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ABBREVIATIONS

ART	Anti Retroviral Therapy
ARV	Anti Retroviral
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
CDC	Centre for Disease Control and Prevention
CSOs	Civil Society Organisations
NASCOP	National Aids and STI Control Programme
FGM	Female Genital Mutilation
HAART	Highly Active Anti-Retroviral Therapy
HCBC	Home and Community Based Care
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
IEC	Information Education and Communication
IDUs	Injecting Drug Users
KAP	Knowledge, Attitude and Practice
MSM	Men who have Sex with Men
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
M&E	Monitoring and Evaluation
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
Q&A	Question and Answer Session
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBAs	Traditional Birth Attendants
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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PREFACE

African Medical and Research Foundation (AMREF) recognises that for HIV and AIDS behaviour change to occur, individuals and communities must be equipped with accurate knowledge, have easy access to services and commodities, and must be in an environment that is conducive and supportive of the desired behaviour. Whereas there are many behaviour change communication (BCC) programmes, behaviour change still remains a challenge due to inadequacy of programmes in addressing the HIV and AIDS crosscutting issues.

This BCC Toolkit addresses the HIV and AIDS crosscutting issues of gender inequalities, legal and human rights violations, harmful norms and cultural practices, stigma and discrimination alongside providing accurate information on HIV and AIDS including services and commodities.

The toolkit, which was developed through a consultative process based on training needs assessment of the Civil Society Organization (CSO) partner agencies, AMREF Maanisha Project Implementing teams, BCC practitioners from partner HIV and AIDS programmes and literature review of existing BCC documents, targets all change agents working in HIV and AIDS programmes for purposes of reducing new HIV infections and improving care and support to persons living with HIV and their families.

FOREWORD

Kenya, as a country, has made significant progress in response to HIV and AIDS with civil society organisations taking the lead in the implementation of HIV programmes. However new HIV infections remain unacceptably high. Annually, an estimated 166,000 Kenyans acquire HIV, according to the NACC. In line with the Kenya National Strategic Plan (KNASP III), AMREF continues to support community initiatives aimed at reversing the HIV and AIDS trend.

Despite global evidence showing that most successful responses to HIV begin at the community level, an urgent gap persists for large scale capacity building of Community Based Organisations (CBOs) to enable delivery of effective interventions against HIV and AIDS. AMREF recognizes that for CBOs to provide HIV interventions able to bring the desired preventative behaviour, they need technical knowledge on HIV, as well as skills of creating an enabling environment for desired behaviour.

Based on experiences and lessons learnt in the implementation of a community focussed capacity building initiative programme, AMREF developed this HIV and AIDS BCC toolkit to guide community HIV and AIDS response. The main thrust of this BCC toolkit, which comprises of a strategy document, Facilitator's and Participants' Manuals, is to equip CBOs with knowledge and skills to mobilise and facilitate communities to analyze and respond to HIV and AIDS crosscutting issues. The toolkit is designed to help users develop, implement and evaluate communication programmes for HIV and AIDS behaviour change tailored to communities in which they live or work.

Dr. Festus Ilako
Ag. Country Director
AMREF in Kenya

OVERVIEW OF THE MANUAL

1.0 Introduction

This Behaviour Change Communication (BCC) Facilitators Training Manual is designed to help users develop, implement and evaluate communication programmes for HIV and AIDS behaviour change targeting communities in which they work or live. The Training Manual seeks to operationalize key aspects of the HIV and AIDS BCC Strategy, which greatly informed the development of this manual. The development of this Training Manual has been guided by the following principles:

- Recognition of HIV and AIDS as a social issue.
- Non-discrimination and non-stigmatization of people living with HIV (PLHIV). During implementation of BCC interventions, change agents should note that the audience comprises of also people living with HIV and their families. Messages should therefore be free from any form of discrimination and stigmatization.
- Gender equality in HIV interventions.
- Rights based approach to create an enabling environment for prevention, care and support programmes.
- Participation of the civil society organisations (CSOs) and target population in the design and implementation of the BCC interventions.

In the context of HIV and AIDS, BCC is an essential part of a comprehensive programme that includes services (such as counselling and testing, care and support), commodities (such as condoms and drugs), and policies that reduce stigma and promote non-discrimination as well as quality service provision and uptake.

1.1 Rationale

This training manual is based on the fact that before individuals and communities can reduce their level of risk or change their behaviour, they must understand the basic facts about HIV and AIDS, assess and modify their attitudes, learn new skills, and gain access to appropriate products and services. They must also perceive their environment as supportive of behaviour change and the maintenance of safe behaviours. Therefore, to be effective, BCC programmes need to be tailored to specific target populations. In the context of HIV and AIDS response, this entails communicating with communities in homogeneous groups, based on factors such as economic sector, type of job, education and gender. It also entails developing specific messages and approaches that will most effectively resonate with a particular group.

1.2 Objectives of the Training Manual

i. Build individual and community skills necessary for applying prevention information and messages for effective promotion and reinforcement of values associated with safer sexual behaviour.
ii. Develop and implement BCC interventions for effective reduction (at individual, household and community level) of stigma and discrimination associated with HIV and AIDS.
iii. Develop and implement effective BCC initiatives aimed at promoting gender equality.
iv. Develop and implement BCC initiatives that enable communities to develop and embrace cultural values that support and sustain BCC interventions.
v. Promote partnerships and networks at community level for management and sustainability of BCC interventions.

1.3 Intended users of the Training Manual

All change agents working in the HIV and AIDS programmes may use the Training Manual. Specifically, BCC trainers, and those working in gender-related fields, including human rights organisations, service providers, HIV and AIDS trainers and counsellors, among others, may use this Training Manual. This Training Manual is therefore written for skilled people, who work with local groups in small-scale development settings, such as professional staff or volunteers, social workers, community leaders, health workers, counsellors, AIDS educators, members of AIDS support groups, religious leaders, among others.

1.4 Target populations

Primary target: These are individuals or groups whose behaviour the training manual would like to influence and support. It is therefore intended for the following:

i. Youth in and out of school
ii. Sex workers and their clients
iii. Intravenous Drug Users (IDUs)
iv. Men who have Sex with Men (MSM)
v. PLHIV
vi. Widows/widowers
vii. Discordant couples
viii. Married couples
ix. Prisoners
x. Uniformed staff (police, prison officers, game wardens/rangers, soldiers, security guards)
xi. Community leaders (such as council of elders, chiefs and church leaders, etc)
xii. Persons with disabilities
xiii. Fishing communities
xiv. Mobile communities (long distance truck drivers and pastoralists)

Secondary target: These are individuals or groups who can affect the BCC activities or be affected by them, even though these BCC activities were not designed to reach them directly. They are often people whose support or neglect determines whether or not the primary audience responds to communication messages. They include:

i. Opinion leaders (such as government officials, religious leaders)
ii. Gatekeepers (such as police officers, brothel owners, elders, village headmen, women group leaders and youth leaders)
iii. Policy-makers
iv. Owners of long distance trucks
v. Sexual partners of men who frequent sex workers.

1.5 Content and organisation of this Training Manual

This manual has been designed for a five-day training workshop (Appendix 1). It aims at empowering programme workers and CSOs to impart knowledge and skills to communities on key issues that need BCC interventions in order to reduce HIV infections. The manual introduces participants to various documented effective BCC strategies appropriate for CSOs adoption. The aim is to empower participants, in a practical and interactive way, gain knowledge and skills on key HIV and AIDS BCC issues so as to strengthen their risk perceptions, increase demand for services and address HIV cross-cutting issues in order to reduce HIV infections and improve quality of life for PLHIV. The main thrust of this manual is to facilitate communities/organizations to identify, analyze and respond to gender inequality, legal and human rights violation issues, stigma and discrimination, culture and social norms issues that promote the spread and make worse the impact of HIV and AIDS in their respective communities. However, other curriculums offering in-depth trainings in the various suggested BCC strategies are recommended since such trainings require between 5 to 14 days of training that could not be condensed in this particular training.

The manual contains themes as they relate to BCC issues, and is organized into eight modules, each divided into several sessions. This design allows for flexibility to adaptation of individual modules for stand-alone use, based on specific needs and objectives of the participants.

1.6 Methodology

The experiential activities in this manual are designed to help participants gain information, examine attitudes and practise skills. Specific techniques included in the training manual are mini lectures, group work, role plays, video shows, demonstration, social mapping, question and answer sessions and guest speakers. A guide on how to use this manual is included. Evaluation of knowledge and skills acquired will be done through administration of a pre-test and post test questionnaire (Appendix 3).

MODULE 1: CLIMATE SETTING

Overview

This module sets the tone of the workshop during the five days. Participants and the facilitator get to know each other and share their expectations during the workshop. Participants identify priority community specific BCC issues for particular emphasis. The underlying philosophy of this approach is that whereas strategies and programmes have been developed for the continued prevention and treatment of HIV and AIDS, several diverse community specific issues have constrained efforts to reduce infection rates, including gender inequalities, culture and social norms, human and legal rights violations, stigma and discrimination among other barriers to reducing transmission and promoting uptake of HIV and AIDS services. Addressing these issues that cut across communities and those that are specific to certain areas is key to the success of BCC programmes.

Goal of the module

To enable participants understand the goals and objectives of the workshop while at the same time understand the central role of BCC as a strategy in HIV and AIDS prevention, care and support.

Module objectives

By the end of this module the participants and facilitator should be able to:

- Familiarize themselves with each other on a first name basis.
- Identify priority BCC issues pertinent or key to the community that will need particular emphasis during the workshop.

Module duration: 1 hour 30 minutes

SESSION 1.1: Introduction to the training

Objectives

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

i. Get acquainted with each other and with the facilitator
ii. Articulate their expectations of the training
iii. Understand the objectives of the workshop
iv. Review the agenda for the training.

Duration: 45 minutes

Materials & preparation

- Flipchart with training objectives and schedule
- Markers
- Pens and markers for participants
- Copy of blank pre-test form for each participant

Activity 1: Registration of participants

- The facilitator should make a sitting arrangement (chairs and tables) possibly in an arch formation to make the sessions more interactive.
- Greet participants as they come in.
- Provide each participant with a registration form asking them to fill in their details (name, address, organisation represented and email if available).
- After registration give participants nametags or ask them to write their names on a label, which should be pinned on their shirt or blouse lapels.

Activity 2: Welcoming participants

- When all are settled you should once more greet them and formally welcome them to the workshop and introduce yourself by name as the one going to facilitate the workshop.
- If possible invite a member of a government ministry or organisation to officially open the workshop and give a brief statement, which centres on the importance of addressing behaviour change in HIV and AIDS programmes in the community and in the country at large. This statement should be made after introductions.

Activity 3: Introductions

- Ask the participants to introduce themselves using nicknames/images/or adjectives to describe themselves (appropriate where participants are familiar with each other. If not let them give their official names and designations with an option of a nickname).
- Pass around the pre-test forms and give participants 15 minutes to fill them out.
- Review the training agenda.

Activity 4: Expectations survey

- Each participant is provided with a blank paper on which they briefly state their concerns and expectations of the training workshop. Allow five minutes for this exercise.
- Pin these expectations on a board in the room. They shall be reviewed during the wrap up session on the last day of the training.

Activity 5: Setting the ground rules

- Ask the participants to list down the rules on a flipchart that they wish to adhere to during the workshop.
- Review the rules together to come to a consensus.

Facilitator's notes

Setting ground rules is crucial for meeting participants' expectations, thereby attaining the objectives of any workshop. Ground rules must be set together by everybody, on day one, at the beginning of the workshop and it is important to ensure adherence. Some common rules include:

i. Punctuality - coming to workshop venue on time.
ii. Active participation – do our best in all the exercises, games and discussions.
iii. Understanding and tolerance – listening and respecting each other.
iv. Teamwork – help and support each other in assigned tasks.
v. Honesty– being honest and objective in our contributions and discussions.

Activity 6: Overview of the training

- Read out the purpose and objectives of the workshop to the participants.
- Distribute workshop programme/timetable (See annex 1).
- Explain the workshop programme and answer any questions on any of the material already covered.

SESSION 1.2: Analysis of BCC issues

Session Objectives

By the end of this session, participants should be able to identify and analyse the BCC issues in their community in order of priority.

Duration: 45 minutes

Materials and preparation:
Flip chart, Cards in different colours, Markers and pens and Masking tape

Methods and training activities:
Group work, Plenary discussion

Activity 1: Identifying BCC issues

Participants will individually write on cards the BCC issues that are common in their community.

- Participants make a circle.
- Cards are laid on the floor in different colours.
- Participants pick one colour for ideas of one thematic area e.g. gender violation, HIV and AIDS, stigma and discrimination etc.
- Participants write defining each challenging issue.
- Cards with similar ideas are arranged in one area or side of the room and with the help of the facilitator, they are grouped and named according to the concept they fall under.
- Participants move around the class as each writer explains his/her ideas and challenges.
- Allow 15-30 minutes for the exercise
- Facilitator summarises and reconciles the different thoughts.
- Facilitator then leads the participant in arranging the BCC issues in order of priority and need of emphasis in terms of actual pressing issues in the specific community.
- Review the issues mentioned above, putting then in the order of priority for the target community, while at the same time ensuring those listed below in the session notes are covered.

Facilitator's notes

Whereas programmes have been developed for the continued prevention and treatment of HIV and AIDS, several issues have constrained efforts to reduce infection rates. Addressing these issues that cut across communities and those that are specific to certain areas is key to the success of BCC programmes. The issues include:

- Poverty and HIV and AIDS: The relation between poverty and HIV and AIDS is profound. The most vulnerable groups, women, youth and persons with disabilities often encounter challenges negotiating safer sex with partners and as such, are at increased risk of HIV infection.
- Although the government provides free treatment for HIV and AIDS, PLHIV can easily slip into poverty through job loss based on discriminatory practices. Nutrition of children can be compromised in HIV-affected households given the limited resources and also the increasing demands on household income for nutrition to support use of antiretroviral.
- Gender and HIV and AIDS: As young women become more vulnerable in the HIV and AIDS epidemic, unequal gender relations are increasingly being seen as the root causes and consequences of HIV and AIDS. Gender relations shape sexual behaviour, social attitudes, economic position, degrees of empowerment and vulnerability affecting both men and women choices and sexual behaviour. Gender-based violence limits women's ability to demand safe sexual practices. Sometimes disclosing HIV status of partners and/or third parties may increase the risk of violence. Female sex workers who are stigmatized are also not in a strong position to seek information about safer sex and to negotiate safely with partners.
- Stigma and Discrimination: creates barriers to HIV services uptake including HIV Testing and Counselling (HCT) and treatment.

MODULE 2: BEHAVIOUR CHANGE COMMUNICATION

Overview

Behavioural and social change is possible through strategic communication interventions that are well founded on research. The communication approaches you choose will depend upon your intervention goals. This module introduces participants to the definitions and objectives of behaviour change and behaviour change communication. Behaviour change does not happen at once, it is a process that also requires different communication approaches. This module discusses the stages of behaviour change and provides an overview of the different evidence informed behaviour change communication approaches that can be applied to promote HIV and AIDS prevention, care and support interventions.

Goal of the module

To equip participants with knowledge on behaviour change and different behaviour change communication strategies in HIV and AIDS prevention, care and support.

Module objectives

- To enhance understanding of behaviour change communication.
- Promote knowledge on the process of behaviour change.
- To promote knowledge on the different BCC strategies.

Module duration: 4hours 45 minutes

SESSION 2.1: What is behaviour change Communication?

Objectives

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

- Define the term behaviour.
- Define Behaviour Change and Behaviour Change Communication.
- Understand that behaviour change is a process.

Duration: 20 minutes

Materials Needed

- Flipchart
- Markers
- Masking tape

Activity 1: Defining the term "Behaviour"

Divide participants into pairs and then ask them to brainstorm on the meaning of behaviour. Write their responses on a flip chart.

Activity 2: Plenary session reports

- Let the pairs report and discuss in the plenary session what in their opinion, is the meaning of behaviour.
- Share with the participants the definition of behaviour as contained in the facilitator's notes.

Activity 3: Definition of Behaviour Change and BCC

Divide the participants into four groups. Two groups will work on the definition of Behaviour Change and two groups will work on the definition of Behaviour Change Communication.

- Tell participants that each member of the group will try to define/describe behaviour change or BCC (whichever term the group is assigned). Each individual should come up with the phrase that he or she thinks best defines behaviour change or BCC. Select a group secretary to collect the cards and write the answers on the group's flipchart. While doing this, members of the group are not to discuss their definitions to each other.
- After each member has written his or her phrase on the flipchart, each member of the group should put a tick mark next to the phrase he/she thinks best defines behaviour change or BCC. While doing this, members are not to discuss their thoughts with each other.
- After everyone has put a tick mark next to a phrase, ask the groups to make a definition of BC or BCC using the concept that has the most tick marks (the phrase with the most tick marks is the one that the members of the group have agreed best defines behaviour change or BCC).
- One member from each group then presents the group's definition to all the participants. This will help the facilitator to determine if the participants understand the basics of behaviour change and BCC and will facilitate the discussion when the group leader gives the definitions of behaviour change and BCC.

Facilitator's notes

Give the participants the following definitions:
Behaviour : Is an action - something doable, can be observed or modelled. Behaviour is different from what drives it (i.e. cultural beliefs), it is an act, for instance sex with multiple partners.
Behaviour change: Refers to a comprehensive process in which one passes through the (stages of: Not thinking > thinking >> action/practice >>>doing always or relapse).
Behaviour change communication: This is a process through which individuals are engaged in dialogue to honestly reflect on their behaviours, attitudes, believes and practices with the aim of helping them see how they would benefit from the change in different areas of their lives. BCC can also be defined as an interactive process with communities (integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviour; to promote and sustain individual, community, and societal behaviour change; and to maintain appropriate behaviour.

Activity 4: Stages of behaviour change

The facilitator continues this session by asking participants to share things from their practical life experience:

- Ask participants if any of them have gone through the process of behaviour change (e.g., has anybody stopped smoking? or has anybody who used to have more than one sexual partner reduced their number of partners to one or none?) and ask them how and why they changed that behaviour.
- Following the description of these experiences, pick out one experience and take the class through the stages that one passes through to achieve the desired behaviour change.
- Take the participants through the stages and process of Behaviour Change. (See figure 2.1 below)

Facilitator's notes

Behaviour Change is a process that involves a series of steps. Individuals and communities go through a sequence of stages sometimes moving forward, sometimes moving backward and sometimes missing some stages. Even when individuals or communities adopt new behaviour, they may sometimes regress to the old behaviour due to various circumstances. Understanding where individuals or communities are in the change process is important in designing appropriate BCC messages.

Different communication channels have been documented to be more effective at different stages in the behaviour change process achieving different goals. Mass media communication can guarantee correct information dissemination to specific target populations and can influence positive attitudes, but when individuals are motivated to adopt new behaviour, policies and larger social environment becomes more important. When the target population is ready to change, the activities, services or products being promoted must be available to them, otherwise the BCC objective may fail i.e. you cannot promote HIV testing and counselling (HTC) services while the target population cannot access the services/services.

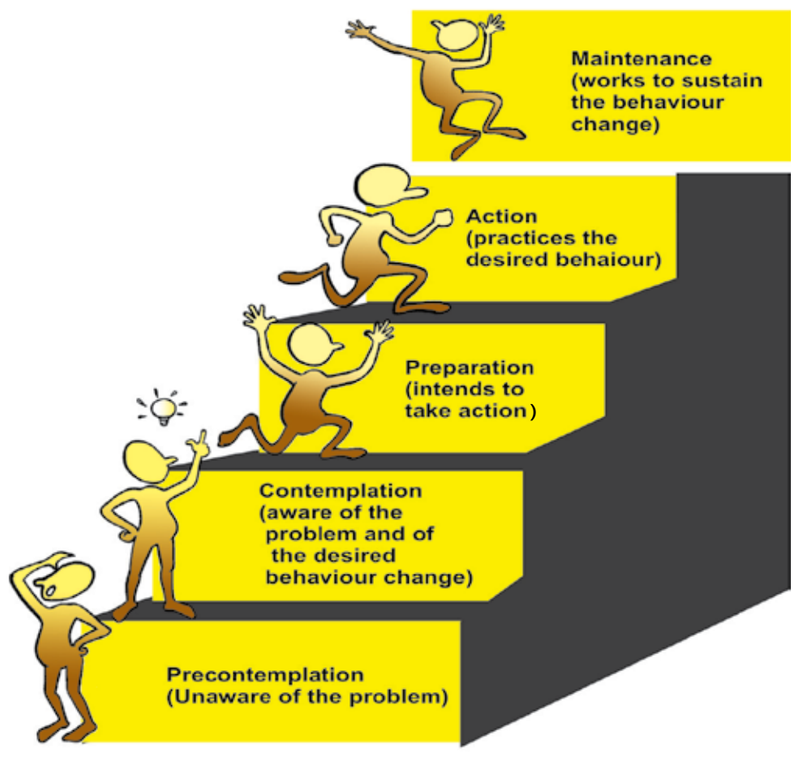

Figure 2.1.1.: Stages of behaviour change

Process/context of Behaviour Change

The following is an illustration of the stages of the behaviour change continuum, enabling factors, and channels.

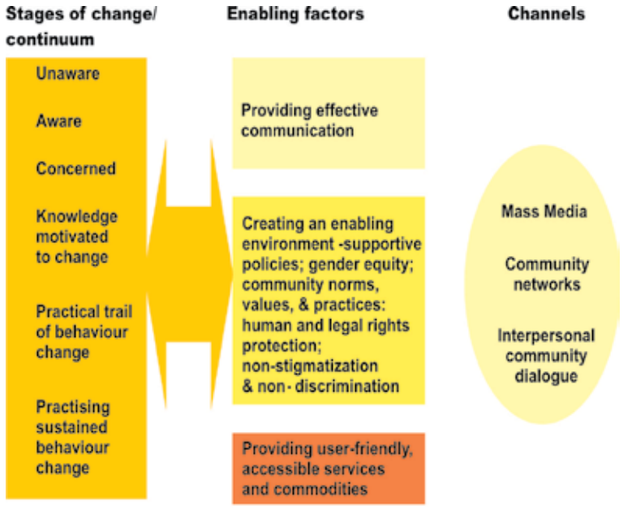

Diagram 2.2: Process of behaviour changes

SESSION 2.2: Why behaviour change communication?

Objectives

By the end of this session participants will be able to understand the role of BCC in HIV prevention.

Duration: 10 minutes

Materials

Flipcharts, markers and masking tape

Method

Mini-lecture, Brainstorming sessions

Activity 1: Roles of BCC in HIV and AIDS

Ask the participants to brainstorm on the major roles BCC programs play in HIV and AIDS prevention, care and impact mitigation programmes. Write the responses on black board/ flipchart.

