor, or a member of the multidisciplinary care team for help.

Peer Educators should help each other fill out the forms and should ask each other, their supervisor, or other members of the multidisciplinary care team if they have questions.



SESSION 13.3: Module Summary (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Interactive Trainer Presentation

- Step 1:** Ask participants what they think are the key points of this Module. What information will they take away from the Module?
- Step 2:** Summarize the key points of the Module using participant feedback and the content below.
- Step 3:** Ask if there are any questions or clarifications.
- Step 4:** Review the learning objectives with participants and make sure all are confident with their skills and knowledge in these areas.
- Step 5:** If there are areas participants do not fully understand or in which they need more help, go back and review those sessions before moving ahead to the next Module.

KEY INFORMATION



LOUISA SAYS, “REMEMBER THESE KEY POINTS!”

- Keeping good records can help Peer Educators show the work they have done, plan for what do next, and follow up with clients.
- It is important that Peer Educators keep good records of their work and submit monthly reports on time to their supervisor. These reports should be shared among and discussed by Peer Educators, supervisors, and the multidisciplinary care team.
- **There are at least 2 types of forms that Peer Educators should fill in:**
 - A daily register for Peer Education sessions, group sessions, and referrals
 - A monthly report showing the totals of their daily activities
- Peer Educators should help each other fill out the forms and if they have questions, they should ask each other, their supervisor, or other members of the multidisciplinary care team.

APPENDIX 13A: Sample Peer Educator Daily Recording Form (adapt to local setting)

PEER EDUCATOR DAILY REPORTING FORM

Peer Educator Name: _____ Clinic Name: _____

Reporting Week/Year: _____ Supervisor's Name: _____

Today's Date: _____	
Number of one-on-one sessions conducted:	Females (tick): OOOOOOOOOOOOOOOOO Males (tick): OOOOOOOOOOOOOOOOO TOTAL: _____ with female clients _____ with male clients
Number of referrals made:	Females (tick): OOOOOOOOOOOOOOOOO Males (tick): OOOOOOOOOOOOOOOOO TOTAL: _____ with female clients _____ with male clients
Group sessions conducted:	How many sessions: _____ Topics covered (list): _____ Approximate # of participants: _____

Today's Date: _____	
Number of one-on-one sessions conducted:	Females (tick): OOOOOOOOOOOOOOOOO Males (tick): OOOOOOOOOOOOOOOOO TOTAL: _____ with female clients _____ with male clients
Number of referrals made:	Females (tick): OOOOOOOOOOOOOOOOO Males (tick): OOOOOOOOOOOOOOOOO TOTAL: _____ with female clients _____ with male clients
Group sessions conducted:	How many sessions: _____ Topics covered (list): _____ Approximate # of participants: _____

APPENDIX 13B: Sample Peer Educator Monthly Reporting Form (adapt to local setting)

PEER EDUCATOR MONTHLY REPORTING FORM

Peer Educator Name: _____ Clinic Name: _____

Reporting Month/Year: _____ Supervisor's Name: _____

Number of one-on-one sessions conducted this month:	TOTAL: _____ with female clients	_____ with male clients
Number of referrals made this month:	TOTAL: _____ with female clients	_____ with male clients
Group sessions conducted this month:	TOTAL number of sessions: _____	
	Approximate total # of participants: _____	
Major achievements during the month:		
Major challenges during the month:		
Other comments:		
Peer Educator's Signature:	_____	
Date report submitted:	_____	

MODULE 14: Supervised Practicum



DURATION: 2-4 days



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Practice skills learned during the training in a health facility offering HIV prevention, care, and treatment services to ALHIV
- Demonstrate competency in the major skills taught during the training
- Identify skill areas where further on-the-job practice and mentoring are required



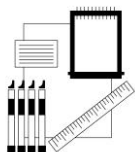
CONTENT:

Session 14.1: Practicum Preparation
Session 14.2: Supervised Practicum
Session 14.3: Practicum Debriefing



METHODOLOGIES:

- Interactive trainer presentation
- Large group discussion
- Supervised practicum
- Trainer/preceptor discussion
- Small group work



MATERIALS NEEDED:

- *Appendix 14A: Peer Educator Supervised Practicum Checklist* (one practicum checklist should be prepared for each participant)
- Enough Peer Educator reporting and recording forms in *Appendix 13A* and *13B* for each participant



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
- If the training is conducted at a health facility where ALHIV seek services, explore ways to conduct parts of the training followed by all-day practicum sessions.
- If the training is not conducted at a health facility, select sites for the practicum. Ideal sites are busy hospitals and health centers offering HIV care and treatment services to ALHIV where Peer Educators will actually be working and, most importantly, where there will be many ALHIV clients. Trainers and preceptors should plan accordingly and find out if there are specific days/times that ALHIV receive services. This could be in a pediatric clinic or in an adult clinic—the most important thing is that there are ALHIV clients present during the practicum times.
 - Meet with facility leadership and staff to discuss the Adolescent Peer Educator program, the training, and the supervised practicum. Ideally, members of the multidisciplinary care teams from practicum sites will have been involved in the training.
 - If possible, orient some of the facility staff to be preceptors during the practicum and orient them on the key skills taught during the training, the roles of Peer Educators at the site, and the practicum checklist. Preceptors will also need to be oriented on how to coach youth.
 - Get a sense of daily activities at the facility (including the hours that ALHIV come to the clinic and any group activities that take place during those times) and how participants may be able to observe and practice applying the skills they have learned.
 - Plan when Peer Educators should come to the clinic (dates and times) with the clinical team. Ideally, the practicum should occur at times when there are many youth clients at the clinic to allow for maximum interaction between Peer Educators and clients.
- Depending on the role Peer Educators will play, you may also want to organize a community-based practicum where participants practice conducting follow-up visits or speaking with community groups, youth groups, etc. If there is a community-based component to the practicum, this will require careful planning and preparation. Be sure to explain the Adolescent Peer Educator Program and training well to community members who are involved in the practicum.

- Assign participants to preceptors. Depending on the number of participants and preceptors, it is best to split up the group so that preceptors have no more than 4-5 participants each during the practicum.
 - Orient preceptors on methods of coaching, mentoring, and giving feedback if they are new to this type of training. Also orient them on basic communication and coaching approaches with youth specifically. Ideally, preceptors should be pre-selected and be able to participate in some/all of the classroom training. Make sure that there are some multidisciplinary care team members who both participate in the training and can act as preceptors.
 - Work with preceptors and facility staff to decide how the practicum will be structured. Review the practicum checklist as a group and decide how participants will practice the key skills. For example, if participants are to practice giving a group education session on adherence, this must be arranged in advance and clients must be present, a space for the talk must be identified, etc.
 - Arrange for transport to and from the practicum site(s) and lunch for participants and preceptors.
 - Photocopy *Appendix 14A: Peer Educator Supervised Practicum Checklist*. Preceptors should have one checklist for each participant in their group (and a few extra copies just in case). Preceptors will fill in the checklist for each participant throughout the course of the supervised practicum.
 - Photocopy Peer Educator recording and reporting forms that the Peer Educator Program will use (refer to *Appendix 13A* and *13B*). Make sure there is at least one copy of each form for each participant (and give extra copies to preceptors just in case).
 - If possible, it is best to bring all participants back together for the debrief after the practicum and to then close the Training with *Module 15*.
-

SESSION 14.1: Practicum Preparation (60 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion

- Step 1:** Review the Module learning objectives.
- Step 2:** Introduce the practicum to participants and tell them that this is the time they will get to take all of the information and skills they have learned and practice them at a clinic, with real ALHIV clients, working with members of the multidisciplinary care team.
- Step 3:** Introduce the identified preceptors. (Ideally, these preceptors have been present and have participated in the entire training.)
- Step 4:** Review the practicum logistics and tell participants to which preceptors they have been assigned. Allow time for questions.
- Step 5:** Hand out a copy of *Appendix 14A: Peer Educator Supervised Practicum Checklist* and copies of the Peer Educator recording and reporting forms to each participant.

Go over the major activities that will be conducted during the practicum (supervised individual Peer Education sessions, supervised group education sessions, assistance with reporting and recording, etc.) and the key skills Peer Educators will be asked to demonstrate, using the checklist as a guide. Try to make this participatory by asking different people to read the skills out loud to the large group.