Activity 2: What effective BCC can achieve

After brainstorming, explain to the participants that effective BCC can:

- **Increase knowledge** by ensuring that people are given the basic facts about HIV and AIDS in a language or visual medium (or any other medium) that they can understand and relate to.
- **Stimulate community** dialogue by encouraging community and national discussions on the basic facts of HIV and AIDS and the underlying factors that contribute to the epidemic, such as risk behaviours, risky cultural practices related to sex and sexuality, and marginalized practices (e.g., drug use).
- **Promote appropriate** attitude change about topics like perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health-supporting services, provision of compassionate and non-judgmental services, open-mindedness concerning gender roles, and the basic rights of those vulnerable to and affected by HIV and AIDS.
- **Reduce stigma and discrimination** through communication about HIV prevention and AIDS mitigation that addresses stigma and discrimination and attempts to influence social responses to them.
- **Create a demand** for information and services by spurring individuals and communities to demand information on HIV and AIDS and appropriate services.
- **Lead policy makers and opinion leaders** toward effective approaches to the epidemic.
- **Promote services for** (1) prevention, care, and support for people with STIs, IDUs, and OVC; (2) HTC for mother-to-child transmission; (3) support groups for PLHIV; (4) clinical care for opportunistic infections; and (5) social and economic support.
- **Improve skills and sense of self-efficacy** by focusing on teaching or reinforcing new skills and behaviours, such as condom use, negotiating safer sex, and safe injection practices. This can contribute to a sense of confidence in making and acting on decisions.

SESSION 2.3: Overview of theories of behaviour change

Objective

By the end of this session, participants should be able to:

- Identify and be familiar with the theories of behaviour change.
- Identify and be able to utilize a theoretical framework that is appropriate to their community.

Duration: 15 minutes

Materials

Flipchart, markers/felt pens and masking tape

Method and activity

- Group work and Plenary session
- PowerPoint or Prepared flipcharts presentation of the theories with brief explanations sighting examples where applicable (See Appendix 4 for notes on Theories on behaviour change).

Activity 1: Introduction to theories of behaviour change

- Divide participants into three groups and assign them or ask them to identify two behaviours that they will discuss. These could be, for instance, smoking of cigarettes or engaging in sexual intercourse without using condoms.
- Ask participants to brainstorm on the following:
  i) What influences a person to engage in a particular behaviour?
  ii) What prompts or influences a person to stop or change from that particular behaviour?
- Let the participants report to plenary as all responses are recorded on the flipchart.
- Summarize the responses and link them to the theories of behaviour change as defined below.

Facilitator's notes

Behaviour Change Communication has its roots in behaviour change theories. The behavioural theories help programmes to understand why people behave as they do. Subsequently, programmes seek to develop strategies based on the theories that reinforce healthy behaviour or change unhealthy behaviour. Theories on behaviour change that can be applied to HIV and AIDS BCC Programmes include:

i. Diffusion of innovations theory: This theory posits that people are most likely to adopt new behaviour based on favourable evaluations of the idea communicated to them by other members whom they respect. When the diffusion theory is applied to HIV risk reduction, normative and risk behavioural changes can be initiated when enough key opinion leaders adopt and endorse behavioural changes, influence others to do the same and eventually diffuse the new norm widely within peer networks. When beneficial prevention beliefs are instilled and widely held within one's immediate social network, individual's behaviour is more likely to be consistent with the perceived social norms.

ii. Stages of Change model: Behaviour change does not occur at once. For instance people don't change because they know HIV and AIDS has no cure. Change happens in stages sometimes moving forward, sometimes moving backward and sometimes missing some stages. Even when individuals or communities adopt new behaviour, they may sometimes regress to the old behaviour due to various circumstances. Understanding where individuals or communities are in the change process is important in designing appropriate BCC messages.

iii. Self-efficacy model: This theory suggests that people change by observing successful changes amongst their peers. "If the peer educator who is like one of us can do it, then we can do it".

However, in general, the aforementioned theoretical models take cognizance of the fact that human behaviour is determined by the broader socio-economic, cultural and environmental factors and hence BCC strategies and programmes must also target social norms and institutions. Human behaviour remains critical in preventing HIV transmission and thus, interventions at individual, small group and community level can generate safer behaviour.

SESSION 2.4: Developing BC and BCC objectives

Objectives

By the end of this session, participants should be able to:
- Define "Objective" and "BCC Objectives."
- Identify factors that hinder effective BCC in HIV and AIDS prevention and care.

Duration: 30 minutes

Materials

Flipcharts, markers and masking tape

Methods

Activity 1: Defining "Objective" and "BCC Objectives"

- Ask participants to define the term Objective and BCC Objectives. Write their responses on flipchart.
- Explain to the participants the following definitions in facilitator notes using appropriate examples. The facilitator should expound further on these definitions to suit the local community by giving appropriate examples.

Facilitator's notes

An objective is a goal that is intended to be achieved. Something that one's actions or efforts are intended to attain

BCC objectives are related to specific issues identified when assessing the situation, knowledge, attitudes and skills that may need to be altered to work toward behaviour change and program goals. Examples of BCC objectives include:
- Increase in perception of risk or change attitudes toward condom use.
- Increase in demand for services, like for treatment of STIs and HTC
- Create demand for information on HIV and AIDS, products like condoms
- Interest policy makers to provide services to MARPs like sex workers, IDUs and MSM.
- Promote community/family acceptance of youth sexuality and the need to talk about it frankly.

Activity 2: identifying behaviours that need to be changed or encouraged

- Divide participants into three groups.
- Ask each group to discuss and record the answers to the following questions on flipchart
- What risk behaviours, attitudes and practices should be changed?
- What behaviours, attitudes and practices should be encouraged?
- What factors may hinder effective BCC in HIV and AIDS prevention and care within your community?
- Give the group leaders 10 minutes to present their work in plenary
- Be sure the information below is included.

Facilitator's notes

Risk behaviours and attitudes that need to be changed
- Multiple sexual partners
- Unprotected sex
- Gender based violence – rape and sexual coercion
- Beliefs like AIDS is witchcraft and people with HIV are promiscuous
- Harmful traditional practices like wife inheritance
- Misguided attitude like "a bull must die with grass in its mouth". An expression of masculinity meaning that a man should not be scared of anything/should be fearless.

Behaviours, attitudes and practices that should be encouraged
- Abstinence
- Faithfulness
- Consistent use of condoms
- Respect and compassion for PLHIV
- Provision of care and support to PLHIV and the affected.

Factors that may hinder effective BCC intervention
- Messages that stigmatize those who are infected
- Messages that are not properly structured to address sensitive cultural practices like FGM, wife inheritance and topics considered "taboo"
- Cultural/societal norms that marginalise women/girls in respect to owning property/land or inheritance leading to poverty and a dependence complex
- Peer pressure especially among the youth
- Inappropriate use of media channels that are not available to the community
- Glorification of sex in advertisements
- Easy access to pornography by the youth on the Internet, TV, magazines etc
- Use of language that is not target audience specific
- Lack of adequate and proper information.

SESSION 2.5: Analysis of risky sexual behaviour

Objectives

The following are the objectives of this session:

- To increase understanding of risky sexual behaviour among different target audiences.
- To identify possible Behaviour Change interventions to reduce vulnerability.

Duration: 30 minutes

Materials and preparation

Flipchart, markers, papers and pens

Activity 1: Why people engage in risky sexual behaviour

- Write on a flipchart the following categories of people:
  - » Sex workers
  - » Youth in school
  - » Youth out of school
  - » Migrant workers - husbands who leave their spouses back at home
  - » Wives whose husbands work away from their rural homes
  - » Married couples
- Divide participants into three groups
- Ask each group to pick two categories of the above target audience and brainstorm on the possible reasons of engaging in risky behaviour that would make them vulnerable to contracting STIs as well as HIV.
- Ask each group to brainstorm on what needs to be done, and by who, to correct and change such risky sexual behaviour.
- Give the groups 10 minutes to discuss.
- At plenary session, let each group present their findings.

Facilitator's notes

Key points to consider while conducting this session:

- The youth out of school: Unemployment, drug abuse and alcoholism could be major driving forces. Therefore BCC has to take cognizance of these deep underlying root causes of the problem in the community.
- Youth in school: There is little communication between parents and their children on issues of sexuality, leaving the work to the school. Parents need to come to the fore and address issue of sexuality of their children.
- Sex workers: Without addressing the issue of poverty or alternative means of sustaining their livelihoods, they will always slide back to their old habits.
- Migrant workers: The culture of men in our community where polygamy or having a mistress is "an acceptable norm".
- Married couples: There is an increase in the prevalence of HIV among married couples. This obviously means spouses are increasingly having extramarital affairs, thereby bringing HIV into marriage institution, which was at one time considered to be safe. Therefore addressing the married couples is becoming vital for a sustainable HIV and AIDS programming.

SESSION 2.6: Development of behaviour change messages

Objectives

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

- Describe and define what a message is.
- Determine when a message is a behaviour change message.
- Develop sample behaviour change messages.

Duration: 45 minutes

Materials

Marker pens, paper and flipchart

Method

Lecture session, Group work, plenary and discussion

Activity 1: Defining the term "Message"

- In plenary, ask the participants to define the term message and explain the objective of a message in an HIV and AIDS awareness campaign programme.
- Discuss the responses and clarify giving explanations as indicated in facilitator's notes below.

Facilitator's notes

A message consists of carefully crafted information that is targeted at specific population groups. It should be designed to meet BCC objectives and to stimulate discussion and action. A message will only be considered a behaviour change message when it focuses on the desired changes and when it directly addresses the target population and touches them emotionally. Most messages focus on increasing knowledge. However, increasing knowledge alone does not necessarily result in changes in risk behaviour. Even when people know how to prevent HIV and AIDS, they need encouragement to change behaviour.

Activity 2: Procedure in developing behaviour change messages

Using the prepared flipchart, take the participants through the stages of creating behaviour change messages.

Facilitator's notes

The following is a standard methodology of developing a behaviour change key message:
Step 1: Develop a profile of the target population from formative assessment (who are the target population,
what are their current behaviour, what do they already know, what are the possible channels of reach/communication etc)
Step 2: Identify desired behaviour change (condom use for every sexual act, reduction of multiple sexual partners).
Step 3: Understand and take into account the varying situations that could affect action and decision making (false trust, misconception about pleasure, social norms).
Step 4: Identify information or data that you want understood by the target population (trusted partner myth)
Step 5: Develop key benefit statements that take the hopes and aspirations of the target population into account. If I use condoms for every sexual act, I will benefit by protecting my sexual partner or wife from HIV and AIDS. Whatever the benefit, it will have to outweigh any disadvantages or costs the audience may feel.
Step 6: Develop messages from key benefit statements. Messages should be simple, attractive and make clear the benefits of what is being promoted, through words or images. (See Figure 2.6.1)

Messages that promote services or products such as HTC or condoms should include information on where to get those services or products and how to use them (products). The services or products being promoted must be accessible. Described in the next session BCC strategies that can be used to deliver behaviour change messages.

Diagram 2.1 :
Steps in developing BCC messages

Activity 3: Group work – developing sample messages

- Divide participants into groups of four or less depending on number of participants.
- Ask participants to pick on one behaviour change issue e.g. condom use, reduction of sexual partners, myths in community about HIV and AIDS, stigma and discrimination in the community, and HTC.
- Ask the group to develop a simple BCC message on the chosen issue.
- In plenary, review together the messages discussing the merits and demerits that the groups have come up with.

SESSION 2.7: BCC strategies

Objectives

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

- Identify and explain different participatory BCC strategies that can be used in HIV and AIDS activities in their own community.
- Identify appropriate media that can be used in the community for BCC activities.

Duration: 45 Minutes

Materials

Flipchart, markers and masking tape

Method

Brainstorming, mini-lecture, group discussion

Activity 1: Identifying BCC approaches

- Ask the participants to identify the different types of BCC activities that they can employ when carrying out HIV sensitisation in their community.
- Write their responses on a flipchart.
- Review the responses together, ensuring that the strategies highlighted in the facilitator's notes below are included.

Facilitator's notes

Human behaviour is complex. It even gets more complicated particularly when it comes to sexual behaviour, which in most African communities is taboo to discuss openly yet majority of the new HIV incidences are as a result of sex. To promote safer sexual behaviour and create demand for HIV and AIDS care and support services, different communication approaches are employed at the community level. Common communication approaches used to influence behaviour change may be categorized as follows:

1) Interpersonal communication approaches

This involves personalized communication which includes:

- **Peer education** - This typically involves the use of members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies. It is one of the most popular approaches for the in-school, out of school, workplace and with vulnerable groups such as sex workers, IDUs and MSM who are not easily accessible because of criminalization of their activities.
- **Advocacy, outreach and sensitization workshops/meetings** - Outreach uses trained people to reach target audience members with information and/or products (e.g. education materials, condoms) in a specific geographic area. HIV outreach programmes have tremendous potential for reducing the transmission of HIV disease through activities that target populations at high-risk for HIV. Reaching many of the vulnerable groups requires that programmes reach out into the places people work and live. Such approaches can more effectively reach both static workers, such as workers in factories, as well as mobile workers and marginalized groups such as truckers, sex workers and MSM.
- **Counselling** uses trained personnel to help others understand their problems, identify and develop solutions, and make their own decisions about what to do. Counselling involves listening to client's problems and fears, helping to increase client's self-esteem, and giving correct and useful information. Counselling can be conducted on one to one basis or involving a group of people with a common issue.
- **Small group discussions:** This is a form of community dialogue where the facilitator(s) introduces a topic on a behavioural challenge issue such as multiple sexual partners to a community group and moderates the participants into a discussion around

concerns that the participants have, the barriers that they express that prevent them from adopting the desired behaviour, discuss ways of overcoming the behavioural challenge including those among them who have overcome the similar challenges sharing their solutions.

- **Life skills training** - Life skills are essentially the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. The United Nations Children's Fund (UNICEF) defines life skills as "a behaviour change or behaviour development approach designed to address a balance of three areas: knowledge, attitude and skills". The UNICEF definition is based on research evidence that suggests that shifts in risk behaviour are unlikely if knowledge, attitudinal and skills based competency are not addressed. Life skills empower particularly young people to take positive action to protect themselves and promote health and positive social relationships. The life skills include decision making, self esteem and assertiveness skills among others.

2) Mass Media approaches

Mass media approaches are most effective when they are used to support interpersonal activities or to create awareness of specific issues. The most common media approaches are:

- **Folk media:** Includes drama, puppetry, music, poetry and dance. It can disseminate important information in a community setting (e.g., illustrating ways to deal with peer pressure). Folk media is an entertaining medium that can attract large groups of people.
- **Mass media:** Includes radio, television, newspapers, magazines and billboards. It is particularly useful for creating awareness and influencing social norms (e.g., showing PLHIV working productively with co-workers). Mass media is best used as part of a communication campaign which may also involve interpersonal communication and community participation approaches.
- **Information, Education and Communication (IEC) materials development and dissemination** - Involves posters, leaflets, flip charts, brochures, and videocassettes among others. IEC can provide detailed information about topics presented through the mass media. In HIV and AIDS, IEC is most effective in raising the levels of knowledge, attitude and practice (KAP) that may prevent the acquisition and spread of HIV and create demand for HIV and AIDS services.

Activity 2: Summary

Wrap up the session by emphasising that:

- Different BCC strategies can be used inter-changeably and even combined to get impact in the community in regard to positive response and as an indicator in behaviour change.
- Different BCC strategies produce different results.
- This training manual provides overviews of drama and peer education strategies commonly used by CBOs in the community. Training in drama or peer education requires more than what is provided in this manual. Projects interested in employing these strategies are advised to seek further training using other manuals developed by experienced and recognized HIV BCC implementing agencies.

SESSION 2.8: Overview of drama strategy

Introduction

Drama is a popular and effective medium of disseminating educational messages on issues that may be sensitive to the communities. Using drama that is developed by the community enables the target audience to reflect on the issues raised. While identifying themselves with the characters depicted in the drama/performance, the audience is able to reflect on their own actions in life that affect their well being.

Objectives

By the end of this session, participants should be able to:

- Define the term theatre.
- Identify the main forms of theatre.
- Give examples of non-conventional theatre.
- Explain why theatre is a good communication tool.

Duration: 30 minutes

Materials

Flipchart, markers and masking tape

Method

Lectures, brainstorming, enactment, group discussions

Activity 1: Why theatre/drama?

- Ask participants to define the term theatre/drama. Write their responses on the flipchart.
- Ask the participant's to list down some of theatre activities or performances that do exist in their communities. Are they popular?
- If popular, why are they popular?
- Let them list down some of the issues that are tackled in these performances.
- Let them discuss whether the members of the community learn anything from these performances.

Activity 2: Definition of theatre/drama

Explain and expound on the following basic facts about the term theatre:

- In this manual we shall not seek to define the terms skit, role-play, drama or theatre but will use the terms conveniently to refer to one and the same thing.
- Theatre is the imitation of life. We can observe what is happening around us and act it out in front of other people who can watch for entertainment or learn from it.
- Theatre is also a convenient tool of dealing with sometimes taboo topics and provides a safe mode of communicating and dealing with embarrassing topics.
- Theatre is fun and educational.

Activity 3: Different forms of theatre

Take the participants through a discussion on two forms of theatre that they can use in their communities. Make sure you link them to the participants' earlier responses in the definitions of the term theatre.

Stage Theatre (commonly referred to as Conventional Theatre) is the performance of drama that deal with an unlimited range of themes before a paying audience. Most people are familiar with stage theatre, where a drama presenting an introduction, conflict and resolution, is performed to an audience whose only contribution is watching and enjoying the performance.

Community Theatre (or non-conventional theatre) refers to all forms of community based theatre that deal solely with issues affecting members of the particular community, and involves them actively in participating in decision making or problem solving. Examples of non-conventional theatre include:

- **Participatory Educational Theatre -** theatre used in and with the community to promote and explore education through a participatory as opposed to top- bottom manner.
- **Theatre for Development -** theatre that proposes awareness and participation in improving a community's developmental status.
- **Theatre in Education -** theatre as an alternative method of teaching or use of theatre within educational setups.
- **Magnet Theatre -** audience specific, fixed site form of participatory theatre intended at behaviour modification.
- **Ritual Theatre -** long established methods of performance that link the human and supernatural worlds in cultural practices like religion and witchcraft.

Activity 4: Benefits of the theatre strategy

Wrap up the session explaining to the participants the benefits of using theatre as a strategy in BCC:

Facilitator's notes

Benefits of theatre

- Theatre/drama is the mirror of society - the reflection of what goes on in society.
- The re-enactment of situations/issues by performers is devoid of shyness, thereby allowing people/the audience to easily relate to the characters and issues raised in the performance.
- Theatre helps to magnify to the wider community what the audience have learnt about healthy behaviour choices.
- Increases dialogue amongst the audience and communities on sensitive issues related to HIV and AIDS, sexual reproductive health, relationships, gender based violence, drug abuse and self esteem.
- Provokes deeper reflection amongst people in dilemmas.
- Encourages the exploration of the consequences of the behavioural choices that we make particularly in relation to our health.
- Provides the audience with a forum for creating messages, sharing skills and trying out new behaviours and strategies for staying safe and healthy.
- Provides the audience with a forum for entertainment while at the same time providing vital education and information messages.

A detailed manual on how to use for example Magnet Theatre and TFD (Theatre for Development) can be found at: _http#. www.pathkenya.org / _http#.www.psikenya.org

SESSION 2.9: Overview of peer education strategy

Introduction

A person's knowledge about HIV and AIDS can be influenced by a variety of different people, including family, friends, and the wider community. This is complimentary to the education that would be provided by health personnel and government officials. Education about HIV, sexual abstinence, condom use, health issues, alcohol and drug avoidance has a better chance of leading to behavioural change when its source is a peer. This applies to MARPs like sex workers, IDUs, MSM, and other special vulnerable populations like the youth, persons with disabilities and PLHIV. By using familiar people, giving locally-relevant and meaningful suggestions, in appropriate local language and taking account of the local context, will most likely promote health-enhancing behaviour change.

Duration: 30 minutes

Objective

By the end of this session, participants should be able to familiarize themselves with the concept of peer education

Materials

Flipchart, cards, pens, markers and masking tape

Method

Question and answer sessions, brainstorming sessions, lecture session

Activity 1: Definition of a peer

- Ask participants to answer the question,"Who is a peer?"
- Distribute a small blank card to participants and ask them to write their answers.
- Pin/stick all responses on a board/wall.

Activity 2: Definition of a Peer Educator

- Ask participants to answer the question,"Who are Peer Educators?"
- Write all responses on a flipchart.

Activity 3: Definition of Peer Education

- Ask the participants to answer the question,"What is Peer Education?"
- Write all responses on a flipchart.

Activity 4: Goals of a Peer Educator

- Ask the participants to answer the question,"What are the goals of a Peer Educator?"
- Write all responses on a flipchart.

Activity 5: Brainstorming and definitions of above terms

- Have a small discussion about the participants' responses.
- Conclude by providing them with the answers in the facilitator's notes below.

Facilitator's notes

A peer is a friend who has a similar background such as profession (or linked to the profession), age and language, lives in the same geographical area, has similar social status etc.

Peer education is a process of carrying out informal or organized educational activities with individuals or small groups of peers over a period of time.

Who is a Peer Educator?

- One who influences other people's behaviour positively.

- People with whom others share certain characteristics.
- People who spend more time together and use similar language.
- Peer Educators therefore have a lot of access to their peers and there are few barriers to communication between them.
- Their activities are influenced by the social learning theory that posits that we learn more by observing others and especially those we consider role models.
- They are driven by self efficacy - 'if the peer educator, who is like one of us, can do it, then we can do it.'

Goals of a Peer Educator

- Reduce risky sexual behaviour amongst peers
- Increase VCT uptake
- Encourage positive living and uptake of treatment
- Support reduction of stigma and discrimination
- Create greater openness about HIV and AIDS, sex and sexuality

SESSION 2.10: The role of communities in BCC for HIV prevention

Introduction

It is vital for community members to understand the importance of the programme, so that they can initiate, implement and own it, by supporting activities that are sustainable and which reduce vulnerability, while increasing information dissemination for the benefit of the community.

Duration: 30 minutes

Objectives

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

- Identify the roles of communities in BCC
- Identify obstacles to community involvement and participation in BCC activities
- Identify possible solutions/strategies to overcoming the identified obstacles
- Identify the benefits of greater male involvement in BCC activities.

Materials

Flipcharts, markers and pens

Method

Group work and plenary session

Activity 1: Role of community in BCC

- Divide the participants into two groups.
- Ask group one to discuss and numerate on the flip chart the different ways that their community members can get involved in BCC activities, clearly defining the suggested roles of community members.
- Ask group two to outline the different existing obstacles of community participation and the expected or threat obstacle to community involvement in BCC activities.
- The two groups then present their discussions in the plenary.
- All the participants with the guidance of the facilitator come up with recommendations and solutions to the identified obstacles by group two. Write their responses on flipchart.

Activity 2: Male involvement in BCC

Divide the participants into two groups:

- Ask the groups to discuss and list down the different HIV and AIDS BCC activities that exist in their community.
- Let the participants discuss who dominate the programmes - in terms of attendance. Is it female or male members of the community?
- Ask the participants to discuss why men are not actively involved in the HIV and AIDS BCC activities.
- Let the participants discuss and list down the negative effects on family/community, when men do not participate or are not targeted in BCC activities.
- Let the participants discuss how the men folk can be actively incorporated in the BCC programmes.
- Let the participants list down the benefits of male involvement in HIV and AIDS BCC activities in relation to married couples/family.

Facilitator's notes

a) Men play important roles in supporting a couple's reproductive health needs. Men often influence effective use of a contraceptive method, and even satisfaction with the method chosen. A man's support often contributes to better use of female methods and, for many couples, a male method may be an excellent choice.

b) Male participation in preventing sexually transmitted diseases, including HIV, is crucial. A man must actively participate for a couple to use condoms correctly and consistently, and he must remain faithful if a couple seeks protection through a mutually monogamous relationship.

c) Change is needed, not only at individual levels but throughout society, and among men as well as.
d) Peer group values and norms are important and the men, women and youth in any community should have the opportunity to be informed about HIV and AIDS issues and be able to form their own (positive) attitudes towards behaviour change for the achievement of an HIV and AIDS-free community.
e) The potential benefits of men involvement and participation in BCC include:
    - Expanded rights for women
    - Improved family health
    - Better communication between partners
    - Joint and informed decision making within households due to improved intra-family communication
    - An empowered community in HIV and AIDS-related matters – discussing HIV and AIDS freely, supporting PLHIV, OVC, youth, widows/widowers among others.
    - A healthy community in general.
f) It should however, also be noted that focusing on specific target groups of men tend to overlook married men who live at home with stable family lives but who also sometimes exhibit high risk behaviour and as a consequence, put themselves and their wives at risk of STIs – including HIV – and unintended pregnancy.
g) Community education to promote community members' involvement in BCC for HIV prevention must also be linked to service provision. It will not be enough if there is no clear understanding of what services are provided, how they can be used and in what way they (services) benefit the various categories of people who may need those services – males, females, families, PLHIV, youth and sex workers among others.

Activity 3. Strategies to achieve male involvement

Wrap up the session by emphasizing the following points on strategies for addressing community involvement and participation:

- Counselling on issues such as HIV and AIDS and other aspects of health-seeking behaviour must address cultural challenges.
- Focus on areas that would help foster husband-wife communication and sharing of responsibility for SRH-related practices (like in promotion of condom use as a dual method).
- Encourage men to make decisions that are good for both themselves and their families – as a way of working towards gradually changing traditional values and community perceptions on issues such about gender and gender roles and HIV and AIDS.
- Community involvement campaigns need to also educate the seemingly 'safe' demographic and social group. For instance, men should be educated in all aspects of SRH as direct beneficiaries and partners. This is necessitated by the fact that a focus solely on traditional high-risk groups is no longer likely to succeed in the era of HIV and AIDS pandemic among whole populations.

MODULE 3: HIV AND AIDS

In any community, there are commonly held beliefs about HIV and AIDS, most of which are just myths. The existence of myths is evidence of the absence of facts. HIV and AIDS myths promote prejudice, stigma and may also lead to HIV infections. To promote knowledge, skills and behaviour for HIV prevention, this module discusses myths about HIV and AIDS existing in the community, facts about HIV and AIDS, other sexually transmitted infections and their relationship with HIV and AIDS, condom use, and HIV Counselling and Testing as an integral service in HIV prevention. Information on TB and HIV, ART and HCBC services is also provided to enhance demand creation and referrals by BCC implementers. Further the module educates participants on identification and referral of clients to available HIV and AIDS services in their area of jurisdiction.

Module objectives

By the end of this module, participants should be able to have a clear understanding of:

- The facts about HIV and AIDS.
- The relationship between STIs and HIV.
- The modes of HIV transmission and stages in HIV progression.
- Methods of HIV prevention.
- The management of HIV and AIDS.

Module duration: 8 hours 15 minutes

SESSION 3.1: Dispelling myths about HIV and AIDS

Objectives

By the end of the session participants should be able to:

- Identify commonly held myths about HIV and AIDS.
- Relate how these myths contribute to the spread of HIV.
- Provide solutions on how these myths can be dispelled.

Materials

Handouts, flipcharts, pens and paper.

Duration: 30 minutes

Activity 1: Group work – identifying myths in the community

- Ask the participants to form groups of three or four, depending on the number of participants. If it is a mixed group of men and women/boys and girls, encourage them to pair with opposite sex.
- Give a pen and paper to each pair and ask them to reflect and write down the myths about HIV and AIDS that are common in their community. Go round the groups encouraging all to participate and ensure that no one person dominates.
- Go through the myths listed, one by one, and ask the participants to comment and discuss on:
  - » The reasons why such myths exist in the community.
  - » The effects of those myths to the individuals and the community.
  - » Corrective measures that should be taken, and by who, to counter and dispel these myths.

Facilitator's notes

These are some of the myths to look out for from the participants' responses. During the plenary session discuss them, including new ones that will come out from the group sessions.

Myth 1: Only homosexual men and drug abusers get AIDS
Response: At the onset of the epidemic in the United States, AIDS clustered in these populations. It is now known that anyone can be infected with HIV and AIDS. MSMs are particularly at high risk due to high susceptibility of tears providing portals of entry for HIV during intercourse. Use of same unsterilized needle to inject drugs makes it easier for exchange of blood that if infected provides direct transmission.

Myth 2: AIDS can be transmitted through food, sharing clothes or shaking hands
Response: HIV, which causes AIDS, can only be transmitted by the direct exchange of bodily fluids such as blood, semen and vaginal secretions from PLHIV. Mothers living with the virus can also pass it to infants through breastfeeding. Sharing food, hugging a PLHIV does not lead to infection. Those who engage in unprotected intercourse, share needles, or are born to mothers living with HIV are at high risk.

Myth 3: HIV can be transmitted by mosquitoes
Response: HIV cannot reproduce inside an insect. Therefore, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites.

Myth 4: Older people don't contract AIDS
Response: Anyone infected with HIV can develop AIDS. Older people are less likely to be infected with HIV because they are less likely to be sexually promiscuous or injecting drug users.

Myth 5: When you contract AIDS, you die
Response: Before the mid-1980s, AIDS was considered a killer. However with medical research, a regimen of medications called ART have been able to stop the virus from multiplying in PLHIV, and the occurrence of opportunistic infections is reduced greatly.

Myth 6: Women living with HIV should not have children
Response: There is concern of transmission, but certain steps, including medications, can be taken to greatly reduce transmission of HIV from mother to child. Women living with HIV can therefore safely give birth without transmitting HIV to the child as long as the necessary precautionary steps are taken.

Myth 7: HIV and AIDS can be cured
Response: There is no "cure" for HIV. ARVs reduce replication of the virus, which reverses the immunodeficiency syndrome therefore patients rarely die of opportunistic infections.

Myth 8: Having sex with a virgin can cure HIV
Response: This myth is common in some parts of Africa, and it is totally untrue. The myth has resulted in many rapes of young girls and children by HIV positive men, who often infect their victims. Rape won't cure anything and is a serious crime all around the world.

Myth 9: HIV can pass through the condom
Response: Some people have been spreading rumours that the virus is so small that it can pass through 'holes' in condoms. This is untrue. HIV exists in a body fluid, which cannot pass through a condom. The fact is that condoms block HIV, as well as sperm - preventing pregnancy, too.

Myth 10: AIDS is a curse
Response: In some communities in Kenya, AIDS has been associated with a curse from God for the sins committed by PLHIV. It has also been associated with witchcraft. This is not true because HIV is transmitted through sexual intercourse, blood transfusion, sharing and using contaminated needles.

FACT

Figure 3.1.1: Women living with HIV can give birth to HIV negative children

MYTHS

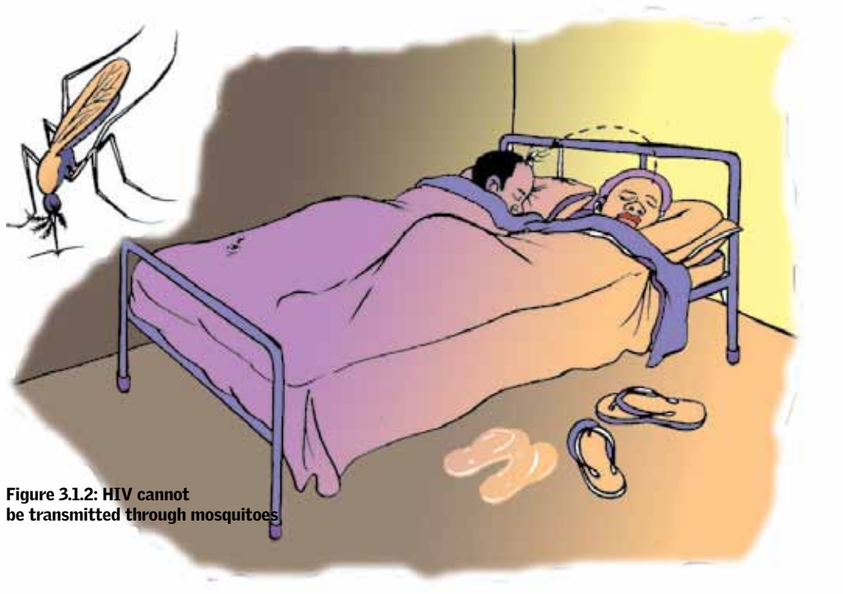

Figure 3.1.2: HIV cannot be transmitted through mosquitoes

Figure 3.1.3: HIV cannot be transmitted through food sources, sharing clothes or shaking hands

SESSION 3.2: Facts about HIV and AIDS

Objectives

By the end of this topic participants should be able to:

- Understand the meaning of HIV and AIDS.
- Differentiate between HIV and AIDS.
- Explain the modes of transmission of HIV.
- Explain HIV prevention mechanisms.
- Explain the importance of ARVs and ART in HIV management.
- Appreciate the importance of seeking HIV services such as Prevention of Mother-to-Child Transmission (PMTCT), VCT and ART.

Materials and preparation

- Resource persons. (Although this is optional, this session would benefit if an expert in the field of medicine can be invited to expound on the medical issues that will arise during discussions.)
- Projector (optional), flip charts and handouts.

Method

Lecture, question and answer and discussions

Duration: 2 hours

Activity 1: Defining HIV and AIDS

- Divide the participants into two groups.
- Ask each group to:
  - » Define the terms HIV and AIDS.
  - » Distinguish the differences between HIV and AIDS.
  - » Explain how HIV makes ones sick.
- Allow 15minutes for the exercise.
- The presentations and discussions should be carried out in the plenary.

Facilitator's notes

The following are common definitions you can use, but depending on the level of literacy of the participants you may need to apply commonly used terms in that community:

HIV is a virus and stands for:
HUMAN: Because it only infects human beings

IMMUNO-DEFICIENCY: Something lacking in the system that protects the body.

VIRUS: A germ that attacks the body and leads to illness. As a virus, HIV attacks, weakens and destroys the natural defences of the body.

AIDS is a condition and stands for:
ACQUIRED: Something that is passed on to you.

IMMUNO-DEFICIENCY: Something lacking in the system that protects the body

SYNDROME: A condition or signs and symptoms that indicate disease.

AIDS is not a disease, but is the condition resulting from HIV infection in which the body is weakened and becomes susceptible to infections and diseases called 'opportunistic infections.' It is the end stage of HIV infection.

Activity 2: Stages of HIV infection

- Ask the participants to explain some of the signs and symptoms of HIV and AIDS that they are aware of. Write the answers on a flipchart.
- Review the answers and take the participants through the stages of HIV infection linking their answers to the stages as classified below.

Facilitator's notes

Stages in HIV progression
When HIV enters the body, it infects CD4 cells and kills them. CD4 cells help the body fight off infections and diseases. When the body progressively loses CD4 cells, it reaches a point where the immune system breaks down and therefore cannot fight infections and diseases anymore. At this stage one is said to have AIDS. HIV therefore causes AIDS through progressive destruction of the body defence system. (See Figure 3.2.1).

a) Primary HIV infection or sero-conversion
It is the period between the initial infection and development of antibodies to HIV (sero-conversion). This period is also called the window period, which is the time from initial infection to sero-conversion. During this period the virus may not be detected clinically because the antibodies to fight the virus may not have developed. Infected persons will not be aware they are infected, as they will not experience any ill health. During this time, there is a large amount of HIV circulating in the blood and thus the person is very infectious.

b) Clinically asymptomatic stage
During this period, the person has developed the antibodies that clinically can prove the presence of HIV. The infected person remains well but highly infectious throughout this period, which may last up to 8 – 10 years or more depending on the lifestyle of the person. However, the virus continues to replicate causing damage to the immune system.

c) Symptomatic HIV Stage
This is the stage where many signs and symptoms occur. The HIV has stayed in the body for long and the immune system begins to lose the struggle to contain it. The infected person experiences opportunistic infections that the immune system would normally prevent as CD4 cells are gradually being destroyed. Treatment for the specific infection is often carried out but the underlying cause is the action of HIV as it erodes the immune system. Unless HIV itself can be slowed down, the symptoms of immune suppression will continue to worsen.

d) AIDS full-blown stage
The immune system is totally suppressed. The body is no longer able to fight off common diseases and opportunistic infections become frequent and severe. Some of the signs and symptoms of full-blown AIDS include: Loss of weight (10% of body weight within a month), Herpes zoster, pulmonary infections like TB, loss of hair, night sweats, dry coughs, skin rashes, fever; chronic diarrhoea, fatigue, breathlessness, palpable lymph nodes, and frequent vomiting among others.

Activity 3: Modes of HIV transmission

- Ask the participants to name and explain the various modes of HIV transmission.
- Write the answers on a flipchart.
- Group together the common modes or categories that are on the list.
- Review the answers ensuring that the modes described in the notes below are included.

Facilitator's notes

Modes of HIV Transmission
HIV is found in body fluids. The following body fluids have the highest concentrations of HIV: blood, pre-come and semen, vaginal fluids and breast milk. HIV is transmitted through three basic routes:

1. Sexual transmission
HIV can be passed from an infected to an uninfected partner through unprotected male to male or male to female sexual intercourse whether vaginal, oral or anal.

- **Vaginal sex:** If a man with HIV has vaginal intercourse without a condom then HIV can pass into the woman's body through the lining of the vagina, cervix and womb. The risk of HIV transmission is increased if the woman has a cut or sore inside or around her vagina; this will make it easier for the virus to enter her bloodstream. Such a cut or sore might not always be visible, and could be so small that the woman wouldn't know about it.
- If a woman with HIV has sexual intercourse without a condom, HIV could get into the man's body through a sore patch on his penis or by getting into his urethra (the tube that runs down the penis) or inside of his foreskin (if he has one). Any contact with blood during sex increases the chance of infection. For example, there may be blood in the vagina if intercourse occurs during a woman's period. Some sexually transmitted diseases – such as herpes and gonorrhoea - can also raise the risk of HIV transmission.
- **Oral sex** with an infected partner carries a small risk of HIV infection. If a person gives oral sex (licking or sucking the penis of a man with HIV, the infected fluid could get into their mouth. If the person has bleeding gums or tiny sores or ulcers somewhere in their mouth, there is a risk of HIV entering their bloodstream. The same is true if infected sexual fluids from a woman get into the mouth of her partner. However saliva does not pose a risk. HIV infection through oral sex a lone seems to be rare.
- **Anal sex:** receptive anal intercourse (i.e. being the "bottom") carries a higher risk of HIV transmission than receptive vaginal intercourse. The lining of the anus is more delicate than the lining of the vagina, so is more likely to be damaged during sex. Any contact with blood during sex increases the risk of infection. If a man takes the insertive ("top") position in anal sex with a man or woman who has HIV, then he too risks becoming infected

2. Through blood and contaminated skin piercing instruments
Anything that potentially allows another person's blood to get into your bloodstream carries a risk particularly so if the equipment in use has not been sterilized. There are a number of ways in which the virus is passed on through blood. These include:

- Blood transfusion through the use of HIV infected blood in blood transfusions.
- Sharing contaminated needles by drug users or injections by health workers.
- Sharing contaminated sharp items. Traditional practices such as male circumcision and female genital mutilation involving the multiple use of contaminated instruments are significant sources of transmission.

3. Mother-to-child transmission
Mother-to-child transmission (MTCT) is when a woman living with HIV passes the virus to her baby. This can occur during pregnancy, labour and delivery, or breastfeeding.

- If a woman knows she is infected with HIV, there are drugs she can take to greatly reduce the chances of her child becoming infected.
- Without treatment, around 15-30% of babies born to HIV positive women will become infected with HIV during pregnancy and delivery. A further 5-20% will become infected through breastfeeding. In high-income countries MTCT has been virtually eliminated thanks to effective HIV Testing and Counselling, access to antiretroviral therapy, safe delivery practices, and the widespread availability and safe use of breast-milk substitutes. If these interventions were used worldwide, they could save the lives of thousands of children.

Activity 4: Methods of HIV prevention

- In plenary, ask participants to explain the various ways of HIV prevention
- Discuss with the participants each identified means of HIV prevention while ensuring that the following points are covered.

Facilitator's notes

1. Sexual transmission
Sex with an HIV infected person is the most frequent cause of passing on the virus. Avoiding, or at least minimizing, the potential for HIV infection can be achieved in the following ways:

- Avoiding any form of sex (abstinence)
- Avoiding sex without a condom. Proper use of condoms (either male or female) for every sexual act prevents HIV infection.
- Being faithful to one uninfected partner (where already living with the virus, helps avoid re-infection by use of condoms).
- Not having sex with multiple partners. Unprotected sex with multiple partners increases the risk of HIV infection since they may have other partners whose HIV

status you do not know. Know your HIV status. Knowledge of HIV status coupled with counselling on risk sexual behaviour empowers one to make decisions to avoid HIV infection including re-infection/infecting others unknowingly. Married couples should particularly go for HCT to know their HIV status.

2. Blood borne transmission of HIV

- Make certain that any blood used in transfusion has been tested for and is free from HIV.
- Do not share unsterilized needles/syringes with injecting drug users or any other person. When offered medical treatment involving an intravenous injection, make certain that needle and syringe are sterile.
- Avoid unprotected contact with blood. Use disposable gloves when providing treatment
- During traditional practices such as male circumcision, excision and face markings, avoid using the same materials on more than one person and always sterilize instruments before use.
- When blood is spilled always clean with disinfectant.
- Do not leave knives or sharp objects hanging around in the home. Dispose them properly.
- Do not share toothbrushes.

3. Prevention of mother-to-child transmission

Effective PMTCT requires a three-fold strategy:

- Preventing HIV infection among prospective parents - making HIV testing and other prevention interventions available in services related to sexual health such as antenatal and postpartum care.
- Avoiding unwanted pregnancies among HIV positive women - providing appropriate counselling and support to women living with HIV to enable them to make informed decisions about their reproductive lives.
- Preventing the transmission of HIV from HIV positive mothers to their infants during pregnancy, labour, delivery and breastfeeding. This can be assured through hospital delivery and adherence to exclusive breastfeeding or use of alternative feeding for infants of HIV positive mothers as advised by a health care provider.
- PMTCT is possible through use of antiretroviral drugs, safer infant feeding practices and other interventions.

Activity 5: Male circumcision

- In plenary, ask the participants to discuss whether circumcised males are at a reduced risk of HIV infection.
- Take the participants through a discussion on how male circumcision can help prevent HIV.

Facilitator's notes

- Scientific trials conducted in Kenya, Uganda and South Africa have shown that male circumcision reduces, by up to 60 percent, a man's risk of becoming infected with HIV during heterosexual intercourse. As a result in 2007, the United Nations Joint Programme on HIV and AIDS (UNAIDS) and the World Health Organization (WHO) recommended circumcision as an important new element of HIV prevention.
- There are several possible reasons why circumcision has this effect. The foreskin creates a moist environment in which HIV can survive for longer in contact with the most delicate parts of the penis hence increasing the risk of HIV infection.
- Removing the foreskin also means that the skin on the head of the penis tends to become tougher and more resistant to tear hence infection. Any small tears in the foreskin that occur during sex make it much easier for the virus to enter the body.
- It is important to note that the proven benefit only applies to men. The studies so far conducted suggest that male circumcision probably doesn't have a substantial effect in reducing HIV transmission from an infected man to a woman
- It is also a misconception that circumcised males are therefore not at risk of contracting HIV. Some experts fear that a lower perception of vulnerability among circumcised men may result in more sexual risk-taking behaviour, thus negating its preventive effects. However, studies indicated that adult male circumcision was not necessarily associated with increased HIV risk behaviour.
- Circumcision should be promoted as a package included in other HIV prevention measures and not as a standalone method.

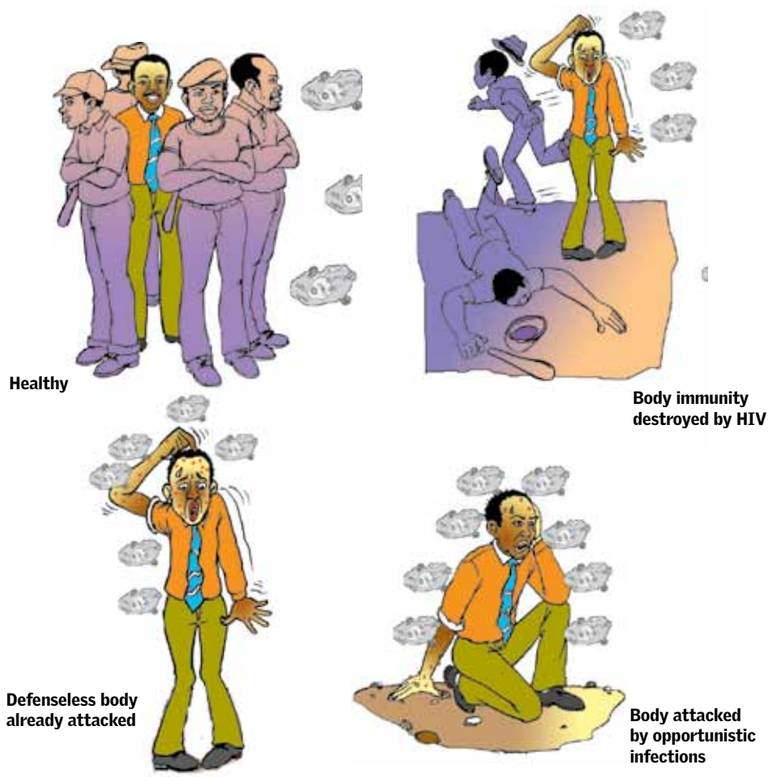

Figure 3.2.1: HIV progression

SESSION 3.3: STIs and HIV and AIDS

Objectives

By the end of the session, participants should be able to:
- Understand the different types of STIs.
- List signs/symptoms of STIs in both men and women.
- Understand measures of preventing STIs.
- Understand the relationship between STIs and HIV infection risk.
- Find out referral sites for testing and treatment of STIs.