Ask participants if there are skills or areas on the practicum checklist that they do not feel comfortable with or of which they would like to review. Take the time needed to review content areas and skills, repeating case studies or reviewing curriculum content as appropriate and as time allows. Alternatively, you may also schedule an optional review session before the practicum begins.

- Step 6:** Lead a discussion on practicum conduct, touching on the following points:
- *We are guests at the health facility and must respect the wishes of the facility's health care workers and managers.*
 - *Keep all discussions and observations during the practicum confidential. Only share with other participants, trainers, or preceptors.*
 - *Never wander off without the preceptor. Always inform the preceptor if you need to take a break or leave the facility for any reason during the practicum.*
 - *Always introduce yourself to health care workers and clients. Tell them that you are a Peer Educator in training and explain a bit about the program if the person is interested.*

- *Always ask clients for their verbal consent to talk with you or to participate in a group session. Remember that during the practicum any client can refuse to participate or stop participating at any time.*
- *Always ask the preceptor if you have a question or a concern. Remember: This is a chance to learn!*

Step 7: Discuss plans for the practicum follow-up, which will also be the last official day of the training. All trainers, preceptors, and participants should attend.

Step 8: Close by reminding participants that the practicum is a great chance to apply all that they have learned during the training and to make improvements where needed so that they can be the best Peer Educators possible.

KEY INFORMATION

See Appendix 14A: Peer Educator Supervised Practicum Checklist

Peer Educators should remember these points:

- We are guests at the health facility and must respect the wishes of the facility's health care workers and managers.
- Keep all discussions and observations during the practicum confidential. Only share with other participants, trainers, or preceptors.
- Never wander off without the preceptor. Always inform the preceptor if you need to take a break or leave the facility for any reason during the practicum.
- Always introduce yourself to health care workers and clients. Tell them that you are a Peer Educator in training and explain a bit about the program if the person is interested.
- Always ask clients for their verbal consent to talk with you or to participate in a group session. Remember that during the practicum any client can refuse to participate or stop participating at any time.

SESSION 14.2: Supervised Practicum (2-4 days)



TRAINER INSTRUCTIONS

Methodologies: Supervised Practicum, Trainer/Preceptor Discussion

DURING THE PRACTICUM:

- Step 1:** Attend practicum sessions and provide supportive supervision to preceptors and Peer Educators on areas that need improvement. Work with the multidisciplinary care team and the preceptors to make sure the practicum goes smoothly.
- Step 2:** Help preceptors and Peer Educators introduce the program to clients and be sure to get consent from each client that the Peer Educators work with.
- Step 3:** Make sure that preceptors and Peer Educators are attending and carrying out the practicum sessions as planned and that the preceptors are completing the practicum checklist for each Peer Educator. Remember to praise Peer Educators for skills well done!

AFTER THE PRACTICUM:

- Step 4:** Bring together all of the preceptors, trainers, and the Peer Education Program Coordinator after the practicum.
- Step 5:** Review each participant's practicum checklist and discuss as a group whether or not each person is ready to graduate from the course and become a Peer Educator. Trainers and preceptors should have a plan for Peer Educators who will not graduate (for example, they could be asked to repeat the training).
- Step 6:** Identify and discuss common areas of weakness seen during the practicum and arrange for refresher training and on-site mentoring in these areas. It is unlikely that each participant will have mastered all of the skills over the short training and practicum period, so plans for future training and on-site supportive supervision are important. Explain that in order to continue to develop and maintain their learning and skills, Peer Educators should have regular communication with their supervisor and the multidisciplinary care team in the form of meetings, supervision, and ongoing training.
- Step 7:** Thank preceptors for their hard work and dedication to the program.

KEY INFORMATION

See *Appendix 14A: Peer Educator Supervised Practicum Checklist*

SESSION 14.3: Practicum Debriefing (50 minutes)



TRAINER INSTRUCTIONS

Methodologies: Small Group Work, Large Group Discussion, Interactive Trainer/Preceptor Presentation