Materials

Flipchart, papers and markers

Duration: 50 minutes

Activity 1: Group work on STIs

- Divide participants into four groups. Ask each group to answer the following questions (Write answers on a flipchart):
  - » What are some of the infections you have heard about that are passed through unprotected sexual activity?
  - » Although there are not always signs, how can you tell if your female partner has an STI?
  - » How can you tell if your male partner has an STI?
  - » What should you do if you think you have an STI?
  - » Where can you get tested and treated for STIs?
  - » How can you prevent STIs?
  - » What is the relationship between STIs and HIV?
  - » Allow about 10 minutes for discussions.

Activity 2: Plenary session

Ask the group leaders to present their answers in plenary session. Ensure the answers are highlighted in the plenary discussions.

Facilitator's notes

Examples of STIs: Gonorrhoea, syphilis, chlamydia, genital warts, herpes, hepatitis A, B and C, HIV and AIDS, pelvic inflammatory disease, and candidiasis.

Symptoms of STIs: Explain that sometimes STIs have no obvious signs, that is why they can be easily passed to others unnoticed.

How to tell if your female partner has an STI
Answers include but not limited to:
- A discharge from the vagina that is thicker or thinner than usual and has a foul smell or an unusual colour
- Pain in the lower abdomen
- Pain or a burning feeling when passing urine
- Pain during sexual intercourse
- Abnormal bleeding from the vagina
- Itching in the genital area
- Abnormal swelling or growth on the genitals
- A wound, sores, ulcer, rash, or blisters on or around the genital area.

How to tell if your male partner has an STI: Answers include:
- A wound, sores, ulcer, rash, or blisters on or around the genital area
- A discharge, like pus, from the penis
- Abnormal swelling or growth on the genitals
- Complaints of pain or a burning feeling when passing urine
- Pain during sexual intercourse or pain in the testicles
- Growth around the genitals or penis (warts)
- Swollen testicles.

What to do if you think you have an STI
- Consult a health worker for advice
- Go for tests in a medical health facility and get treatment

Tell participants that all people are at a risk of contracting STIs as long as they engage in unprotected sexual intercourse. It is therefore important to assess your partner for obvious signs of an STI. However since most people have few or no symptoms of an STI, it is important to seek help even if you only think you are at risk for STIs. Add that in women because of their genital make-up, some infections like candidiasis is not necessarily as a result of sex with an infected person but can occur due to unhygienic reasons.

How to prevent STIs:
- Abstaining from sexual activity
- Being in a mutually faithful relationship with a partner who is not infected and
- Using condoms.

Relationship between STIs and HIV infection
- Ulcerative sexually transmitted infections - most notably genital herpes have been found to facilitate HIV transmission during sex. Treating these other infections may therefore contribute to HIV prevention.
- Presence of an STI is a show of risky sexual behaviour that can also lead to HIV infection.

Key information points
- STIs are dangerous to your health. They can cause disease, infertility, cancer, and even death.
- Many STIs can be treated. If you have any STI symptoms, go to a health centre immediately for treatment by a trained health care provider.

Figure 3.3.1: Methods of prevention

Activity 3: STI video show

Silent Epidemic video by Ace Communication (available in most HIV and AIDS resource centres)

Procedure

- Set the video and let the participants watch the video
- Then carry out an experience sharing discussion on their view about what they have seen in the video.

SESSION 3.4: Condoms in HIV prevention

Objectives

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

- Comfortably handle condoms.
- Have a clearer understanding of the strength and size of condoms.
- Demonstrate correct use and disposal of both male and female condoms.

Materials

- Flipchart paper and markers
- Female and Male condoms, approximately two per person.
- Penile and vaginal models
- Many potatoes (Irish) in piles in two to three different places in the room

Method

Q & A sessions, Group work exercise.

Duration: 1 hour

Activity 1: Male condom strength demonstration

Duration: 15 minutes.

i. Hold up a condom in its wrapper and ask: What is this?
ii. Pass out a condom to each participant. Demonstrate how to carefully open the wrapper and remove the condom. Ask everyone to open his or her packages.
iii. Explain that we are going to play a game to find out how many potatoes can fit inside one condom.
iv. Divide participants into equal groups. Let the groups gather around the piles of potatoes.
v. Explain that you will say, "start," and they should begin putting as many potatoes into their condoms as possible. The person who has the most (with the condom still intact) wins.
vi. After three minutes, ask participants to say how many they were able to fit inside the condoms.
vii. Ask the participants the following questions:
  - » What does this make you think about the size and strength of condoms? Encourage a discussion.
  - » How big did your condom get?
  - » What happened as the potatoes were placed inside?
viii. Ask participants to remove the potatoes from the condoms and place the potatoes back in the piles. Safely dispose off the condoms.

Activity 2: Male condom sensitivity demonstration

Duration: 15 minutes.

i. Ask participants to return to their seats and select partners. Pass out new condoms to each pair.
ii. Ask participants to open the packets and remove the condoms. Encourage them to stretch and play with their condoms. With the help of their partners, ask participants to place the condoms over their hands (being careful of sharp fingernails). Ask the participants with the condoms to close their eyes, and ask their partners to touch their hands.
iii. Ask participants wearing the condoms on their hands:
  - » Can you feel your partner's hand touching you?
  - » How much can you feel through a condom?
iv. Now ask the partners to switch roles and repeat steps 2 and 3.
v. Ask participants to safely dispose off the condoms and return to their seats.
vi. Ask the question: How does a condom protect against HIV transmission?

Facilitator's notes

Emphasize the following points explaining that:

- When used properly, condoms prevent HIV, STIs and pregnancy. A condom blocks sexual fluids from coming into contact with a sex partner's body - preventing infection and pregnancy.
- Condoms are very strong and can become very big. No condom is too small for a penis.

Activity 3: Sources of condoms

Duration: 5 minutes

- After participants have discussed the above ask the question: Where can people get condoms in our community (either to buy or for free)?
- Ask participants to spend some time before the next meeting finding places where condoms are sold or given for free. For each place, participants should write down:
  - » The name of the place
  - » The address
  - » Who can get condoms (is there an age limit?)?
  - » If there is a limit (for condoms that are for free)

Activity 4: How to use a male condom

Duration: 20 minutes

Materials

- Flipchart, cards and markers
- Condoms, enough for every one (facilitator included) and one for every two- session participants
- One penile model for two participants
- Cards with instructions on how to use a male condom. One step per card.

Steps on how to use a male condom

- Let the participants know that this session is about proper use of male condoms.
- Shuffle the cards. Give one card to each participant. Some participants can have more than one card if they are fewer than 16.
- Explain that each card has a step for correct condom use. Ask participants to arrange the cards in the correct order of steps. Encourage participants to spend time talking together about the correct order.
- Once participants have placed the cards in the correct order, demonstrate proper condom use by doing a simulation using a penile model as they read the steps aloud. Provide additional information at each step if necessary.
- Divide participants into pairs and give each pair a condom and a penile model.
- Ask the pairs to take turns demonstrating and explaining how to use the condom correctly.
- Facilitate a discussion with the following questions:
  - » How easy or difficult was it to demonstrate condom use?
  - » How do men feel when they get or buy condoms? What about women?
  - » What would you say to a friend who said he/she is not comfortable using condoms?
- Answer any questions participants have.
- Ask: Where should condoms be stored? Where should condoms not be stored?

Facilitator's notes

i. Partners talk about condom use.
ii. Buy or get condoms.
iii. Store the condoms in a cool, dry place.
iv. Check the expiry date.
v. The man has an erection.
vi. Establish consent and readiness for sex.
vii. Open the condom package.
viii. Unroll the condom slightly to make sure it will face the correct direction over the penis (so that it can be unrolled).
ix. Place condom on the tip of the penis. (If the condom is placed on the penis backward (cannot be unrolled), do not turn the condom around; throw it away and start over with a new one).
x. Squeeze the air out of the tip of the condom and leave a little room at the end.
xi. Roll the condom onto the base of the penis, while holding the tip of the condom.
xii. The man inserts his penis for sexual intercourse.
xiii. After ejaculation, hold the condom at the base of the penis while still erect.
xiv. The man carefully removes his penis from his partner, still holding the base of the condom.
xv. Take the condom off and tie it to prevent spills.
xvi. Dispose the condom properly—never re-use a condom.

Figure 3.4.1: Negotiating for safer sex

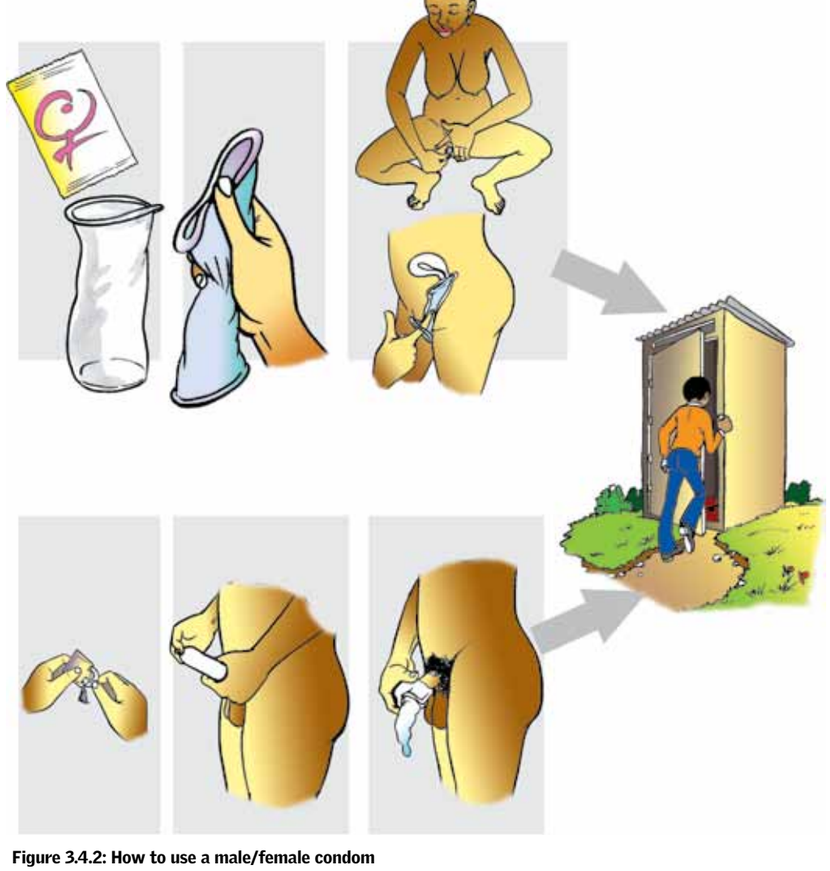

Figure 3.4.2: How to use a male/female condom

Activity 5: How to use a female condom.

Duration: 15 minutes

Materials

- Flipchart, paper and markers
- Enough female condoms for participants
- Vaginal model
- Cards with instructions on how to use a female condom. One step per card.

Steps on how to use a female condom

- Let the participants know that this session is about proper use of a female condom.
- Shuffle the cards. Give one card to each participant. Some participants can have more than one card if they are fewer than 16.
- Explain that each card has a step for correct condom use. Ask participants to arrange the cards in the correct order of steps. Encourage participants to spend time talking together about the correct order.
- Ask participants to arrange their cards in the correct order. Encourage participants to spend time talking together about the correct order.
- Once participants have placed the cards in the correct order, demonstrate proper condom use by doing a simulation using a vaginal model as they read the steps aloud. Provide additional information at each step if necessary.
- Divide participants into pairs and give each pair a condom and a vaginal model.
- Ask the pairs to take turns demonstrating and explaining how to use the condom correctly.
- Facilitate a discussion with the following questions:
  - » How easy or difficult was it to demonstrate female condom use?
  - » How do men feel when they get or buy condoms? What about women?
  - » What would you say to a friend who said he/she is not comfortable using condoms?
- Answer any questions participants have.
- Ask: Where should condoms be stored? Where should condoms not be stored?

Facilitator's notes

i. Check the expiry date on the condom, and open the package.
ii. Unroll the condom and find the ring on the closed end.
iii. Find a comfortable position, such as squatting, lying down, or standing with one leg raised. Squeeze the ring (on the closed end) together with your thumb and middle finger, and insert that end of the condom into your vagina.
iv. Put your index or middle finger into the condom, and push the ring you've inserted as far into your vagina as it will go. The ring at the open end should remain outside of the vagina.
v. Make certain that the condom isn't twisted inside the vagina.
vi. During intercourse, guide the penis into the outside, open ring of the condom. (If the outer ring slips into the vagina during intercourse, you should remove the female condom and replace it with a new one).
vii. After intercourse, twist the outside end of the condom gently to close it off and hold in the semen. Gently pull the condom from the body.
viii. Wrap the twisted condom in some tissue, or the package it came in, and throw it away in a garbage can or pit latrine. Do not flush the female condom. (see Figure 3.4.2)

Emphasize the advantages about the female condom:

- The woman controls its use, and it covers more surface area. This allows it to protect more thoroughly against STIs that are spread through skin-to-skin contact.
- It can also be inserted earlier on during foreplay, or even up to 8 hours before you have sex, since it doesn't require an erect penis to use.
- Condoms should never be re-used.
- Condoms should be stored in a cool, dry place.

SESSION 3.5: Basics of HIV testing and counselling

Objectives

By the end of this session participants will:

- Become familiar with the practice and basic principles of HIV Testing and Counselling (HTC).
- Feel confident describing, recommending, and referring people to HTC services.

Materials

- Test kits for participants to view
- markers and flipchart

Method

Lecture, group work and discussion, gallery walks for the test kits, prepared flipcharts

Duration: 45minutes

Activity 1: Introduction to HTC

- Divide the participants into groups of four.
- Ask the participants to brainstorm and write down what they understand by the term counselling.
- Let the participants write down the meaning of HTC.
- Ask the participants to write down the various steps/stages of an HTC session.
- Review the responses and explain as contained in the facilitator's notes below.

Facilitator's notes

What is HTC?

HTC is the process by which a person is taken through counselling, testing and given an opportunity to make a decision on whether to take a test or not to find out their HIV status. HTC services are always voluntary and strictly confidential. Dignity for the client is carefully maintained. HTC includes HIV and AIDS information and specialized counselling including pre-test or test-decision counselling and post-test counselling.

You cannot tell by looking at someone whether he or she is HIV positive. Someone can look and feel perfectly healthy and still be infected. Many PLHIV do not know it. Neither do their sex partners. Only an HIV test can confirm if one is positive or negative. In Kenya, HIV-antibody test is the common way to tell whether you are infected. When any virus enters your body, your immune system responds by making proteins called antibodies. Different viruses cause the body to make different antibodies. You make antibodies to HIV when you have HIV infection. The HIV-antibody test detects HIV antibodies in your blood. The test does not tell you if you have AIDS or when you will get AIDS. Results can be ready within 30 minutes inclusive of pre and post test counselling. All positive results are confirmed with a second test. Test results are very accurate.

What is HIV and AIDS counselling?

- Counselling is a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and make personal decisions related to HIV and AIDS.
- Counselling helps clients decide if they are ready to take the test and receive results. It also helps them understand the results.
- Counselling helps clients develop a plan to reduce future risk of infection.

The HTC process

- Pre-test counselling
- HIV test done
- Results given
- Post-test counselling

Pre-test counselling

- Client explained all about HIV test methodology
- Client explained benefits of knowing one's status
- It addresses client risk reduction/motivation for seeking the service
- Consent sought for test
- If client ready, test done

Testing

Client tested and results interpreted and given

Post-test counselling

- If test is negative, the client is advised to repeat the test in three months to clear doubts about window period.
- Client counselled on how to maintain the HIV negative status: ABC for HIV and STIs prevention, speedy STIs treatment and partner notification and treatment among other preventive interventions.
- If test is positive the client is counselled on living positively with the virus: appropriate condom use to avoid re-infection, joining local support groups and regular attendance of comprehensive care clinics.

Two types of HIV tests: Antibody and Antigen based

Antibody based

- We all produce specific antibodies against an external challenge. Their presence indicates either vaccination or infection
- Presence of HIV antibodies is therefore an indication of infection
- Test inexpensive
- Easy to do
- Long window period (up to three months)
- Inappropriate for kids under 18 months. (Because at below this age, the child still has the mother's antibodies in his or her bloodstream). Examples are Unigold, determine and bioline

Antigen based

- Active infections, causative agents present (antigens)
- Test looks for the actual virus
- Test is expensive
- Not easy to do, therefore not widely available
- Short window period (within days)
- Only option for kids under 18 months
- Examples are Polymerase Chain Reaction

What are possible test results?

HIV-negative means that antibodies to HIV (for antigen tests) were not detected. In almost all cases this means the person is not living with HIV. However, it is necessary to ensure that the person is not in the window period.

HIV-positive means that antibodies to HIV (for antigen tests) were detected. Testing positive means that the person is living with HIV.

What is the window period?

Antibodies against HIV take from one to three months to develop after the initial infection. The period between infection and testing positive is called the window period. People in the window period can transmit the virus easily.

Activity 2: Benefits of HTC

- In groups of two, ask participants to discuss and list down reasons why it is necessary to take an HIV test
- At plenary, let each group list their findings on a flipchart.
- Review the answers ensuring facts are emphasized as in the facilitator's notes below.

Facilitator's notes

The benefits of HTC?

- You can only know your status through HTC. You may be HIV positive and not show any HIV symptoms.
- Knowing ones HIV status helps reduce risky behaviour.
- Knowing HIV status enables those tested HIV-positive to gain early access to HIV and AIDS care, treatment and support.
- Ensures pregnant women tested positive are able to have access to interventions that prevent transmission of the virus to their infants.
- It is a critical opportunity for HIV prevention particularly for couples where one partner is HIV positive (Known as sero-discordance or discordant couples), and for others with a high risk of acquiring HIV.
- HTC helps clients make informed decisions about the future.
- Clients receive complete information about HIV and AIDS.
- Helps in stigma reduction by reducing the element of denial. HTCs encourage greater openness about HIV and AIDS.
- Increases access to other health services.

Activity 3: Types of HTC

Explain to the participants that HTC comprises of the following types:
Client-initiated HTC: refers to a situation where an individual, couple or group actively seeks out HIV testing and counselling at a site where these services are provided or accessible. This can be in sites such as health facilities, mobile sites or in people's homes.

Provider-initiated HTC (PIHTC): refers to a situation in which the HTC service provider, who may be a health care worker or other type of HTC service provider, offers an HIV test to a client or patient regardless of their reason for attending the health facility. PIHTC makes HTC part of routine care in health facilities in Kenya. PIHTC is however different from Diagnostic HIV Testing and Counselling (DHTC) that targets patients with HIV related signs and symptoms. Prior to receiving an HIV test, the provider will explain the procedure and reasons for requesting the test to the client or patient. If the client or patient agrees to learn their HIV status, s/he will receive an HIV test and will be informed of their status.

Self-testing for HIV: this involves conducting of an HIV test upon oneself. Clients can access test kits from pharmacies or other approved suppliers. Persons must have some basic training on HIV and must be informed that the results of the self-test are not confirmed until a second confirmatory test is conducted. Pharmacists and other suppliers of self test materials should undergo HTC training and be certified by the Ministry of health.

Required HIV testing: HIV testing may be performed without specific consent in certain specific settings such as during military recruitment and specialized employment. HIV testing may also be ordered by a court of law. In all these situations the HIV testing must be confidential and performed with adequate counselling.

HIV testing of blood or tissue donation: Policy guidelines on blood transfusion in Kenya requires that all blood for transfusion must pass the infectious disease screening tests agreed upon by the Ministry of Health before being made available to the recipient. This includes testing for HIV as well as other transfusion or tissue transmissible infections. In all cases, donors should be given general information about HIV testing and should have access to their results.

HIV testing for research and surveillance: research in Kenya may only be conducted after the research protocol has been cleared by the relevant ethical review committee (or board). In general, written informed consent is required for all research participation and this should include consent for HIV testing if necessary. All HIV testing must be accompanied by appropriate counselling in line with HTC guidelines. In Kenya, sentinel surveillance has been based on unlinked anonymous testing of pregnant women attending antenatal clinics and of patients attending STI clinics. Anonymous testing should be complimented with the provision of HIV services including information and confidential HTC.

Activity 4: Video Show – *Hifadhi Vizazi vya Kesho.*

(Available at NARESA - Network of AIDS Researchers in Eastern and Southern Africa - and Silverscreen Pictures). Duration: (45 minutes)

- Let the participants watch the video.
- In a plenary session lead the participants in discussing by asking them the following:
  - » What are the fears of the husband in the video show?
  - » What are some of the misconceptions that the husband has about HIV?
  - » What are some of the commonest fears that men have in their community when it comes to knowing their HIV status?
  - » Should men/husbands accompany their wives to antenatal clinics?
  - » What are the benefits to the family when married couples are aware of their HIV status?
  - » What should be done to encourage married couples to seek HTC services together?

SESSION 3.6: TB and HIV

Objectives

By the end of this, session participants should be able to:
- Explain what TB is
- Describe the relationships between HIV and TB

Materials

Laptop and projector/prepared flipcharts and markers

Method

Brainstorming and group discussion

Duration: 30 minutes

Activity 1: Relationship between TB and HIV and AIDS

- Ask the participants to form three or four groups, depending on the number of participants.
- Give a pen and paper to each group and ask them to discuss and record the answers to the following questions. Allow 15 minutes for this exercise.
  - What is TB? How is it transmitted and which parts of the body are affected?
  - What is the relationship between HIV and TB?
  - How do I know I have TB?
  - Is TB curable?
  - What is the government doing about TB in Kenya?
- What is the role of community members in the fight against TB?
- Presentations and discussions should be done in plenary.
- Ensure the information below is covered
- Conclude the activity with a Q&A session to clarify any issues that may arise

Facilitator's notes

Definition of TB
- TB is an airborne disease caused by bacteria (*Mycobacterium tuberculosis*), spread via droplets in the air.
- TB usually infects the lung and other parts of the body such as bones, kidneys, intestines and brain.
- Most common infection is TB of the lungs.
- PLHIV often get TB infection of other parts of the body due to their lowered immunity.