- Step 1:** Bring together all of the participants, preceptors, and trainers at the set date, time, and location.
- Step 2:** Break participants into small groups of 5. Ask each group to spend about 10 minutes debriefing on the practicum. Ask the small groups to discuss the following questions (you may want to write these on flip chart):
- *What was your overall experience during the practicum?*
 - *What skills were the most difficult?*
 - *What skills were the easiest?*
 - *In which areas would you like more training and support so you can be the best Peer Educator possible?*
- Step 3:** Bring the large group back together and ask each of the small groups to briefly present their thoughts about the practicum. Following the small group presentations, ask some of the preceptors to give their thoughts on the practicum. Encourage open discussion.
- Step 4:** Ask the preceptors to lead a brief discussion on specific skills/areas that they think will require more work (based on overall results of the practicum). Make sure that no one person is singled out or feels ashamed of his or her performance during the practicum. Remind participants that they will be provided with ongoing support, mentoring, and training to sharpen their skills and to also learn new ones.
- Step 5:** Congratulate preceptors and participants on a job well done!

KEY INFORMATION



Congratulations to everyone for completing the practicum! Remember, Peer Educators will be given ongoing support, mentoring, and training to sharpen their skills and to also learn new ones as they gain experience!

APPENDIX 14A: Peer Educator Supervised Practicum Checklist

Instructions: Preceptors should complete one checklist for each Peer Educator during the practicum. As you observe a specific skill being demonstrated, tick your rating as GOOD, FAIR, or POOR. If you want to make comments or recommendations, write in the right-hand column and be sure to share comments with the Peer Educator. Note that it is unlikely that all items on the checklist will be observed during the practicum. This extensive list of skills is intended to be a guide for preceptors and Peer Educators. At the end of the practicum, complete the final evaluation for each participant.

Name of Participant: _____ Name of Preceptor(s): _____

Dates of Practicum: _____ Name of Practicum Site: _____

Key Skill Area	Preceptor's Rating (Tick One)			Comments
	Good has mastered the skill	Fair needs more practice	Poor needs more training	
General Communication Counseling Skills with Individuals and Groups				
Introduces self and role as a Peer Educator and identifies self as a ALHIV				
Ensures privacy and explains confidentiality to clients				
Demonstrates at least 3 of the 7 essential communication skills				
Uses the Talking Tree as a guide for at least 1 client during a one-on-one Peer Education session				
Basic Communication about HIV				
Explains the difference between HIV and AIDS				
Explains how HIV affects the immune system				
Explains the different ways HIV is transmitted				
Clarifies the way HIV is NOT transmitted				
Explains the different ways HIV can be prevented				
Sexual and Reproductive Health				
Describes the functions of reproductive and sexual body parts				
Describes ways to practice safer sex and prevent HIV				
Demonstrates male and female condom use				

Key Skill Area	Preceptor's Rating (Tick One)			Comments
	Good has mastered the skill	Fair needs more practice	Poor needs more training	
Gives clients basic information about signs and symptoms of STIs				
Advises on complete treatment of STIs for self and partner				
Comprehensive HIV Care and ART				
Describes the components of comprehensive HIV care				
Explains why HIV care is important, even if a person is not on ART				
Explains the most common medical issues that YLIHIV may experience, some basic symptoms, and basic ways to prevent them				
Explains who needs ARVs and ART				
Provides basic information about ARV side effects				
Recognizes when a client describes dangerous side effects and provides an immediate referral to the multidisciplinary care team				
Advises clients never to stop taking ARVs without coming to the clinic first				
Escorts clients to referral points within the health facility				
HIV Prevention, Care, and Treatment for Young Pregnant Women and Their Children				
Explains the definition and importance of PMTCT services to young pregnant women				
Adherence Support				
Explains the importance of adherence to care and medicines				
Uses the Adherence Support Tree to help at least 1 client (and caregiver) make an ART adherence plan (Who, What, When, Where, and How)				
Helps support clients who are having adherence challenges by giving practical examples about adherence strategies				
Asks about adherence at follow-up visits				
Psychosocial Support				
Can suggest positive and practical ways to cope when a client expresses psychosocial needs and concerns				
Offers practical suggestions to clients to cope with and fight stigma and discrimination				