Relationship between HIV and TB
- Both HIV and TB suppress the immune system.
- HIV increases the risk of acquiring TB by 50 percent in a person's lifetime up from 5 percent in those who are HIV negative.
- Having undiagnosed, untreated or poorly treated TB in a PLHIV increases the chance of that person dying.
- Due to HIV, TB cases are on the increase in Kenya.

Symptoms of TB
- Coughing for more than two weeks
- Night sweats or evening fevers
- Bloody sputum
- Unexplained weight loss and loss of appetite

Is TB curable?
- Yes!
- Diagnosis of TB is easy - all health facilities should be able to do it
- Drugs are free at all public health facilities

What is the government doing about TB in Kenya?
- Promoting screening of all PLHIV for TB.
- Promoting screening of all TB patients for HIV.
- Promoting the integration of TB and HIV services at the all levels of health care.
- Providing free TB drugs and ARVs at all public and mission facilities.
- Promoting TB/HIV collaboration at all levels.

Role of community members in the fight against TB
- Promote awareness within the community of the relationship between HIV and TB.
- Promote awareness of common signs of TB and the need to go for TB testing whether they have symptoms or not.
- Ensure that PLHIV are screened for TB.
- Support PLHIV suffering from TB to adhere to medication.
- Sensitive community members to participate in TB/HIV collaboration committees at the community, health facilities and district levels.

SESSION 3.7: ART

Objectives

By the end of this session participants should be able to:

- Acquire knowledge on ART.
- Explain how ART works.
- Assist a client with ART adherence and be able to monitor responses and give referrals.

Materials

Laptop and projector/prepared flipcharts, markers, blank flip chart and samples of ARVs

Method

- PowerPoint presentation/prepared flipcharts
- Brainstorming
- Group discussion

Duration: 40 minutes

Activity 1: Overview of ART

- Ask the participants to form three groups.
- Give a pen and paper to each group and ask them to discuss and record the answers to the following questions.
- What is ART?
- Why should PLHIV use ART?
- Go round the groups encouraging all to participate and ensure that no one person dominates.
- Allow 10 minutes for this exercise.
- Presentations and discussions should be done in plenary.

Facilitator's notes

Definition of ART
Antiretroviral Therapy or Treatment (ART) is a triple antiretroviral drug combination for treating HIV.

Goals of the therapy

- Prolong and improve quality of life of PLHIV
- Suppress viral replication
  - Reduce viral load as much as possible for as long as possible
  - Halt and reverse disease progression
- Reduce the risk of HIV transmission from mother-to-child
- Emergency prevention of HIV infection (Post Exposure Prophylaxis (PEP) – administered in less than 72 hours for a period of 28 days)
- Reduce stigma (as PLHIV have no or very few symptoms of HIV and AIDS)

Drugs used in HIV therapy
Standard antiretroviral therapy consists of at least three types of ARVs:

i. Reverse Transcriptase Inhibitors (RTIs) that stop the virus from replicating. These include Zidovudine (AZT), Stavudine (d4T), Didanosine-ddI, Lamivudine (3TC), Tenofovir(TDF), Nevirapine (NVP), Efavirence (EFV), and Delaviradine (DLV).
ii. Protease Inhibitors (PI) – they prevent HIV from being successfully assembled and released from the infected cells. Examples include: Lopinavir/Ritonavir (Lpv/r), Nelfinavir (NFV), Ritonavir (RTV), Saqunavir (SQR), Indinavir (IDV), Atazanavir (ATV), and Amprenavir (APV).
iii. Fusion inhibitors (FI) such as Enfuvirtide (T20).

There are two PEP regimens for adults: Zidovudine + Lamivudine or Stavudine and Lamivudine taken twice daily for 28 days.

Initiating ARV therapy

- ARV therapy is never an emergency
- If patient has serious other infection, this should be treated or stabilized first
- If patient is on treatment for TB including rifampicin, choose ARVs with minimal or no interactions, or delay ART

Initiating ARV therapy

- Every patient who enquires about ARVs is given basic information by doctor/health worker
- Every patient receives counselling by a counsellor trained in ARVs issues before prescriptions
- Counselling enables patient and family to make own decision and commitment to long-term adherence

WHO recommends the following baseline tests before initiating ARV therapy

- Minimum – Haemoglobin (Hb) and pregnancy tests
- Desirable – CD4 count
- Optional/ideal – viral load

Adherence

- Adherence is a voluntary commitment made by the patient to stick to the prescribed regime, based on an understanding of the information given
- It is a willing partnership.
- Adherence has been found to be an important determinant of outcome of Highly Active Anti-Retroviral Therapy (HAART)
- Adherence is a crucial component in
  - Maintaining therapeutic drug levels
  - Ensuring virological suppression
  - Reducing the risk of drug resistance

Ref: ARV Therapy Guidelines, Journal of American Medical Association, JAMA, July 10, 2002, 288

Monitoring of ART
ART is monitored using clinical information and laboratory parameters

Clinical information

- Body weight
- Signs and symptoms
- Past and present medical history
- Physical examination

Laboratory parameters

- Minimum - HIV Test, Hb, pregnancy test
- Standard - FBC, SGPT/ALT, Cretainine
- Desirable - CD4
- Optional/ideal - viral load

Ref: ARV Therapy Guidelines, Journal of American Medical Association, JAMA, July 10, 2002,

Conclude the session by giving the participants the following take home messages on ART:

- Not an emergency treatment
- Should not be initiated while an inpatient
- Treat opportunistic infections first
- Opportunistic infections cause over 90 percent of morbidity in HIV
- ART is only one part of HIV care
- All who require ART should first be on septrin
- Optimize nutrition
- Adherence to counselling essential
- Patients should be able to demonstrate an understanding of:
  - » Importance of strict adherence
  - » Their ability to access drugs on long term
  - » Life-long treatment, monthly follow-up
- Follow the Kenyan National Guidelines on ART

SESSION 3.8: Home and community based care

Objectives

By the end of this session, participants should be able to:

- Describe the basics of Home and Community Based Care (HCBC)
- Understand the importance of administering HCBC to PLHIV

Materials

Laptop and projector/prepared flipcharts, markers and blank flipcharts

Method

PowerPoint presentation/prepared flipcharts, brainstorming and group discussion

Duration: 45 minutes

Activity 1: Defining HCBC

- Ask the participants to form three groups
- Give a pen and paper to each group and ask them to discuss and record the answers to the following:
  - » Define the HCBC Concept
  - » Reasons for HCBC
  - » The benefits of psychological support, nutrition and social support in HCBC.
    Each group should pick one type of care
- Go round the groups encouraging all to participate and ensure that no one person dominates.
- Allow 30 minutes for this exercise.
- Presentations and discussions should be done in plenary.
- Ensure the information below is covered.

Facilitator's notes

HCBC: Is the care of PLHIV and persons affected by HIV and AIDS that is extended from the hospital or health facility to the patient's home through family participation and community support. HCBC consists of clinical care, nursing care, counselling and psycho-spiritual care and social support.

Reasons for HCBC

- Prevent medical complications
- Take care of existing problems
- Enable people to know when to get professional help (referral)

Psychological support

A diagnosis of HIV infection or AIDS causes psychological distress such as deteriorating health and losses in strength and appearance, ability to function within the family and community, mobility, friends and security. All these require support from relatives, friends and the community at large. The support includes:

- Reducing stress and anxiety, promoting positive living, plan for future and behaviour change, making decisions on HIV testing.
- Social and economic support including joining support groups, access to welfare and legal services and material assistance.

Nutrition

PLHIV may lack appetite. Their bodies often do not use food properly due to conditions like diarrhoea or vomiting, changes in metabolism and immune reactions. This may cause weight loss and health deterioration. They therefore need enough nutritious food to maintain weight and keep the body strong.

Good nutrition

- Provides the nutrients needed for tissue growth and repair
- Helps the body fight opportunistic infections
- Prevents malnutrition and wasting

- Helps maintain body weight
- Improves effectiveness of drug treatment
- Improves quality of life

Social support

PLHIV usually suffer from anxiety, anger, guilt, distorted imagination. They need a lot of assurance and acceptance. Include them in day-to-day activities such as preparing and sharing meals and socializing. This improves their mental status and gives them a sense of belonging.

Positive living

- It is a concept in which people understand and learn how to take care of themselves whether living with HIV or not.
- A family will need to learn how to live with a PLHIV without stigmatizing or discriminating the PLHIV and without risk of getting infected.
- For PLHIV, positive living is the patient's method of doing everything to help their immune system cope with the AIDS virus, or any other disease, in order to live healthy as long as possible.
- Early knowledge of HIV positive status leads to early management. Good nutritional value and maintaining good health status are crucial in HIV management. It could mean many years of life even after HIV infection.
- ART is recommended only when CD4 cell count is below 200 per cubic mm of blood as one can live positively for the rest of their lives without ever being put on ARVs.
- Anyone with 300 CD4 cells per every cubic mm of blood does not require to be put on ARVs. Those who are already on ARVs need also to monitor their CD4 cells regularly to ascertain the efficacy of the ART combination they are taking and how well his/her immune system is doing.
- Positive living also entails fully and religious utilization of risk reduction mechanisms which involves always using condom whenever engaging in sexual intercourse, observing good nutritional guidelines and treating any opportunistic infections.

Activity 2: Overview of opportunistic infections

- Write on the board/flipchart the common opportunistic infections listed below.
- Ask the participants simple methods used in managing such infections. Write down their responses on the board.
- Review answers/responses with clarifications from the notes below on managing common opportunistic infections.

Fever and flu

Fever can be caused by infections like malaria and TB. In case of fever and flu:

- Wash with cool water and wipe skin with wet cloth
- Take two aspirins or paracetamol tabs every 4 hours
- If fever is due to malaria, take full course of recommended anti-malaria drugs
- Drink a lot fluids
- Seek medical help promptly

Skin problems

PLHIV may have itching skin or have Herpes-zoster *(kisipi)*

- Wash with soap and water
- Keep the area dry and apply gentian violet solution (GV)
- Dress the wound with cloth strips that have been washed and dried in the sun
- If the wound infected and produce pus, handle bandages with care. Soak them in solution of 1part jik to 6parts water for 10 minutes before washing
- Take 2 aspirins/paracetamol every 4-8hrs (depending on severity of pain)
- Go to a health facility for stronger pain medicine and for dressing

Rashes

- Apply calamine lotion to relieve itching in case of rashes. Seek medical care
- Seek medical care

Herpes zoster
- Take 2 aspirins/paracetamol every 4-8hrs (depending on severity of pain)
- Go to a health facility for stronger pain medicine and for dressing

Cough or difficulty in breathing
Pneumonia and TB can be treated effectively with modern medicine. TB is contagious if not treated. Seek medical care.

Sore throat and thrush
Treat quickly to avoid difficulty in eating. To keep mouth healthy:
- Rinse mouth with warm salty water
- For white patches, suck a lemon to ease sores on lips and mouth
- Eat soft foods
- Apply gentian violet solution to sores on lips and mouth
- Seek medical care

Tiredness/weakness
- Rest as needed - learn to accept help from others
- Find ways to make activities easier, for instance, sit rather than stand when washing
- Ask for help if needed

Note: In all illnesses, seek medical care from a recognized health facility.

Activity 3: Getting medical help

Discuss the following with the participants

Getting medical help
For the conditions that can't be treated at home, seek advice and medical care early enough to avoid them developing to something more serious like pneumonia. Avoid the following troublemakers:
- Alcohol of any kind, beer or hot drinks (Chang'aa does not cure pneumonia)
- Tobacco
- Excessive medication other than prescribed drugs. Avoid self medication
- Anxiety and depression
- Straining from too much work or exercise

Care of caregivers
Caregivers get physical and emotional challenges taking care of people suffering from incurable condition. They need support to help them do their jobs well and avoid 'burn-out' and to keep themselves going and ensure they remain free of infections

SESSION 3.9: Mapping HIV and AIDS services

Objectives

By the end of the session, participants should be able to:
- Identify and list types of available HIV and AIDS-related services in their area/community/ neighbourhood.
- Identify sources of/facilities that offer those services in the area.
- Identify barriers to accessing the available HIV and AIDS-related services.
- Outline strategies for encouraging uptake of available HIV-related services in the area by community members.

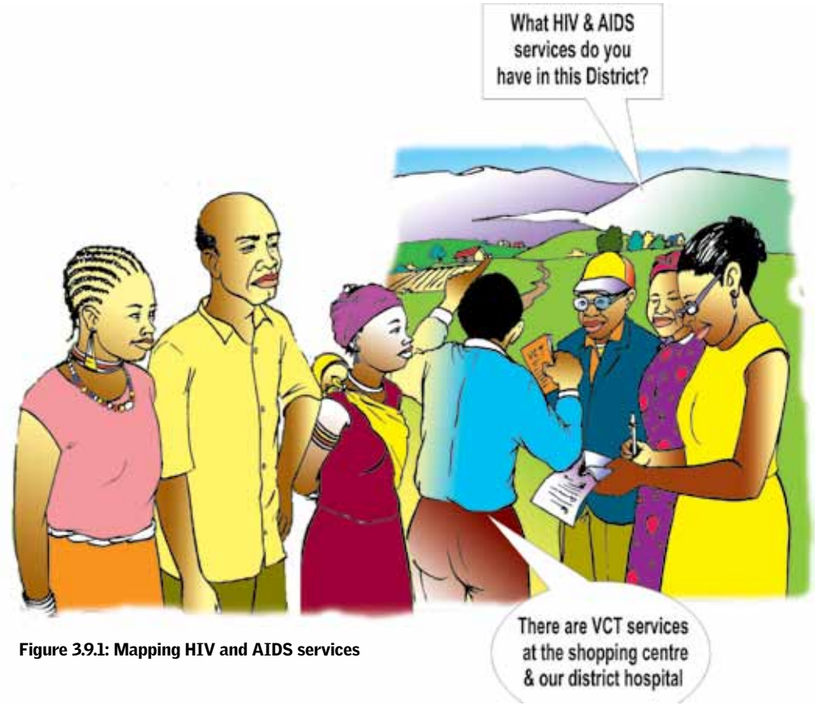

Figure 3.9.1: Mapping HIV and AIDS services

Session preparation

Steps to follow in implementing this exercise

- Make prior arrangements for the physical location of the exercise in the community.
- Decide and obtain beforehand the materials necessary for the exercise including but not limited to felt pens, flipchart, pins, ink, etc.
- Divide roles to be played by the different participants (who will draw the map, allocate health points etc).
- Once the drawing is complete, let participants sit around the drawing to discuss related issues including services available, obstacles to services especially for men, what needs to be done and the functioning of a referral system.
-

Method and activities

- Divide participants into groups of three to four.
- Ask each group to draw on the ground or on flipcharts the map of the area and to point out/mark on the map the sources/areas or facilities where HIV and AIDS services are currently being provided.
- Ask the groups to write down the types of HIV-services that are offered in each source/ facility and referral points.
- Ask the groups to write down services not available within the area.
- Ask them to also list services that are found within the communities.

- Ask them to write down who provides the services.
- Ask them to write down who is targeted with those community-based services? (Which population categories – youth, OVC, sex workers, PLHIV, widows/widowers, etc?)
- Is there any community involvement in the services provided?
- What are the problems for community involvement?
- What ought to be done?
- Summarise the key emerging lessons and recommendations.

Duration 30 minutes

Facilitator's notes

Mapping will help in identifying:
- Service delivery points - facility and community based
- Types of services available
- Challenges in accessing some of the services and identification of referral potential in the community.

Special attention should be paid to challenges to accessing the services by the different categories of people who may need those services - men and women (and even couples), PLHIV, widows/widowers, sex workers and youth.

- Mapping can be time consuming but sufficient time needs to be availed for the activity.
- If drawn on the ground, efforts of redrawing on paper need to be made for future reference. Alternatively, photographs of the drawing may be taken.
- Allow time for discussing related issues including, types of services available, obstacles to services and referral systems and tools.

MODULE 4: GENDER INEQUALITY AND HIV AND AIDS

Overview

Although HIV and AIDS is a disease affecting both men and women, recent trends show that more women than men are becoming infected and at a much younger age than men. The 2007 Kenya AIDS Indicator Survey (KAIS) showed that there were more women (8.4 percent) than men (5.4 percent) among the 15-64 age group that were living with HIV. Other studies conducted over the past decade shows that gender roles and relations directly and indirectly influence the level of an individual's risk and vulnerability to HIV infection and impact. This module examines gender concerns in HIV and AIDS including development of gender specific response strategies for reduced incidence and impact of the disease.

Goal

To build capacity of participants to identify gender issues and how they contribute to the spread of HIV and acquire necessary skills to effect behaviour change activities to reduce the spread and impact of HIV and AIDS in their community.

Objectives

By the end of this module, the participants should be able to:
- Understand the concepts of gender, gender relations, gender roles, gender inequality, sex, sexuality and sexual orientation.
- Understand relationship between gender inequality and HIV and AIDS.
- Examine and identify actions to respond to gender inequality issues that increase the spread and make worse the impact of HIV and AIDS in the community.

Module duration: 2 hours 45 minutes

SESSION 4.1: Gender concepts

Objectives

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

- Define gender, gender relations, gender roles, gender inequality, gender equity, gender equality, gender sensitivity, gender awareness, gender blindness, sex, sexuality and sexual orientation.
- Explore the different gender roles of men and women.
- Identify how the gender roles can be objectively understood and used as a weapon against HIV and AIDS.

Duration: 45 minutes

Materials

Pens, paper and flipchart with pre-written definitions of gender inequality and gender roles

Method

- Q & A session
- Mini lecture
- Group work
- Plenary session

Activity 1: Definition of gender concepts

- Ask the participants in groups of two to give their definition or understanding of the terms gender, gender relations, gender roles, gender inequality, gender equity, gender equality, gender sensitivity, gender awareness and gender blindness. Write down the responses on a flipchart.
- Once there is a consensus on the definitions, ask the participants to give examples of how gender inequality manifests or exists in their communities.
- In plenary discuss the responses together guiding the discussion with the definitions below:

Figure 4.1.1: Gender roles

Facilitator's notes

Gender refers to the socially determined ideas and practices of what it is to be female or male. It is the expectations of people, communities, and cultures about men and women. These ideas and expectations are learned from family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, advertising and the media. They reflect and influence the different roles and responsibilities, behaviour, social status, economic and political power of women and men as assigned by society. Gender therefore refers to personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis. It is a social construct that varies from society to society and changes overtime.

Gender relations refers to the way men and women relate to each other in their individual relationship and in groups in a particular society. Gender relations define power relations between the two sexes – does either one have more power or authority than the other? Gender relations will therefore define equality or inequality in the relationship between men and women.

Gender roles are those responsibilities learned from time of birth and are reinforced by parents, teachers, peers and society in general. Gender roles are based on the way a society is organized and also vary by sex, age, culture, class and ethnic group. These gender roles also define the ways in which women and men are expected to relate to one another. Gender roles vary from culture to culture and generation to generation and overtime due to societal changes. People's and communities' understanding of gender roles can and do change.

Gender inequality refers to obvious or hidden disparities between individuals on the basis of a person's sex, authority, opportunities, allocation of resources and/or benefits and access to services. Gender inequality therefore means that women and men do not enjoy the same status and have unequal conditions for realizing their full human rights and potential to contribute to national, political, economic, social and cultural development and in benefitting from the result.

Gender equity is the process of being fair to both women and men. To ensure such fairness, measures must put in place to compensate for historical and social disadvantages that prevent men and women from operating on a level playing field.

Gender equality refers to the absence of discrimination on the basis of a person's sex in authority, opportunities, allocation of resources and/or benefits and access to services. Gender equality therefore means that women and men enjoy the same status and have equal conditions for realizing their full human rights and potential to contribute to national, political economic, social and cultural development and to benefit from the result.

Gender sensitivity is the ability to perceive existing gender differences, issues and equalities and incorporate these into strategies and actions.

Gender awareness is the understanding that there are socially determined differences between men and women based on learned behaviour (e.g. through socialization), which affect ability to access and control resources.

Gender blindness is the failure to recognize that gender is an essential determinant of social outcomes, including health and economic undertakings

Activity 2: Defining sex and sexuality concepts

- Divide participants into three groups.
- Provide flipcharts and two mark/felt pens to each group.
- Allow time for groups to write down their definitions of sex, sexuality and sexual orientation.
- Groups report to plenary. Allow for input from other group members during plenary session.
- Ask the participants if they are aware of people of in their community who have some of the different sexual orientations identified.

Facilitator's notes

Sex refers to physiological attributes that identify a person as male or female. Sex is therefore biological and manifests in the physical difference between males and females. Sex is manifested in:

- Type of genital organs (penis, testicles, vagina, womb and breasts)
- Type of predominant hormones circulating in the body (oestrogen or testosterone)
- Ability to produce sperm or ova (eggs)
- Ability to give birth and breastfeed baby

Sexuality refers to those aspects of gender identity that relate to sex. These include sexual desire, sexual behaviour and sexual orientation. Achieving gender equity around sexuality means respecting both male and female sexuality, sexual needs and rights and helping both sexes to have fulfilling, safe and non-exploitative sexual relationships. This is especially important for curbing the spread of HIV and reducing incidences of unintended pregnancy.

Sexual orientation is an individual's preference for sharing sexual expression with members of the opposite sex (heterosexuality); or one's own sex (homosexuality or lesbianism) or both sexes (bisexuality) A person's sexual orientation is influenced by social expectations regarding his/her behaviours and roles according to his/her biological sex. Some common types of sexual orientation include:

- **Heterosexual:** a person attracted to people of opposite sex
- **Homosexual:** person physically attracted to people of same sex
- **Gay:** male homosexual
- **MSM:** Men who have sexual relations with other men but do not identify themselves as homosexual
- **Lesbian:** female homosexual
- **Bisexual:** person physically attracted to people of both sexes.

The facilitator is advised to approach the subject with the sensitivity it deserves in the community he/she is working in. Let the participants understand that these are cases which are happening but not much is discussed in the open.