Key Skill Area	Preceptor's Rating (Tick One)			Comments
	Good has mastered the skill	Fair needs more practice	Poor needs more training	
Uses the Talking Tree to help at least 1 client address a psychosocial concern				
Support Groups for ALHIV				
Demonstrates effective group communication skills				
Suggests and helps lead at least 1 youth-friendly activity or game				
Positive Living				
Describes the importance of positive living for ALHIV				
Understands when to make referrals for serious problems, like when a client appears to be very stressed or sad				
Explains healthy and unhealthy behaviors for ALHIV				
Encourages ALHIV be involved in their own care				
Disclosure Support				
Freely discloses own HIV-status to clients and health care workers				
Provides disclosure support to clients and caregivers, using tools like the Talking Tree				
Community Outreach, Education, and Linkages				
Provides clients with basic information about available community resources, using a resource map or inventory				
Record-keeping and Reporting				
Correctly completes daily activity recording form and monthly reporting form				
Communication with Supervisor and Multidisciplinary Care Team				
Can appropriately communicate about client issues with other Peer Educators, supervisor, Program Education Coordinator, and relevant members of the multidisciplinary care team on a daily basis				

Final Evaluation by Preceptors:

Name of participant: _____

Tick one:

- Demonstrated a majority of skills effectively and is ready to start work as a Peer Educator
- Demonstrated some skills effectively, but still needs more practice before becoming a Peer Educator
- Unable to demonstrate most skills and should participate in the training course again before becoming a Peer Educator

Additional comments:

Preceptor(s) Signature: _____ Date: _____



MODULE 15: Next Steps, Course Evaluation, and Graduation



DURATION: 120 minutes (2 hours)



LEARNING OBJECTIVES:

By the end of this Module, participants will be able to:

- Review and reflect on the overall learning objectives of the Adolescent Peer Educator training
- Discuss their vision and hopes for the Peer Education program and for their future as Peer Educators
- Agree on next steps for when they return to their respective health facilities
- Complete a final learning assessment
- Complete a training evaluation
- Graduate from the training



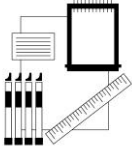
CONTENT:

Session 15.1: Reflection on Learning Objectives
Session 15.2: Next Steps for Adolescent Peer Educators
Session 15.3: Final Learning Assessment/Post-Test
Session 15.4: Training Evaluation
Session 15.5: Graduation and Closing



METHODOLOGIES:

- Interactive trainer presentation
- Large group discussion
- Guest Speaker
- Learning assessment
- Participatory evaluation
- Celebration!



MATERIALS NEEDED:

- Flip chart
 - Markers
 - Tape or Bostik
 - Copies of *Appendix 15A: Peer Educator Bingo* (one for each participant)
 - Training completion certificates
 - Camera (optional)
 - Peer Educator kits (optional, see below)
-



WORK FOR THE TRAINER TO DO IN ADVANCE:

- Read through the entire Module and make sure you are familiar with the training methodologies and content.
 - Make copies of *Appendix 15A: Peer Educator Bingo* (one for each participant).
 - Invite the Peer Educator Program Coordinator or Manager to this final training day if he or she is not already a participant in the daily training activities. Ask him or her to present:
 - Practical guidance on next steps for Peer Educators at the site level, including when they should report to their site, how they will be introduced to the multidisciplinary care team, etc.
 - The plan for supervising and mentoring Peer Educators in their work
 - The plan for continuing education of Peer Educators at the site level (through refresher and advanced training, at monthly and quarterly meetings, etc.)
 - Arrange the Peer Educator graduation ceremony in advance. Consider:
 - Location, date, and time
 - Inviting guest speakers and attendees
 - Informing local press
 - Preparing training completion certificates for each participant
 - Preparing Peer Educator kits containing t-shirts or uniforms, notebooks, recording forms, job aids, or other materials provided by the program. These could be provided as part of the graduation ceremony.
-

SESSION 15.1: Reflection on Learning Objectives (20 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion

Step 1: Review the Module learning objectives.

Step 2: Review the overall training objectives with participants, referring to the flip chart page prepared on the first day of training (or by rewriting the learning objectives on flip chart and referring participants to their Participant Manuals).

Ask for a volunteer to read each of the learning objectives out loud. After each, discuss as a group:

- *Did we meet this learning objective during the training?*
- *How confident do you feel that you will be able to do this when you return to your site?*
- *What extra support would you like in this area?*

Write answers on flip chart or in a notebook, especially the areas requiring extra support.

Step 3: End by explaining that each Peer Educator now has a wide range of skills and knowledge but will have different strengths, weaknesses, and interests (e.g. some will be most effective at group work, some will be more confident when working individually with a client, etc.). However, as they mature and gain more experience over time, their confidence and skills will increase—particularly as they discover their “home” within a multidisciplinary care team.