Depending on the types of orientations mentioned, explain to participants that it is important for them as "change agents" to be aware of the existence of such persons in their communities, especially the gay, lesbian and bisexual and to understand that they are minority group which must also be accommodated in BCC programmes because they also have sexual reproductive problems just as much as the heterosexuals.

Activity 3: Identifying the different gender roles of men and women

- Divide participants into groups of no more than six.
- Ask the participants to draw a large chart with columns with categories listed as economy, community, family and sexual relations.
- Ask the participants to discuss and list in turn the roles of men and women in relation to the four categories.
- Let the participants then discus and list down how these perceived roles can:
  - » Lead to vulnerability and the spread HIV and AIDS.
  - » Be used as a weapon to control the spread of HIV in the family.

Facilitator's notes

Gender Roles: Men and women play different social roles. The roles vary from community to community although there are a number of common threads. In some communities for example, it is the women who build houses, yet in some communities, this is unheard of - a taboo!!! These roles inevitably impact on the lives of men and women sometimes in relation to HIV and AIDS. However with the objective of understanding why these roles existed and taking into account the HIV pandemic, communities/individuals can use these roles as a tool to hold the family together and protect them from HIV.

Femininity: The common gender role prescribed for women, or 'womanly', demands:

- A submissive role for the woman
- Passivity in sexual relations, i.e. no power to negotiate for safe sex, and
- Ignorance about sex, in effect restraining women from seeking and receiving information related to HIV prevention.

In most communities/society, bearing children is a key aspect of feminine. Women who would demand safer sex by using contraceptives such as condoms to prevent pregnancy or HIV risk being thrown out of marriage and home. In cultures or communities where virginity is highly prized, girls will do everything to maintain their virginity to the extent of resorting to anal sex. This increases their vulnerability to HIV.

Masculinity: Men are expected to be more dominating, knowledgeable and experienced about sex. These norms promote promiscuity and reinforce risk-taking behaviour.

Explain to the participants that these may be stereotypes or gender roles. Emphasize that gender roles are created by society; and therefore, they vary from society to society. They also change over time, as society and culture change.

Explain that gender describes the ideas and expectations people have about men and women (and which are bound to change anyway). These include ideas about what qualities and abilities are considered feminine and masculine, and expectations about how men and women should behave in different situations. A person's gender is complicated, and is made up of roles, duties, appearance, speech, movement and more.

SESSION 4.2: Gender concerns in HIV infection and impact

Objectives

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

- Understand and explain how gender influences the spread of HIV infection.
- Understand the gender dimensions of the epidemic and how it impacts on males and females differently, socially and economically.
- Develop community actions to prevent HIV infections and promote HIV care and support services.

Duration: 2 hours

Materials

- Comparative data on HIV prevalence in the district/division disaggregated by sex
- Flipchart paper and markers
- Small pieces of paper, tape, pens
- Overhead projector (optional)

Method

- Obtain data on HIV and AIDS prevalence in the district or division from NASCOP offices
- Mini lecture, group activity and plenary session

Activity 1: HIV and AIDS prevalence.

- Provide participants with information on HIV and AIDS prevalence data in the administrative district or division.
- Divide the participants into groups of four and let them discuss and record answers to the following questions:
  - » Why are there more girls than boys becoming infected with HIV?
  - » Why are there more women getting infected than men?
  - » What are gender related factors and behaviours that fuel the spread of HIV?
- Call back the participants to plenary and review the responses, taking note of some of the points below.

Facilitator's notes

Why more women and girls are infected than men/gender related factors and behaviour

- As a receptive partner, women have a larger mucosal surface area exposed during sexual intercourse. Women thus run a bigger risk of acquiring HIV, more so if the intercourse takes place at an age when the mucosal surface is still tender or when it is damaged due to rituals and practices like female genital mutilation and early marriages.
- Young girls tend to marry or have sex with older men who may have had more sexual partners and hence be more likely to be infected.
- Women frequently require blood transfusions during childbirth and abortions, as prevalence of anaemia amongst pregnant women in developing countries is usually very high.
- Insufficient access to sexual and reproductive health and educational services, including PEP and post rape care.
- Inability to negotiate safer sex due to gender discrimination and imbalances of power.
- The lack of female-controlled HIV prevention methods such as female condoms and microbicides (vaginal gels that can help prevent infections).
- The low educational and economic status of women drives them into survival/ commercial sex work.
- Sexual gender based violence (rape and incest) leading to infections.
- Child bearing expectation leading women to go out in search for a child where husband is impotent.

Risk factors that fuel HIV infection among men

- The gender division of labour keeps men away from their spouses for long periods leading to promiscuity and the spread of HIV.
- Multiple sexual partnerships among men increase the risk of contracting HIV.
- Stigma with regard to same sex relationships means that men who have sex with men (or boys who have sex with boys) have secret relationships and at the same time marry due to social pressure.
- Some men who have tested positive continue to be in denial and therefore continue to spread the virus due to the social expectation of "men to be men".
- There are few opportunities for educating couples. This is complicated by the fact that polygamous men find it difficult to fit in the definition of a couple.

Activity 2: Action plans to control the HIV and AIDS prevalence

- Divide the participants into two groups.
- Let group one identify possible strategies that can be implemented at the family level towards reducing vulnerability of women and girls to HIV.
- Let group two identify appropriate strategies at the community level towards reducing vulnerability of women and girls to HIV. Allow 15 -20 minutes for groups to discuss.
- Call back participants to plenary to report on their deliberations.
- Summarize the session by referring the participants to some key points contained in the notes below.

Facilitator's notes

- HIV and AIDS programmes need to address and focus on the "couple" or family including HTC for couple, HIV risk assessment among couples and promotion of condoms use among couples.
- The active participation of men and the larger society is critical. Men should take lead in HIV prevention, care and support activities.
- Advocate against cross-generational sex.
- Advocate against sexual gender based violence.
- Train women and girls on condom self-efficacy and facilitate access to condoms including female condoms.
- Facilitate income generating activities for women.
- The attitude of society towards women, stemming from cultural orientation, needs to change. In tackling HIV and AIDS, the woman also has to have a choice.
- Ensure both male and female participation in (IEC) materials development.
- Evaluate all existing IEC materials for gender gaps and ensure penetration of IEC materials to all levels of community.
- Train local project personnel on having a gender focus when designing projects.
- Sensitize the community including opinion leaders on gender vulnerability to HIV and AIDS.

MODULE 5: HUMAN AND LEGAL RIGHTS

Overview

This module dwells on matters of law, human rights and other legal rights issues that undermine HIV prevention, care and support efforts. HIV and AIDS have created conditions that encourage, promote and allow human and legal rights abuses to take place. The fact that heterosexual intercourse is the primary mode of transmission of HIV has led to implications of promiscuity on PLHIV, which is one of the reasons they are discriminated against and stigmatized, in the community and even in health care institutions. This module presents an overview of human and legal rights, discusses human and legal rights concerns in HIV and AIDS, and the Kenya HIV and AIDS Prevention Act 2006. In the module, participants are facilitated to identify and respond to community specific human and legal rights abuses for reduced spread of HIV, increased care and support of PLHIV.

Goal

To enlighten participants on HIV and AIDS human and legal issues, relate to how violation of the human and legal rights contribute to spread of HIV and make worse the impact of HIV and AIDS, and build capacity of communities to analyze and respond to human and legal rights abuses.

Objectives

- Define and understand the application of a right, legal rights and human rights terms.
- Demonstrate how legal rights and human rights apply to widows, orphans and vulnerable children in the context of HIV and AIDS and to PLHIV.
- Identify human rights and other legal rights issues which fuel the spread of HIV and worsen AIDS impacts among PLHIV.
- To make participants understand that respect for human rights would reduce instances of HIV infection and reduce impacts of AIDS.

Duration: 3 hours

SESSION 5.1: Understanding rights, legal rights and human rights

Objectives

By the end of this session the participants should be able to:

- Define and understand rights.
- Define and understand human rights.
- Understand legal rights and how they apply to our daily lives.

Duration: 45 minutes

Materials

Markers, paper, flipchart and copies of Laws of Kenya

Method

Q&A, mini lecture, group activity and plenary session

Activity 1: Definition of rights

- Start by explaining to participants that in our everyday language we talk about rights. For example a person will say "I have a right to do this or that" or "We have a right to speak or say what we feel about something or an issue."
- Ask the participants to give examples from their own experiences of the use of the word rights.
- Write on the board/flipchart the response in the following format:
  - "….I have the right to…"
  - "We have the right to…"
- Pose the following questions to the participants:
  (a) Who gave us these rights?
  (b) Where do we get our rights?
  (c) Can they be taken away?
  (d) Why do we have these rights?
- Encourage discussion and especially diverse viewpoints. And if participants for example say, "the government gives us rights", challenge with a contrary question, "can the government then decide which rights to give us?" "Did we still have those rights before governments existed?"
- Check out the answers to question (d) above and discuss with participants the definition of a right as follows.

A right is something you are born with, and you will die with, granted to you by your "creator" (whatever you imagine the creator is). We have these rights simply because we are "humans", hence human rights.

Activity 2: Definition of human rights

- Once there is clear understanding of what rights are, explain to the participants that as human beings we have a claim to those rights. They are therefore referred to as human rights.
- Explain to participants that we get these rights from:
  - International treaties of which Kenya is a signatory.
  - The Constitution of Kenya, in the provisions contained in Chapter 4, dealing with the Bill of Rights.
  - The Laws of Kenya.
- Explain that the government has the obligation to observe, respect, protect, promote and fulfil these rights. Use the notes below to supplement.

Facilitator's notes

Human rights are freedoms, immunities, privileges, entitlements and benefits that everyone should be able to claim in the society in which they live, on the basis that one is a human being. They include the right to life, freedom from discrimination, freedom of movement and the right to marry and raise a family. These rights are natural because they form part of the truthfulness and uphold the dignity of a person as a human being.

The Universal Declaration on Human Rights, the Kenya Constitution and Laws of Kenya together with other international treaties guarantee human rights. Below are some of the rights contained in these treaties that easily apply to issues of HIV and AIDS:

i. The right to non-discrimination and stigmatization
ii. The right to life
iii. The right to freedom of movement
iv. The right to privacy
v. The right to freedom of opinion and expression and the right to freely receive and impart information
vi. The right to freedom of assembly and association
vii. The right to marry and found a family
viii. The rights of children

See Appendix 6 for further details

Activity 3: Understanding legal rights

- Now that the participants understand what human rights are, ask them the following:
  - What is the meaning of legal rights? (Give examples of legal rights).
  - Who provides or formulates these legal rights?
- Write down the answers while leading the responses on examples of legal rights by pointing to different laws like criminal law (rights of accused), legal rights in marriage, and legal rights in succession.

Facilitator's notes

Explain that a legal right is an entitlement, privilege, immunity or freedom recognized and provided for by laws which are formulated and enacted by parliament to govern the country. Below are some of the laws that expound further what various legal rights entail.

Rights under Criminal Law: These are rights under laws relating to crimes, which are provided for primarily in the Penal Code and the Criminal Procedure Code. Examples of such rights include the right of an accused person to be presumed innocent until proven guilty (it must be proved that one has committed a crime); the right of an accused person to remain silent in the face of accusation of criminal conduct; the rights of a person who has been accused of a criminal offence not to be compelled to give incriminating evidence, that is, evidence that tends to show that one committed the crime with which he/she has been charged and; the right of an accused person to be represented by a lawyer in certain serious criminal cases, such as murder and manslaughter.

Rights under Family Law: There are a number of laws governing marital and family relationships, including the Marriage Act, the African Marriage and Divorce Act, the Matrimonial Causes Act, the English Married Women's Property Act and Common Law. Under these laws, and others, there exist a variety of legal rights on matters, including right to live in and enjoy the matrimonial home, conjugal rights of spouses and right and duty of care between spouses.

Legal rights under the Law of Succession: In a situation where a person dies without having written a will, the law requires that the deceased's next of kin apply to court to be granted what is known as "letters of administration" to permit him or her to administer the deceased person's property, including distribution of property among those who are entitled to inherit. Traditional customs are recognized, even on matters concerning ownership, distribution and use of family agricultural land of a deceased person, but only if the customary rules are not repugnant (opposed) to justice and morality.

Therefore, any traditional custom that allows a widow to be thrown out of her deceased husband's land or to be prevented from using that land, even if she does not have children, would be considered repugnant to justice and morality and therefore, null and void. Any act in perpetration of such a customary rule would be considered in law as a punishable crime.

It should also be explained that where a man has no wife and no children and dies without having written a will, Cap. 160 provides the order of priority in which property is to be

shared in Section 39 – first by the deceased's father and if father is dead, by mother. If there are no surviving parents, by brothers and sisters and any child or children of deceased's half brothers and half sisters, in equal shares. If there are no brothers and sisters and children of half brothers and sisters, property shall be shared by half brothers and half sisters and any child or children of the deceased's half brothers and half sisters in equal shares. If none of the above exist, property shall be shared by the closest surviving relatives in equal shares. If there are no relatives at all, property reverts to the state.

Rights under contract laws: Generally, contract laws are laws that govern agreements that people have freely entered into. Such agreements include sale agreements, insurance agreements and employment agreements. Contract laws are contained in the Law of Contract Act - a number of statutes governing certain transactions (for instance Insurance Act and Company Act), laws governing certain contractual relationships (for example, the Employment Act), laws governing sale of goods (Sale of Good Act), Common Law governing contractual relationships, and Case Law on a variety of contractual relationships. Basically, the Law of Contract requires that where two parties have freely entered into an agreement, they must honour their part of the agreement. However, often, some parties fail to do so. For example, some insurance companies deny benefits in the case of AIDS-related illnesses or deaths.

Rights under land law(s): Land laws are laws governing acquisition, ownership, use and disposal of land. It is important for participants to be well acquainted with land laws because land is a very important resource and in relation to HIV and AIDS, many disputes have arisen over land especially concerning acquisition (where in some cases husbands deny their wives opportunity to own land), ownership, use (where wives and widows are denied a chance to utilize land owned by their husbands) and disposal (sale, transfer and/or giving for free) of land.

SESSION 5.2: Reproductive health rights in relation to HIV and AIDS

Objective

By the end of the session, participants should be able to understand reproductive rights in relation to HIV and AIDS.

Duration: 45 minutes

Materials

- Large sheets of white chart paper (at least three sheets per participants)
- Sets of felt pens in red, blue, green, and black
- Masking tape
- Scissors

Method

Group activity, plenary session and lecture

Activity 2: Reproductive health rights

- Divide participants into three groups.
- Each group to answer one of the below questions in 10 minutes.
- Ask participants to brainstorm, reflecting on their own communities, and list down answers to the following:
  - » Do girls/women have the same access to reproductive health information as boys/men? If not, what are the reasons? And how does it affect their lives?
  - » Is information about HIV and AIDS available to all persons in the community? If not, where are the gaps?
  - » Do girls or women have a choice as to whom and when they should marry, whether to have or not bear children? And should HIV positive people marry and bear children?
- Call back participants to plenary to report. Allow 10 minutes of discussion on each presentation just to clarify issues, and list down the fundamental issues agreed upon.
- Summarise the responses as in the International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights outlined below.

IPPF's charter

Reproductive health is a state of complete physical, mental and social well-being – not merely the absence of disease or infirmity – in all matters relating to the reproductive system and to its functions and processes. Reproductive health rights therefore ensure that people are able to have a satisfying and safe sex life, that they are able to reproduce and that they have the freedom to decide if, when and how often to do so. Addressing reproductive health rights of women and girls provides a good platform in reducing vulnerability to sexual and reproductive health problems that include HIV and AIDS. In 1995, IPPF and its 127 member associations approved a Charter on Sexual and Reproductive Rights, based on international human rights instruments. Below is a summary of rights related to HIV and AIDS:

i. The right to life should be invoked to protect women whose lives are currently endangered by pregnancy for example an HIV pregnant mother with a high viral load and low CD4 cell count.
ii. The right to liberty and security of the person should be invoked to protect women currently at risk from female genital mutilation(FGM) or subject to forced pregnancy, sterilization or abortion (FGM can lead to infection).
iii. The right to equality and to be free from all forms of discrimination should be invoked to protect the right of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to sexual and reproductive health.
iv. The right to privacy should be invoked to protect the right of all clients of sexual and

reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers such as HIV or PMTCT counsellors.

v. The right to information and education should be invoked to protect the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.

vi. The right to choose whether or not to marry and to find and plan a family should be invoked to protect all persons against any marriage entered into without the full, free and informed consent of both partners (regardless of HIV status).

vii. The right to decide whether or when to have children should be invoked to protect the right of all persons to reproductive health care services which offer the widest possible range of safe, effective and acceptable methods of fertility regulation, and are accessible, affordable, acceptable and convenient to all users.

viii. The right to health care and health protection should be invoked to protect the right of all persons to the highest possible quality of health care, and the right to be free from traditional practices, which are harmful to health (including access to medication-ARVs and against forced inheritance/cleansing).

ix. The right to be free from torture and ill treatment should be invoked to protect children, women and men from all forms of sexual violence, exploitation and abuse.

Ref: ICPDA, 1994.

SESSION 5.3: Human rights in the context of HIV and AIDS

Objectives

By the end of this session, participants should be able to:

- Identify human rights violations in the community and how they negatively impact on women, widows, PLHIV, orphans and vulnerable children in the context of HIV and AIDS.
- Make participants to understand how human rights abuses fuel the spread of HIV and worsen the impact of AIDS among vulnerable groups of people in the community.
- Identify ways and means of addressing these abuses.

Duration: 1 hour 30 minutes

Materials

Markers, paper, flipchart and copies of Laws of Kenya

Method

Q&A, mini lecture, group activity and plenary session

Activity 1: Human rights violations that fuel spread of HIV and AIDS

- The participants have now been taken through the concept of rights, human rights and legal rights. It's time for them to look back at their own communities and identify the occurrence of violations of rights, particularly on the vulnerable populations and most-at-risk populations, the focus being on how human rights violations contribute to the spread of HIV and make worsen the impact in the community. Remind participants to discuss referring to the basic rights as discussed in Sessions 5.1 and 5.2.
- Divide the participants into four groups.
  - » Group 1: brainstorm on the violation of rights of girls, women and commercial sex workers.
  - » Group 2: brainstorm on the violation of rights of widows and orphans.
  - » Group 3: brainstorm on violation of rights of persons with disabilities.
  - » Group 4: brainstorm on violation of rights of PLHIV.
- For each issue let the participants discuss the following:
  - » Examples of rights violations.
  - » How these violation of rights contribute to spread of HIV.
  - » The mechanisms or solutions that can be effected at the family and community level to stop these violations.
- Call back the participants to report in plenary session their findings. Discuss the responses together ensuring that the points noted below in the facilitator's notes are captured.

Facilitator's notes

Rights abuses, including cases of failure to provide redress for rights abuse and non-realization of the rights increase chances of HIV infection, especially among girls, widows, women, orphans and vulnerable children. An environment in which human rights are respected ensures that vulnerability to HIV and AIDS is reduced, those living with and affected by HIV and AIDS live a life of dignity (without discrimination and stigmatization) and the personal and societal impact of HIV and AIDS is alleviated/minimized.

1. Violation of the rights of girls, women and sex workers

- Cases of girl child defilement leading to HIV infection.
- Early marriage of girls below the age of 18 severely increases young girls' vulnerability to HIV, as they are most likely to be forced into having sexual intercourse with their (usually much older) husbands. Young girls have softer vaginal membranes, which are more prone to tear, especially on coercion, making them susceptible to HIV and other STIs.
- Gender inequalities, built into economic structures, lead to women having less control and access to economic resources than men. Women and girls living in poverty may

Figure 5.3.1: Right to access HIV information and services by all

adopt behaviour that exposes them to HIV infection, including the exchange of sex for money.
- In most communities women have unequal – and less – access to education and skills training.
- GBV, particularly rape including marital rape, puts women and girls at risk of HIV. The fear of physical violence may also make it difficult for a woman to demand condom use for HIV prevention or disclose HIV status thus leading to more infection and re-infections.
- Despite having knowledge of their spouse's extra-marital sexual interactions, women are often unable to protect themselves due to an imbalance of power within relationships created by economic and emotional dependence.
- Sex workers have limited access to HIV and AIDS information, education and services due to limited access. They are more often victims of sexual violence with men whose HIV status they do not know.

The Children Rights Convention prohibits child abuse that includes defilement and child marriages while the Constitution of Kenya gives women the rights to acquire and own property, rights to live in and enjoy living in their matrimonial home regardless of HIV status (case of Midwa vs Midwa – court of appeal, civil application no. 197 of 2000), outlaws violence against women including GBV. The Kenya laws prohibit extra marital affairs and this is identified as grounds for divorce.

2. Violation of the rights of widows and orphans
- Widows have been disinherited and thrown out of their matrimonial homes especially when they refuse to be inherited upon their husband's death. Subsequently their land and property are taken away by their in-laws confining them and their children to destitution.
- Early marriages and child labour.

3. Violations of rights of PLHIV
- Cases of discrimination at work places are common.
- They are cases where they have been denied travel to some countries.
- Cases of breach of confidentiality and right to privacy of their HIV status leading to their being laid off in employment. (J.A.O. vs. Home Park Caterers Ltd. and two Others Nairobi High Court Civil Case No. 38 of 2003). J.A.O. (real name withheld), sued the respondents, a medical doctor, among others, for disclosing her HIV-positive status to her employer and releasing her medical report to the employer, in breach of the doctor's duty to confidentiality, where she was subsequently dismissed from employment. She maintained that the doctor disclosed her HIV-positive status to her employer without her knowledge or consent and thereby, violated her constitutional (human rights) to privacy and confidentiality, as a result of which she suffered dismissal from employment. She also claimed that her dismissal from work due to her HIV-positive status was in breach of her human right to freedom from discrimination. She sought relief to redress the violations of her human rights. In an application by the doctor's lawyer to have the case struck out on the basis that J.A.O. did not have a cause of action, the court ruled that J.A.O. had a good case and declined to dismiss the case as the doctors, through his lawyer, requested.
- Some churches have been known to demand "HIV and AIDS free" certificates before they can solemnize marriages.
- Some health facilities have been known to be hostile to PLHIV thereby denying them the chance to access life saving ARVs as well as information on positive living.
- Denial to bear children.

4. Violations of rights of people living with disabilities

Few health facilities exist that can cater for the special needs of this category of people.
- Communication between the deaf and health care providers is impaired.
- Access to information by the blind is difficult since there are few or no publications that have been written in Braille.
- There are very few or no HIV and AIDS programmes for people with intellectual disabilities. Some have even been the target of sexual rituals of some HIV positive persons with a false belief that, sex with a person with a disability is a cure for HIV and AIDS.

Activity 2: Women's property rights and HIV and AIDS

- Ask participants the following questions and write down the answers on the flipchart.
  - » Who owns land in your community? Is it the husband or is it the wife?
  - » Who inherits land when the father dies?
  - » Are girls allowed to inherit family land or property?
  - » Is a wife allowed to buy or dispose off land?
  - » When a husband dies, are there cases where the widow is dispossessed of her land or property, and why?
  - » Who made these rules about ownership and inheritance of land or property in the community?
- Allow for brief discussions on each of the responses/answers but remind participants that the focus of the session is what is actually happening in the wider traditional community set up.

Factors that contribute to women's property rights violations

A number of factors contribute to women's property rights violations. Key among them are discriminatory laws and customs, biased attitudes, unresponsive authorities, and ineffective courts. In addition, women face many obstacles to claiming their property rights, including low levels of awareness of their rights, the time and expense of pursuing claims, and the social stigma of being considered greedy or traitors to culture if they assert their rights.

Figure 5.3.2: Women have a right to own and inherit property. Violation of this right and others hurts development

Activity 3: The effects of property rights violations

- Divide participants into three groups and let them brainstorm and discuss on the topics below:
  - » The consequences of property rights violations in relation to HIV and AIDS.
  - » The effects of property rights violations on women and general development of the family/ community/country.
  - » What the community members/individuals can do to remedy violations of women's property rights.
- Call the participants to plenary and let each group give their presentation.
- Review the findings.

Facilitator's notes

The consequences of property rights violations in relation to HIV and AIDS epidemic
Property rights violations keep women unequal and dependent on men, and can even threaten their survival. After suffering property rights violations, women end up impoverished, living in squalor, and at risk for violence and disease. In communities with high HIV and AIDS rates, there will be many more young widows in the coming years than would have been the case without AIDS. These women, already disadvantaged by stigma and discrimination, will be gravely threatened by property rights violations.

As they struggle to care for their families, the least they should count on is a roof over their heads and keeping their possessions. To attain some relief from the agony of AIDS, they will need every last asset to exchange against the cost of medical care and basic survival expenses. Many women have no such luck.

Do women's property rights violations hurt development?
Yes. Gender inequality hinders development. Women's insecure property ownership contribute to low agricultural production, food shortages, underemployment, and poverty.

What can communities/individuals do to prevent and remedy violations of women's property rights?
- Address women's housing problems, especially those of widows, divorced or separated women, mothers, and HIV and AIDS affected women.
- Lobby for government to enforce legislations that protect women's rights.
- Lobby for public awareness campaigns to inform the people about women's equal property rights.
- Lobby for government or programme implementers to include in HIV and AIDS programmes information about the link between property rights violations and, HIV and AIDS.

Wrap up session by explaining that the government has put in mechanisms in addressing issues of HIV and AIDS as contained in the HIV and AIDS Prevention Act 2006.

Provisions of the HIV and AIDS Prevention Act 2006
The principal object of the HIV and AIDS Prevention Act 2006 is to provide a legal framework for the prevention, management and control of the HIV and AIDS scourge. It contains measures for the promotion of public health and the protection, treatment, care and support for persons infected or at risk of HIV and AIDS infection. It also asserts the rights of persons with actual, perceived or suspected HIV status to non discrimination. The act is the product of a Task Force of multi-sectoral representation whose prime mandate was to address the legal issues relating to the HIV and AIDS scourge.

PART I names the Act and provides for its commencement. It defines the words and expressions used in the Act and sets out the object and purpose of the Act.

PART II provides for the provision of HIV and AIDS education and information to the public with particular emphasis on the provision of education in schools, in the workplace, in communities and as a health care service.

PART III prescribes the safe practices and procedures to be followed in relation to the donation of tissue and blood. It empowers the Minister of Health to issue guidelines on surgical and other similar procedures and penalizes the use of unsafe practices or procedures.

PART IV deals with the testing, screening and access to healthcare services by those living with and affected by HIV and AIDS. **Clauses 13 and 14** prohibit compulsory testing and testing without consent except in the few instances authorised by the Act. **Clauses 15 and 16** require the provision of testing facilities and approved testing centres while **clause 17** emphasizes the need for pre-test and post-test counselling.

PART V deals with confidentiality of HIV and AIDS records and information. It seeks to uphold the principle of confidentiality between a healthcare provider and the patient

but takes note of the grave situations posed by the danger of transmitting HIV and AIDS to innocent people. In this regard **Clause 22** sets out the circumstances under which the result of an HIV test or any related assessments may be disclosed.

PART VI deals with the transmission of HIV and AIDS. It places an obligation on a PLHIV to take reasonable measures to prevent the transmission of the virus and criminalizes the deliberate transmission of the virus. Deliberate infection with HIV virus is also addressed as a specific offence with recommended penalty.

PART VII sets up an Equity Tribunal to hear and determine complaints and appeals arising under the Act. This is to achieve an administratively faster and more efficient way of adjudicating disputes in view of the fact that HIV and AIDS is a national disaster. The jurisdiction of the Tribunal excludes criminal jurisdiction but the Tribunal shall, like any other tribunal, be subject to the court system.
PART VIII outlaws discriminatory acts and practices against people with HIV and AIDS. **Clause 31** prohibits discrimination in the workplace. **Clause 32** prohibits discrimination in schools and other educational institutions. **Clause 34** prohibits inhibition from contesting an elective or public office on the basis of a person's HIV and AIDS status. **Clause 35** prohibits the exclusion from credit and insurance services and seeks to facilitate the provision of medical and life insurance cover for HIV positive persons in consideration of the payment of a higher premium. **Clause 36** prohibits discrimination in health institutions. **Clause 37** prohibits the denial of burial services on the basis of a person's HIV status.

PART IX deals with biomedical research on HIV and AIDS and seeks to prevent the exploitation of Kenyan citizens by researchers. The subject of the research must give consent to the research and the research must be carried out in conformity with the law.

PART X sets out a number of miscellaneous provisions. Amongst them is the requirement that the provisions of the Act should prevail in case of inconsistency with any other written law.

Figure 5.3.3: GBV is a violation of human rights. Women living with HIV need care and support not battering and expulsion from their matrimonial homes.

MODULE 6: CULTURE, NORMS AND VALUES

Overview

Addressing HIV and AIDS within the cultural context is the main objective of this module. In many cultures, society's expectations for male and female sexual roles are markedly different. For instance, men are expected to seek sexual variety and quantity, control/dictate the terms and conditions of sexual encounter, while women are expected to be monogamous, uninformed, unaware of and even ashamed to talk about sexual matters. Sex remains the primary source of HIV infection accounting for majority of new infections in both men and women. Teaching sexual negotiation skills should be accompanied by efforts to raise awareness of the legitimacy of challenging sexual gender stereotypes and not accepting them as norms. Sexual education and negotiation skills can equip both men and women with the skills needed to find alternatives to harmful stereotypes.

Harmful cultural practices such as widowhood-related rituals, sexual cleansing and FGM heighten the risk of HIV transmission. These practices are often justified in the name of cultural values and traditions. There is no doubt that cultural values and traditions are important to community identities, however it is important to realize that they cannot be continued at the cost of the right to health of the individual.

Goal

To built the capacity of participants to understand, identify and suggest corrective measures on some of the cultural norms and practices prevalent in their communities, which contribute to the spread of HIV and AIDS and also violate basic rights.

Objectives

By the end of this module, participants should be able to:

- Understand the linkages between culture, gender and HIV and AIDS.
- Identify some of the harmful cultural practices and traditions.
- Identify and develop community responses to cultural practices that violate basic human rights.

Module duration: 2 hours

SESSION 6.1: What is culture?

Objectives

By the end of the session participants should be able to:

- Define and describe aspects of their culture.
- Identify personal decisions and behaviour that are determined by their culture.

Duration: 30 minutes

Materials

Flipchart, paper and markers

Method

Q&A session and mini lecture

Activity 1: Definition of culture

- Introduce the word culture and negotiate equivalent words from their languages.
- In plenary ask participants to describe culture.
- Give the participants a formal definition of the term culture and discuss the three different types of culture.

Facilitator's notes

Patriarchal culture in most communities in Kenya has heavily influenced the legal systems, governance structures and value systems that uphold the unequal status of girls and women. A number of commonly observed traditional practices are now recognized as being directly responsible for the spread of HIV and AIDS. Widow inheritance, widow cleansing, wife sharing, wife exchanging with land or cattle, and polygamy are some of the prominent cultural practices, which are stacked against women's health because the parties involved do not test for HIV before engaging in the practices. Addressing harmful cultural practices is therefore important in preventing new infections and promoting care and support of HIV infected and affected persons.

Culture refers to the system of shared beliefs, values, customs, behaviours, and artefacts that members of a society use to cope with their world and with one another, and that are transmitted from generation to generation through learning and/or socialization.

- **Descriptive culture:** Through which the community is informed and instructed about the dictates of the habitat through oral history, beliefs and practices, technology and/or material culture.
- **Prescriptive culture:** Regulates and controls behaviour of members of the community through customs and social interdictions.
- **Expressive culture:** Where group experience and aspirations are transmitted by an intricate web of communication, visual and performing arts, sports, games, tales, riddles, dirges, song and dance.

Activity 2: Exploring aspects of culture

- Seat participants in a circle.
- Ask any one of them to talk for two minutes about five admirable things about his/her culture.
- Ask the rest of the participants if they agree with the five things mentioned and whether anyone would like to add to or modify what was said.
- Ask participants how they determine a person's tribe. What are the differences between persons from two different tribes? Pick two tribes that they are familiar with or close to (neighbours).
- Through questions, direct the discussion so that people look for differences in appearance, attitudes and beliefs, cuisine, lifestyle, religion, skills, social organization, and any others they would like to add.
- List each category of differences on separate flipcharts.
- Allow the discussion adequate time to cover many different categories and list many differences by category on the flipcharts.
- Next, focus on a single flipchart topic (food, beliefs, lifestyle, pride, cultural practices etc.), choosing one that has relatively more points on it.
- Take each point listed on the flipchart as a difference between the two tribes, and ask if there is anyone in the room who feels he/she does not share that trait.
- Post the flipcharts on the walls around the room and allow participants to walk around and review each topic area.
- Ask participants to help develop a master list of characteristics and traits that are uniquely and universally for their tribe. Ensure through provocative questioning that everyone agrees that the final list is unique and universal and shared with everyone in the room.
- In case all the participants are from the same tribe or community, ask for volunteers who understand and can identify characteristics and traits from another community that they know of.

Facilitator's notes

Through this discussion, identify a unique attribute or trait that is not shared by all people from that particular tribe. Explain to the participants that:

- The combination of universal traits that make a community unique in the way it thinks, lives, eats, interacts and behaves is called culture.
- Culture is determined by the community and has powerful influence over community members.
- Culture predetermines certain actions and beliefs and takes them out of individual choice.

SESSION 6.2: Culture helps and harms

Objectives

By the end of the session participants should be able to:

- Analyze useful aspects of their culture.
- Demonstrate an understanding of how cultural values, beliefs and norms impact on a society's perceptions about sexuality, gender roles and their linkage with HIV infection.
- Understand and challenge the relevance of certain cultural practices, beliefs and value systems in the era of HIV and AIDS.

Duration: 1 hour 30 minutes

Materials

- Flipcharts and markers
- Prepare flipcharts by writing in large letters at the top of each one a single Kenyan cultural characteristic or norm. Use the cultural characteristics defined by participants in the previous session.
- Categories covered should include beliefs, attitudes, food, health, lifestyle, and marriage. There should not be more than 20 pieces of flipcharts.

Activity 1: Culture and norms

- Introduce the idea of a cultural norm. Explain that a norm is a standard of behaviour that is expected to be followed by most people. It is different from a rule in that it is a guideline rather than a law.
- Ask participants which came first, the people or the culture? Provoke thinking by asking questions like:
  - » What were people like before there was a culture?
  - » Who decides what the culture should be?
  - » In your community, do you know of any cultural norm that used to be followed but is not anymore?
  - » Is there any cultural norm you follow now that was not followed before?
  - » Under what circumstances does it become necessary to follow a cultural norm? Ask for examples.
- Develop the argument that culture responds to human needs. For example, in societies where there are more women than men, sometimes men are allowed to marry more than one woman.
- Ask: When a norm is made, does it benefit all equally? Ask for examples.
- Provoke thinking by asking:
  - » Is a married man or woman affected, as much as an unmarried male or female youth by a cultural norm that prescribes how marriages should happen and between whom?
  - » Is a man affected as much as a woman by norms that dictate a woman's role in a family?
  - » Who is allowed to make a new cultural norm?
  - » What is the process by which a new norm is made?
  - » When was the last time a new norm was made? Ask for examples.
  - » Do women and men have equal say or authority in the creation or discussion of cultural norms or norms?

Activity 2: Why culture and norms?

- Divide participants into groups of three.
- Give each group a flipchart with a written cultural norm.
- Give them five minutes to reflect upon the norm using the following guiding questions:
  - » Why does this norm exist? Who made it?
  - » Whom does it help? Whom does it hinder?
  - » How does society benefit as a whole from this norm?
  - » Are any sections or individuals of society harmed by this norm? Who and how?
  - » Under what circumstances is it likely that this norm would be changed?
  - » What are the health risks involved in practicing this norms?
- Based on their discussions, ask each group to decide whether they consider the norm harmful overall or beneficial overall. Post two signs, one that reads "Harms" and another that reads "Benefits." Give a few minutes for each group to present its points for or against the norm. Post the norm under the appropriate sign "Harms" or "Benefits."
- Conduct the above steps using different norms from your list until the session is over.

Facilitator's notes

Whereas a lot of HIV and AIDS programmes have been put in place to combat the spread of HIV, it is critical to explore and understand some of the underlying cultural practices, customs and cultural belief systems including norms and values that influence HIV infection. This session seeks to bring to the fore aspects of culture that need to be addressed for the success of community HIV and AIDS BCC programmes.

Key information points

- A cultural norm is a guideline that most people are generally expected to follow.
- People make their culture in response to their society's needs and preferences.
- Sometimes a cultural norm remains even though the reason it was made is not valid anymore.
- Not all norms benefit all members of a community equally.
- A norm that benefits many more people than it harms is generally useful to retain. (Can use the example of male circumcision. It has been proven that uncircumcised heterosexual males have a higher chance of contracting HIV than circumcised ones).

Other key issues for consideration include:

- Culture, norms and unequal power in sexual relationships and how these impact on HIV transmission.
- Norms of masculinity that inhibit knowledge and support for decision making, and promote aggression and risk taking.
- Norms of femininity that encourage docility and submission and inhibit open discussion on matters of sexuality and sexual and reproductive health generally.
- Gender stereotypes that are reinforced by culture/cultural beliefs and value systems.

Figure 6.2.1: Wife inheritance is one of the harmful cultural practices that fuel the spread of HIV

Activity 3: Traditional practices that are harmful

- Ask participants to identify some of the cultural and traditional practices in their community, which they think are harmful and expose people to HIV infection. Review the responses making sure that some of the cultural practices and customs listed below are included.
- List down the answers and ask the participants to suggest solutions that the communities can adopt to eradicate some of these harmful cultural practices.

Facilitator's notes

Traditional methods of male circumcision
Male circumcision is practiced in many communities in Kenya, however the traditional methods where mass circumcision is conducted using one unsterilized knife poses the risk of passing the HIV virus from one initiate to another.

Female genital cutting/mutilation
FGM or Female Genital Cutting (FGC) is practiced in a large number of countries and cultures including Kenya. Women and girls undergo mutilating operations on their external genitalia in which many suffer permanent and irreversible health damage. FGC/FGM places girls and women at increased risk of HIV infection through several routes:

- Firstly, the use of unsterilized instruments, such as razors or knives, to carry out the procedure among a number of girls risks passing the virus from one girl to the next.
- Secondly, FGM renders the female genitals more likely to tear during intercourse. In cases of sewing up of the vaginal entrance, penetration during sexual intercourse is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV positive partner much more likely.
- Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner's advances and lead him to a more violent approach to sex or to engage in sexual practices with his wife (such as unprotected anal intercourse) which might place her at increased risk of HIV infection. The perpetuation of this practice is a clear example of gender-based discrimination and a violation of the right to health.

Wife inheritance and cleansing rituals
These are customary practices common in some communities in Kenya. In the olden days, the inheritor, was strictly expected to come from within the clan and next of kin to the dead husband i.e. his brothers or cousins, but this is no longer the case as they can be inherited by those who are outside the clan. It therefore means that if the late husband died of HIV and AIDS related illnesses, then if the surviving wife is HIV positive, the inheritor will be infected or vice versa and they will also subsequently infect their spouses.

In some forms of ritual cleansing, a widow has to have sex with a social outcast who is paid by the dead husband's family, supposedly to cleanse the woman of her dead husband's evil spirits. In both practices, condoms are seldom used. Wife inheritance and ritual cleansing are closely related to women's property rights in that many widows are not allowed to stay in their homes or on their land unless they succumb to these practices. These practices are sometimes said to be protective of women since the women gain the legitimacy and security of being in a male-headed household and are "purified" of evil spirits.

Polygamy
The traditional practice of polygamy allows husbands to have more than one wife. In polygamous marriage sexual contact occurs within marriage between multiple wives and their husband, and in addition to any extra-marital sexual contacts that the spouse may have. There is a risk of HIV infection introduced in the marriage through the spouse's extra-marital sexual contacts or where a new wife who is already HIV positive enters the polygamous union.

Wife sharing
Among some communities in Kenya, men of the same age group will let their wives sleep with their visitor who is an age-mate as a sign of respect. This is a practice that predisposes them to risk of contracting STIs and HIV which can easily spread in the entire age group.

MODULE 7: STIGMA AND DISCRIMINATION

Overview

Stigma and discrimination related to HIV and AIDS are almost as old as the pandemic itself, and exist in the family and community settings. Discrimination against PLHIV leaves them with poor quality care. It frightens away potential clients in need of care, and undermines effective HIV prevention efforts by limiting individuals' access to and use of health care services. As HIV and AIDS programmes become increasingly available, access to and use of the lifesaving services will depend on how we welcome and respect the rights of PLHIV.

Module objectives

By the end of this module, participants should be able to:

- Define stigma and discrimination in the context of HIV and AIDS.
- Identify the different forms of stigma.
- Identify the causes, effects and how to cope with stigma and discrimination.
- Understand that stigma and discrimination is a violation of human rights.

Duration: 3 hours 45 minutes

SESSION 7.1: Introduction to stigma and discrimination

Objectives

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

- Define the terms stigma and discrimination.
- Identify manifestations or causes of HIV and AIDS related stigma and discrimination.

Duration: 30 minutes

Materials

Flipcharts and markers

Activity 1: Definitions of stigma, discrimination and vulnerability

Begin the session by asking participants to brainstorm on the definitions of stigma, discrimination and vulnerability. Note responses on a flipchart. Summarize and provide the definitions as detailed in the facilitator's notes.

Facilitator's notes

What is stigma?

- Stigma is an attitude that makes people feel low in esteem due to a condition in them, circumstance or situation that they are facing. It is making someone feel hated, worthless, unwelcome or unaccepted due to an attribute they have or a condition such as HIV and AIDS.
- **Stigma** is an accusation, labelling or reference that disgraces or hurts a person. Stigma literary means a mark or blemish on someone.
- A significantly discrediting attribute that reduces the bearer from a whole and usual person to a tainted, discounted one. For instance, people suffering from leprosy were completely isolated from the rest of the community for fear of infecting others.

AIDS-related stigma refers to the prejudice and discrimination directed at PLHIV and the groups and communities that they are associated with. It can result in PLHIV being rejected from their community, shunned, discriminated against or even physically hurt.

UN Secretary-General Ban Ki Moon states: *"Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."*

What is discrimination?

- It is the negative reaction triggered by stigma.
- Treating a person or group differently (usually worse) from others.
- Discrimination is isolating people because of an attribute or a condition in them, a circumstance or a situation that they are facing. It is treating people unfairly, with bias, and in a manner that indicate they are not tolerated.

Vulnerability refers to the ease with which one can be hurt, harmed or attacked.

Activity 2: Causes of stigma

- Ask participants to pair up.
- Distribute flash cards to all the pairs.
- Ask them to fold the flash card into two.
- Inform the participants that they are going to jointly draw, colour and send a get-well soon card to patients in hospital, so their artistic skills should be put to practice.
- The patients are bed ridden for different opportunistic infections that are as result of their HIV+ status.
- There are four patients:
  - » Trevor, 35 years, got infected through adultery.
  - » Trina, 12 years, got infected after being gang raped.
  - » Troy, 9 years got infected during birth.
  - » Trish, 24 years, got infected when injecting drugs.
- Ask the participants to choose whom they are going to send to a get-well soon card.
- Give the participants 25 minutes to come up with the cards.
- Write the patients names on the cards in bold letters separately and stick them up on the wall.
- Now ask the participants to pick masking tape and stick their cards below the patient they would like to receive the card.
- Note the small discussions and reaction between pairs as they start putting up their cards. Analyse the number of cards per patient.
- Ask the participants to do a gallery walk and read the messages written to the patients.
- Ask the participant to give their reasons why they sent to which patient and not the other.
- Note the responses on a flip chart.
- Ask the participants to raise their hand if they would invite the boy for a holiday to their home.
- Ask the ones who wouldn't give reasons why and note their responses on a flipchart.
- Summarize the session by giving the following information.

Why PLHIV are stigmatized

Fear of getting infected coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV and AIDS. Factors that contribute to HIV and AIDS-related stigma include:

- Ignorance/misconception and luck of knowledge about the disease.
- Fear of contamination, infection and the burden of taking care of PLHIV.
- HIV and AIDS is associated with personal irresponsibility and "bad behaviour" such as homosexuality, drug addiction, prostitution or prostitution and adultery that are stigmatized in many societies.
- HIV infection is a result of irresponsible behaviour such as having sex without using a condom or sharing unsterilized needles when taking drugs.
- HIV and AIDS is a life-threatening disease.
- Most people become infected with HIV through sex. Sexually transmitted diseases are always highly stigmatized.

Negative statements associated with HIV and AIDS

From the early stages in the AIDS epidemic, a series of powerful images were used that reinforced and legitimized stigmatization.

- AIDS kills
- AIDS is a death sentence
- AIDS is a slow puncture
- People who have HIV have nothing to live for
- Youth are most infected
- People who have AIDS deserve it
- HIV as punishment from God (for immoral behaviour)
- HIV is a crime (in relation to innocent and guilty victims)
- HIV as war (in relation to a virus which must be fought)
- Some people believe AIDS is a curse from God or witches
- Belief that it can be acquired through the sharing of household items and touching of an infected person
- Belief that healthy looking people cannot have HIV
- Religious or moral beliefs that HIV infection is a result of immorality and promiscuity
- The fact that HIV is incurable

SESSION 7.2: Naming the problem

Objectives

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

- Identify stigma as a problem.
- Connect to stigma on personal emotional level.
- Describe their own experience of stigma.