KEY INFORMATION

At the beginning of the training, we agreed on a number of learning objectives.

By the end of this basic training course (Modules 1-14), participants will be able to:

1. Work as an integral part of a clinic’s multidisciplinary care team
2. Understand needs and challenges of ALHIV and how to help make clinic services more youth-friendly
3. Give one-on-one peer education and assist with facilitation of group education to ALHIV so they better understand, use, and adhere to HIV prevention, care, and treatment services
4. Demonstrate knowledge about issues related to sexual and reproductive health and show that they are comfortable talking about them
5. Help address the psychosocial needs of ALHIV and caregivers
6. Disclose their own HIV-status to clients, support ALHIV through the disclosure process, and help members of the multidisciplinary care team support caregivers who disclose their perinatally-infected child’s status
7. Be role models of positive living, disclosure, and adherence to care and treatment

8. Help ALHIV and family members live positively with HIV
9. Link ALHIV to required health services or support services within the community and clinic settings
10. Keep basic records of daily and monthly activities

There is also a supervised practicum (Module 15) included in this training. By the end of the practical sessions, which will take place in the clinic setting, participants will be able to:

1. Practice skills learned during the training in a health facility offering HIV prevention, care, and treatment services to young people
2. Show competency in the major skills taught during the training, with supportive supervision and mentoring
3. Identify skill areas where further on-the-job practice and mentoring are needed



SESSION 15.2: Next Steps for Adolescent Peer Educators (30 minutes)



TRAINER INSTRUCTIONS

Methodologies: Interactive Trainer Presentation, Large Group Discussion, Guest Speaker

Step 1: Ask the Peer Education Program Coordinator or Manager to spend a few minutes discussing the next steps for Peer Educators to help them “prepare for the workplace.” Tailor this discussion to the local Peer Education program.

The next steps and preparation discussion could include the following:

- Logistics: when and where will Peer Educators report for work, stipend disbursement, etc.
- How Peer Educators will be introduced to the multidisciplinary care team and other facility staff members
- How supervision and mentoring will work day-to-day at the facility, including lines of reporting and communication
- The role of the Program Coordinator, Peer Education Supervisor, and other multidisciplinary care team members who will be monitoring and regularly communicating with the Peer Educators
- The plan for continuous mentoring
- The plan to update Peer Educators through refresher and advanced training
- What to do if there is a problem
- Other relevant issues (e.g. process followed when a Peer Educator ages out)

Step 2: Remind Peer Educators of the importance of staying up to date on key issues, clinic services, and the Peer Educator program. Peer Educators should take the initiative to stay up-to-date and share information with one another. The Program Coordinator, supervisors, and members of the multidisciplinary care team will make sure Peer Educators are mentored and offered continuing education.

Step 3: Allow participants time to ask questions. Clarify any programmatic or logistical issues as needed.

Step 4: Go around the room and ask each participant to name 2 specific things that, as a result of the Peer Educator training, they will now do better.

Step 5: Next, go around the room and ask each participant to talk about his or her vision and hopes for the Peer Educator program and for him- her herself as a Peer Educator.

KEY INFORMATION

Remember that Peer Educators will continue to get ongoing training and mentorship from their Program Coordinator or Manager and members of the multidisciplinary care team!



SESSION 15.3: Final Learning Assessment/Post-Test (35 minutes)



TRAINER INSTRUCTIONS

Methodologies: Learning Assessment/Post-test

- Step 1:** Begin by congratulating participants on how much they have learned over the past 10 days! Ask them if they can remember *Module 1* and the game they played at the beginning of the training. Pass out new copies of *Appendix 15A: Peer Educator Bingo* to each participant. Give participants about 10 minutes to respond to all of the questions by circling the T (for true) or F (for false) below each question. The first participant to complete ALL of the questions should yell “BINGO!” Ask participants to hand their papers to a trainer when have finished. The trainers should score each Bingo game by referring to *Appendix 15B: Answers to Peer Educator Bingo* as a guide. Trainers can compare the participants’ pre- and post-test scores to see how much learning and improvement has happened as a result of the information presented during the training.
- Step 2:** After the Peer Educator Bingo game, debrief by asking participants how they felt about answering the questions now, on the last day of training, compared with how they felt on the first day of training. Ideally, the final Bingo Game/needs assessment should be a time for participants to feel confident in the skills and knowledge they have learned during the training.
- Step 3:** Review the correct answers for the Peer Educator Bingo Game and encourage discussion. Ask participants to correct any FALSE statements and to offer suggestions for how to make them into TRUE statements.
- Step 4:** Remind participants how much they have learned in the past week and congratulate them on a job well done!

KEY INFORMATION

See *Appendix 15A: Peer Educator Bingo*



Congratulations on a job well done! You have successfully completed the training and are on your way to becoming to qualified Peer Educators!

SESSION 15.4: Training Evaluation (15 minutes)



TRAINER INSTRUCTIONS

Methodologies: Large Group Discussion, Participatory Evaluation

Step 1: Tell participants that it is important to give honest feedback on the training so that the trainers know what went well and what can be done better at future trainings.

Post 2 pieces of flip chart paper on opposite sides of the room. Label the top of one with a smiley face (☺) and the top of the other with a sad face (☹).

Step 2: Ask the group to select 2 note-takers/facilitators and give each a marker. Ask participants to discuss the following questions after the trainers leave the room (you may want to write them on flip chart):

- *What did you like best about the training?*
- *What did you not like about the training?*
- *What do you think could be done better in future trainings?*

Remind participants that this is an anonymous exercise and that the trainers will soon leave the room. Ask the note-takers to write down the input on the appropriate flip chart page and, once finished, to roll up the flip chart pages and to call the trainers back into the room.

Note: This could also be done as an individual evaluation where each participant fills out his or her own evaluation form.

Step 3: All trainers should leave the room.

The nominated note-takers should facilitate discussion using the above questions and write down participants' answers on the appropriate flip chart pages. This should take about 15 minutes. Once finished, the note-takers should roll up the flip chart pages and call the trainers back into the room.

Step 4: Ask if anyone has any feedback to share with the whole group. Discuss and thank participants for their honest feedback.

Step 5: **After the training:** The trainers should meet to debrief, review participant feedback, and discuss what they think went well and what could be improved during the next training.

KEY INFORMATION

It is important for you to give honest feedback about the training—both what you liked and what you didn't—so that the trainers know what went well and what can be done better at future trainings.



SESSION 15.5: Graduation and Closing (20 minutes)



TRAINER INSTRUCTIONS

Methodologies: Celebration!

- Step 1:** Congratulate Peer Educators on a job well done. Ask invited guests to make their remarks and then officially present participants with their training completion certificates.
- Step 2:** This is also a good time to distribute Peer Educator kits containing t-shirts or uniforms, notebooks, recording forms, job aids, or other materials provided by the program.
- Step 3:** Take a group photo, if possible, and make copies to distribute to each trainer and participant after the training.
- Step 4:** Thank everyone for their hard work and officially close the training. If possible, arrange for a small celebration with snacks and drinks.
- Step 5:** Make sure to take care of any remaining logistical issues, including transport stipends, etc. for trainers and participants.

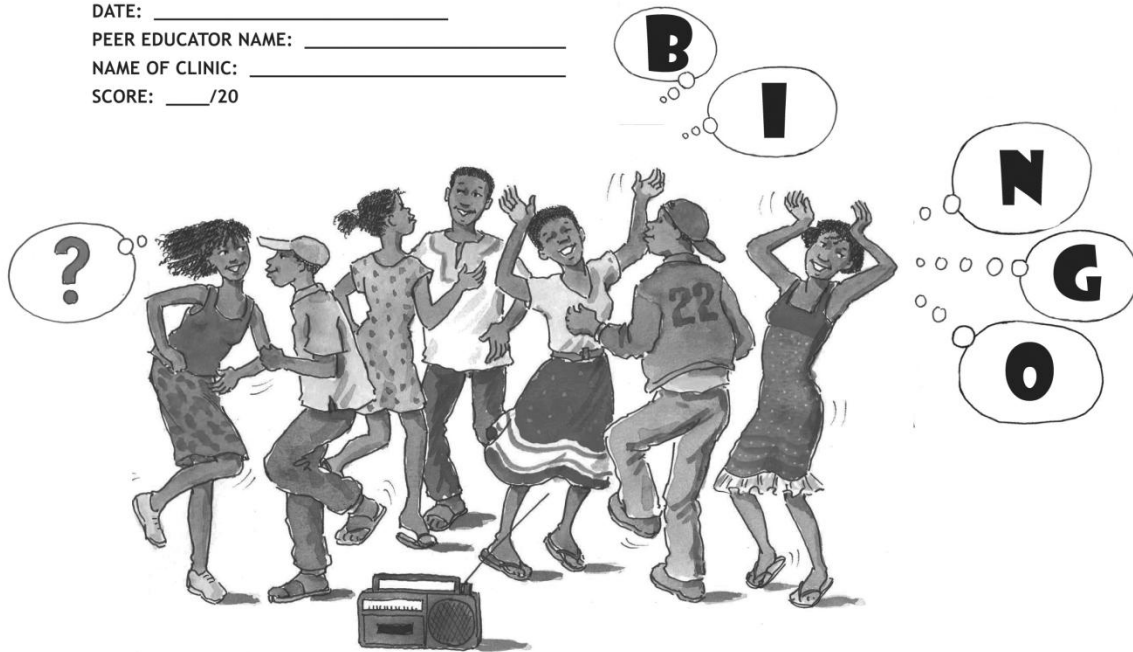
KEY INFORMATION

Thank you for your hard work, time and persistence. Now it's time to celebrate!



APPENDIX 15A: Peer Educator Bingo

DATE: _____
 PEER EDUCATOR NAME: _____
 NAME OF CLINIC: _____
 SCORE: ____/20



Peer Educators are volunteers, so they are not members of the multidisciplinary HIV care team. T? F?	CD4 cells help protect us from infections. T? F?	Dual protection means wearing 2 condoms at a time. T? F?	If a man is circumcised, he still has to use a condom. T? F?
HIV is most commonly spread through having a blood transfusion. T? F?	Counseling includes telling people what you think is best and making sure they follow your advice. T? F?	Shared confidentiality means you should tell a person's family, but not community members, the person has HIV. T? F?	Only people on antiretroviral therapy (ART) need HIV care services. T? F?
If you feel healthy, you probably don't need ART. T? F?	A person on ART can not spread HIV to another person. T? F?	It is safe for pregnant women to take ARVs. T? F?	Adolescents are basically "big children." T? F?
Peer Educators can help clients create an ART adherence plan. T? F?	AZT is a common type of ARV for adolescents. T? F?	Most adolescents miss their ARV doses because they are lazy. T? F?	Missing one ARV dose per week is okay. T? F?
Positive living means telling people you are living with HIV. T? F?	People with STIs are less likely to contract HIV during unsafe sex. T? F?	Disclosure is an ongoing process. T? F?	Peer Educators are also community educators and advocates. T? F?

APPENDIX 15B: Answers to Peer Educator Bingo

#	Questions (tick True, False or Don't Know for each question)	True	False	Don't Know
1	Peer Educators are volunteers so they are not members of the multidisciplinary HIV care team.		X	
2	CD4 cells help protect us from infections.	X		
3	Dual protection means wearing 2 condoms at a time.		X	
4	If a man is circumcised, he still has to use a condom.	X		
5	HIV is most commonly spread through blood transfusions.		X	
6	Counseling includes telling people what you think is best and making sure they follow your advice.		X	
7	Shared confidentiality means you should tell a person's family, but not community members, that the person has HIV.		X	
8	Only people on antiretroviral therapy (ART) need HIV care services.		X	
9	If you feel healthy, you probably don't need ART.		X	
10	A person on ART cannot pass HIV to another person.		X	
11	It is safe for pregnant women to take ARVs.	X		
12	Adolescents are basically "big children."		X	
13	Peer Educators can help clients create an ART adherence plan.	X		
14	AZT is a common type of ARV for adolescents.	X		
15	Most adolescents miss their ARV doses because they are lazy.		X	
16	Missing one ARV dose per week is okay.		X	
17	Positive living means telling people you are living with HIV.		X	
18	People with STIs are less likely to contract HIV during unsafe sex.		X	
19	Disclosure is an ongoing process.	X		
20	Peer Educators are also community educators and advocates.	X		



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