Duration: 30 minutes

Materials

Markers, flipcharts, masking tapes, note books, pens, chalks, card boards, pictures, facts sheets and character descriptions on cards.

Sample picture depictions

1. Picture one: Isolation in classrooms
Pupils have decided not to sit by a particular student because he looks lean and sick. The isolated student feels dejected because he has realized that no one wants to sit by him. This is happening because the students are not sure of what disease this boy is carrying and therefore do not want to risk getting close to him. This happens in our communities.

Figure 7.2.1: Discrimination in school.

2. Picture two: Eviction
A landlord evicts a family from their house on suspicion that a family member is HIV positive. He fears another tenant can get infected and he will be blamed. It happens in my community. Many people are ejected because of their HIV status.

Figure 7.2.2: Eviction from residence for fear of spreading the disease to other tenants

Activity 1: Pictures scenarios

- Put several pictures on the wall that depict different stigma scenarios.
- Divide participants into groups of four or five depending on the number of participants.
- Each group first looks at the pictures on the wall and then picks one picture to discuss.
- The groups should answer the following questions:
  - » What is happening in the picture in relation to stigma?
  - » Why is it happening?
  - » Does this happen in your community?

Activity 2: Reflection on our experience of being stigmatized

- Ask participants to find a quiet space alone and think back to a time in their life when they felt lonely or isolated.
- After a few minutes they share their experiences in pairs and then return to the large group for sharing and processing.
- Based on the reflections, find out from the participants about lessons learnt from the exercise ensuring that the following points in the facilitator's notes are discussed.
- Summarize the effects of stigma as portrayed by the participants. The exercise is supposed to make participants feel stigmatized and reveal how bad it is to stigmatize people no matter what the circumstances.

Stigma scenarios
"I was a student of University of Nairobi and a member of the campus swimming team. In my third year, I got infected with TB. I subsequently lost a lot of weight. I was advised to go for HTC. But as it turned out, I was HIV negative. After recovering from TB, I reverted back to the sport I loved – swimming. However, unlike before I got sick, I could not enjoy the swim with my team mates. Fellow students would leave the pool when I went in for a swim. They believed I was HIV positive and could get infected through sharing the pool with me."

"My father got out of jail after serving 10 years for robbery with violence. He is a reformed man who works hard on our half acre farm to feed us. However, my sisters and I cannot get suitors because the community or society we live in, believe we are a bad seed. No one allows their sons to have a relationship with us because they might have 'thieves' in their families as grandchildren."

"I come from a poor family. My father is a farmer who worked hard so that I could get university education. At the college, I was not evaluated on the merits of my academics, but on the social and economic background. People laughed at my clothes and shoes. And they did not hide their ridicule, all to shame me."

"It was shock and disbelief, especially to my family, when I tested HIV positive. I was ostracized."

Facilitator's notes

Reflections

- The old memories came back strong and fresh.
- It was not easy to forget because I was hurt.
- It is difficult trying to share that experience.
- It is traumatizing.
- Discrimination and stigma are all around us.
- There is prejudice everywhere.
- Some strong feelings make you an advocate to help others.
- It makes me understand what others go through and makes me strong.
- It makes one adjust to situations and helps others in similar positions.
- It makes me more accommodating.
- It makes me recognize problems and deal with them when they arrive.
- We learn best when we experience it ourselves.
- We need to work on negative attitudes to make a positive impact.

SESSION 7.3: Effects of stigma and discrimination

Objective

By the end of the session, participants should be able to identify the effects of stigma related HIV and AIDS

Duration: 30 minutes

Activity 1: Effects of stigma and discrimination

- Using the questions below ask, participants to identify the effects of stigma and discrimination giving examples they can derive from their communities. Write the responses on a flipchart.
- What happens to a person who is infected with HIV when he is sacked from employment?
- What happens to a woman who has been disinherited by her family once the husband dies and she is HIV positive?
- What is the reaction of a PLWHIV when the community or family considers them as outcasts?
- What kind of attention do PLWHA's get in health centres/clinic/hospitals?
- Review the responses and using the notes below expound on the effects of stigma and discrimination.

International Centre for Research on Women states, "The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. This hinders, in no small way, efforts at stemming the epidemic. It complicates decisions about testing, disclosure of status, and ability to negotiate prevention behaviours, including use of family planning services."

Possible consequences of stigma and discrimination include:
- Loss of income/livelihood
- Loss of marriage and childbearing options
- Poor care within the health sector
- Withdrawal of care giving at home
- Loss of hope and feelings of worthlessness
- Loss of reputation
- Prevents people from seeking treatment
- Prevents people from acknowledging HIV status
- Discourages open discussion on the disease
- Makes PLHIV shun health care services
- Makes PLHIV and those affected people feel guilty and ashamed

SESSION 7.4: Types of stigma

Objectives

By the end of the session participants should be able to understand the different types of HIV and AIDS related stigma.

Duration: 30 minutes

Materials

Prepared flipcharts with definitions of types of stigma

Method

Presentations and Q&A session

Activity1: Different types of stigma

- Proceed with the presentation and ensure that it is an interactive session that entails posing and elaboration of points not well understood.
- The use of examples will enhance the presentation.
- Ask for questions and clarifications at the end of the presentation.

Facilitator's notes

Different types of stigma
In HIV and AIDS, stigma could be group into four major types as discussed below.

Self or internal stigma: This is stigma that PLHIV have towards themselves. It is as a result of developing a negative feeling towards self. People with HIV think about themselves and how they believe that the public perceives someone with HIV. It includes feelings of self hatred, shame and blame. PLHIV may impose stigmatizing beliefs and actions on themselves such as:
- Hiding illness or concerns from others. PLHIV want to hide from others, behaviour that might have led to infection.
- Avoiding company of friends or family - a person refusing to go to work or to join the family during functions.
- Avoiding HIV services. Most people who have not accepted their HIV positive status may refuse to access treatment or support group that they are referred to.

Felt stigma: These are attitudes, perceptions or feelings that people have towards PLHIV. They include:
- Feelings of anger toward the HIV positive people or being afraid of them. There are documented experiences where families have sent away their kin because they are HIV positive. And even people who have been killed by their relatives because they are a "bother".
- Feelings that HIV positive person should be separated from others to protect public health.
- Making their names made public.

These feelings are always accompanied by statements such as:
- "They got what they deserve"
- "They should be locked up somewhere"
- "They should be left to die"

Enacted stigma: This comprises of action(s) directed towards HIV positive people such as:
- Name calling, insulting, gossiping and rumour mongering about PLHIV.
- Exclusion from responsibilities, social gatherings and family matters.
- Victimization (punishing people for the mistakes of others).
- Refusal to offer treatment, care and support, HIV testing without consent and lack of confidentiality for PLHIV.

Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many PLHIV do not get to choose how, when and to whom to disclose their HIV status. Studies by the WHO found that 34 percent of respondents reported breaches of confidentiality by health workers.

Associated stigma: this is the stigma that is directed towards family and friends of PLHIV or those suffering from illness associated with HIV and AIDS. They include:
- Forbidding one's children from visiting or associating with the children of PLHIV.
- Refusing to buying food from vendors perceived as being HIV positive.
- Avoiding sharing of cups, clothes with PLHIV for fear of getting infected.
- Associating illnesses such as coughs and skin problems with HIV and AIDS.

There are also experiences of associated stigma like people refusing to visit certain health facilities which are known to treat HIV positive people, and families refusing to accept gifts such as farm produce from a neighbour' whose child is HIV positive.

SESSION 7.5: Self-stigma and self-esteem

Objectives

By the end of the session, participants should be able to:
- Understand the meaning of positive self-esteem.
- Look at how self-esteem develops, is built, and is damaged.
- Consider the role that self-esteem plays in the choices and decisions we make.

Duration: 1 hour

Materials

- Flipcharts and markers, two pieces of paper and a pen/pencil for each participant
- Three cards with text as indicated below:

Card #1: "Self-esteem" is a word used to describe how people feel about themselves. How people feel about themselves influences their actions toward others and what they accomplish in life. People with high self-esteem know that they deserve, love and respect, and they are confident in their abilities. People with high self-esteem are able to work hard, set goals, and achieve what they set out to do.

Card #2: When I get a poor mark, I accept it and work harder. If a boy I like doesn't like me, I am sad about it, but I spend more time with my friends and after a while, I feel better.

Card #3: I do not accept when I get a poor mark. I blame the teacher for giving it to me. If a boy I like doesn't like me, I become depressed and begin to flirt with other boys to try to make him feel jealous.

Activity 1: What is self-esteem?

- Divide the participants into groups of three or four people. Ask them to define "self-esteem."
- After a few minutes, hand out the three cards to three volunteers.
- Ask the first volunteer to read Card #1.
- Ask participants if they understood what was read, if they have any questions or additions.
- Ask the second and third volunteers to read their cards.
- Ask the groups which of these two people has high (or positive) self-esteem and which has low (or negative) self-esteem.
- Continue the discussion for a few minutes with additional questions and by following up on points made by the group. How has their self-esteem affected how they handle situations?
- Discuss the situations and choices in detail and how self-esteem led to different choices.

Activity 2: Developing self-esteem

- Brainstorm with the group and write responses on a flipchart on how they think self-esteem is developed?
- Encourage general discussion around the points listed on the flipchart sheet.
- Give each participant two pieces of paper. Ask them to pretend that one piece of paper represents their self-esteem.
- Tell them that their self-esteem can be damaged by negative things or can be built by positive or good things that happen to them.
- Tell them that you are going to read aloud a series of statements. Ask them to tear off a piece of the paper each time you read a statement that affects their self-esteem negatively. They should tear off bigger or smaller pieces based on how much each statement affects their self-esteem.
- Read the following statements one at a time and allow a few seconds between each one for participants to respond as asked:
  - » Your family can afford to send only one child to university. They choose your brother instead of you.
  - » You missed a penalty kick and your teammates say you lost the game for everyone.
  - » Your best friend always competes with you and puts you down.
  - » The school you applied for rejected your application.
  - » Your mother calls you stupid.
  - » You fall in love with a Muslim. His/her family will not accept you because you are a Christian.
- Discussion: Take a look at your paper and those around you. How has self-esteem been affected by these statements? Did some things affect your self-esteem more than others? Which ones? Why?

Activity 3: Ways to build self-esteem

- Divide participants into the small groups from the start of session.
- Ask them to take their second piece of paper and write at the top "Ways to Build My Self-Esteem."
- Give the groups 5 to 10 minutes to list as many ways to build self-esteem as they can think of.
- In full group discussion, ask each group to share one thing from their list that is easy to do and one that is difficult to do. Try not to have repeats. Make two lists on two pieces of a flipchart as groups are sharing.
- Encourage general discussion around the lists on the flipcharts.
  - » Why is it difficult to build and maintain positive self-esteem?
  - » What is the relationship between values and self-esteem?
  - » In what ways may having high or positive self-esteem or low or negative self-esteem lead a person to make different choices? Can anyone think of possible examples? Remind the group of the two readers from earlier in the session to start ideas flowing.

Facilitator's notes

Emphasize the following information:
- Our self-esteem is influenced by people and things we experience-just like our values.
- Self-esteem can be built by successful experiences and positive comments from us and others.
- Self-esteem can be damaged by put-downs from other people or negative experiences.
- Positive self-esteem relates to sound decision-making.

Activity 4: Importance of feeling good

- Ask participants to draw a picture, make a painting, write a poem, or make a song, and find a way to express "what makes you feel good".
- Ask them to share their work in pairs.
- The same pairs are asked to discuss the following questions:
  - » What do PLWHA need in order to feel good about themselves?
  - » Why is "feeling good (emotional well-being) important for PLWHA to lead long lives?
  - » What might prevent PLWHA from feeling good?
- Ask the pairs to share the assignment in the plenary. Ensure the following points are covered.

What PLHIV need in order to feel good about themselves
- To be loved and cared for
- Listened to
- Given information about HIV and AIDS
- Nutritious food
- Involved in family decision making
- Access to proper medical services
- Legal protection to stop them from being fired from jobs
- Prayer and encouragement from spiritual leaders
- Considered to be productive and contributing to family like others

Why is "feeling good" important for PLHIV?
- If our mind feels good, so does our body
- Less likely to fall sick
- More likely to share problems

What might prevent PLWHA from feeling good?
- Stigma – lack of attention, isolation, lack of care and support
- Self stigma – feeling guilty, loss of friends, stigma by neighbours

Self-esteem and importance of developing self-esteem

- Our self-esteem is influenced by people and things we experience-just like our values.
- Self-esteem can be built by successful experiences and positive comments from others and us.
- Self-esteem can be damaged by put-downs from other people or negative experiences.
- Positive self-esteem relates to sound decision-making.

Elimination of stigma and discrimination is an obligation of every government

Article 58 of the United Nations Declaration of Commitment on HIV and AIDS compels governments to the following: "By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection, while respecting their privacy and confidentiality, and develop strategies to combat stigma and social exclusion connected with the epidemic."

Guideline 9 of the International Guidelines on HIV and AIDS and Human Rights says that states should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

SESSION 7.6: Coping with stigma

Objectives

By the end of the session participants should be able to:

- Recognize the importance of emotional well-being of PLHIV in order to live long and productive lives.
- Identify how we can help PLHIV stay emotionally healthy.
- Identify ways that we can challenge stigma and assist PLHIV to cope with effects of stigma.

Duration: 45 minutes

Materials

Paper and pens

Activity 1: Support individuals and communities to cope with stigma

- Divide participants into groups of four or five depending on the number of participants.
- The groups should answer the following questions:
- How can we support PLHIV to cope with stigma?
- What can groups do to build support for individuals and families in the community?
- Ask each group to share in the plenary what they have come up with.

Figure 7.6.1: Coping with stigma

Facilitator's notes

How we can support PLHIV to cope with stigma

- Encourage PLHIV to talk openly with friends and family about their feelings and situation. Encourage family and friends to also empathize with them.
- Encourage them to get supportive counselling from family, friends and health professionals.
- Encourage them to join a support groups to share feelings and experiences with other PLHIV.
- Support them to continue being productive - to do things which build confidence and self esteem.

- Help them to focus on the positives and have positive attitudes - "I want to stay alive for my children."
- Involve them in meaningful HIV interventions.
- Encourage them to engage in advocacy - join campaigns/lobby for their human rights.
- Challenge stigma and demonstrate that it is wrong to stigmatize.
- Recognize that PLHIV have rights to have sex, get married, have children, have work, have friends and demand for their rights.

Mobilizing community support for HIV affected households

What groups/organization can do to build support in the community

- Organize community meeting to discuss what to do about HIV and AIDS in the community.
- Form support groups for PLHIV for psychosocial support.
- Identify the most vulnerable households such as child/orphan and grandparent headed households and provide support.
- Advocate for consideration of HIV affected families by the government, for instance, the OVC cash transfer programme.
- Provide neutral persons to help mediate disclosure or conflicts in families.
- Facilitate the sharing of "AIDS survival knowledge" among community members.
- Organize a regular system of visits to HIV affected households.
- Donate food, clothing and agricultural inputs to destitute households.
- Carry out repairs to houses or help cultivate the fields of vulnerable households.
- Organize income generating activities to support vulnerable households.
- Provide communal fields for vegetable gardening.
- Form burial associations and rotating credit and loan clubs.

MODULE 8: INTRODUCTION TO MONITORING AND EVALUATION

Overview

It is critical that we monitor and evaluate programmes to justify expenditure of resources and enable them to grow to levels that will ultimately have a sustainable impact. Monitoring and evaluating programmes for HIV and AIDS prevention and care will assist implementers to determine the effectiveness of their programmes. In this session, we provide methods to answer three simple but important questions: Are we doing the right things? Are we doing them right? Are our interventions making a difference? Answering these questions will allow BCC programme implementers to decide how and when to modify existing programmes or design new ones.

The challenge of measuring behaviour change

It is relatively easy to measure changes in knowledge as peer educators know what information they want to teach to their trainees or participants. Measuring attitudes and skills (or at least perceived skills) and behavioural intentions is also relatively easy. Measuring real behaviour change however is complicated, often requiring more sophisticated measurement techniques.

Sometimes changes in behaviour resulting from BCC interventions can only be measured through individuals' reports of their own behaviour, which are hard to check. Moreover, asking questions about behaviour related to sexuality may be controversial and frowned upon in certain cultures or institutions. It is nevertheless important to collect useful behavioural data and to report on the process and outcomes of a programme.

Goal

To describe monitoring and evaluation concepts and equip participants with skills on how to monitor and evaluate BCC programmes.

Objectives

At the end of this session, participants will be able to:

- Understand the basic principles of monitoring and evaluation (M&E).
- Understand how M&E is conducted and be able to identify key tools they can use in their programmes.

Duration: 1 hour 45 minutes

SESSION 8.1: What is monitoring and evaluation?

Objectives

By the end of this session, participants should be able to:
- Define the terms monitoring and evaluation (M&E).
- Identify opportunities and barriers when conducting M&E.
- Identify reasons for M&E.

Materials

Flipcharts and markers

Method

Presentation, group discussions and brainstorming session

Duration: 30 minutes

Activity 1: Definitions of monitoring and evaluation

- Divide participant into two groups.
- Ask each group to define "monitoring" and "evaluation."

Facilitator's notes

Monitoring is an on-going or continuous activity undertaken to track programme implementation progress against the planned tasks or activities. Monitoring aims at improving the efficiency and effectiveness of a project. It is based on targets set and activities planned during the planning phases of work. It helps to keep the work on track, and can let management know when things are going wrong. If done properly, it is an invaluable tool for good management as it provides a useful base for evaluation. It enables you to determine whether the resources you have available are sufficient and are being used well, whether the capacity you have is sufficient and appropriate, and whether you are doing what you planned to do.

Evaluation is the careful examination of an ongoing or completed project. The goal of an evaluation is to find ways to make a programme more efficient and effective. There are three categories of evaluation:
- **Process evaluation** that describes and assesses programme materials and activities. Examination of materials is likely to occur while programs are being developed, as a check on the appropriateness of the approach and procedures that will be used in the programme. For example, programme staff might systematically review the units in a curriculum to determine whether they adequately address all of the behaviours the program seeks to influence. Examining the implementation of programme activities is an important form of process evaluation. Implementation analysis establishes what actually transpires in a programme and how closely it resembles the programme's goals.
- **Outcome evaluations** study the immediate or direct effects of the programme on participants. For example, when a 30-session programme aimed at teaching skills on condom use is completed, can the participants demonstrate the skills successfully? Outcome evaluation assesses programme achievements and effects.
- **Impact evaluation** looks beyond the immediate results of interventions or services to identify longer-term as well as unintended programme effects. It may also examine what happens when several programmes operate in unison. For example, an impact evaluation might examine whether a programme's immediate positive effects on behaviour were sustained over time.

Regardless of the kind of evaluation, all evaluations use data collected in a systematic manner. This data may be quantitative such as counts of programme participants, number of people counselled and tested, or number of condoms distributed. They may also be qualitative such as descriptions of what transpired at a series of counselling sessions or an expert's best judgment of the age-appropriateness of a skills training curriculum. Successful evaluations often blend quantitative and qualitative data collection. The choice of which to use should be made with an understanding that there is usually more than one way to answer any given question.

Activity 2: Principles on which M&E is conducted

Monitoring	**Evaluation**
• Is done routinely and continuously, as part of day to day management	• Is done periodically, often annually or at the midpoint and end of a programme
• Provides detailed information on activities	• Provides information that has been analyzed and summarized
Monitoring helps determine	**Evaluation helps determine**
HOW things are getting done (work performance against work plans and schedules)	Whether **ACCOMPLISHMENTS** have fulfilled original objectives
WHO is doing the work (staff performance plans and appraisals, job descriptions, individual work plans, protocols and standards of practice)	Which **ACTIVITIES** helped to meet these objectives
WHAT materials, supplies, equipment, and funds are being used (availability and use of resources against initial list of activities and resources)	Whether **RESOURCES** were used wisely and efficiently
WHEN activities are carried out and completed (actual times against schedules agreed upon in the project plans and individual work plans)	Whether scheduled activities were completed **IN SEQUENCE and ON TIME**

Formulating an evaluation routine

Steps for an evaluation routine:
i. Get an overview of the programme.
ii. Determine why you are evaluating.
iii. Determine what you need to know and formulate research questions.
iv. Determine what information you need to answer questions.
v. Design the evaluation.
vi. Collection of information/data
vii. Analyze the information.
viii. Formulate conclusions.
ix. Communicate results.
x. Use results to modify programme.

SESSION 8.2: Monitoring BCC programmes

Objectives

By the end of this session, participants should be able to:
- Understand the basic monitoring methods.
- Understand the tools used in monitoring.

Materials

Flipcharts and markers

Method

Presentation, group discussions and brainstorming sessions

Duration: 30minutes

Activity 1: Monitoring methods

- Ask participants to explain what is meant by methods in relation to M&E?
- Explain to participants that M&E methods may be Quantitative and Qualitative.
- Ask the participants to explain the meaning, similarities and differences of the two terms.
- Supplement responses provided with the following information:

Quantitative monitoring tends to document numbers associated with the programme - measuring how much or how many -for instance, how many:
- posters were distributed, how many were posted
- counselling sessions were held
- times a radio spot was on the air
- sex workers were trained as outreach workers.

Quantitative monitoring focuses on which and how often program elements are being carried out. It involves record-keeping and numerical counts. Activities in a project/ programme timeline should be closely examined to see what kinds of monitoring activities might be used to assess progress.

Quantitative methods are those that generally rely on structured or standardized approaches to collect and analyze numerical data. Almost any evaluation or research question can be investigated using quantitative methods because most phenomena can be measured numerically.

Qualitative monitoring answers questions about how well the programme elements are being carried out. It includes questions on topics like:
- Changes in people's attitudes toward abstinence, stigma, fidelity, care and support, or condoms.
- How effective is the video conveying intended BCC messages to target populations?

This type of information and feedback system often uses qualitative methods like in-depth interviews and group discussions.

Activity 2: Monitoring methods and tools for data collection

- Pick four modules from the workshop.
- Divide the participants into four groups and let each group pick a module.
- Ask the groups to discuss and list down the kind of tools that can be used in monitoring the modules that they have covered in this workshop. Give the groups 20 minutes to discuss and draw the list.
- Call back the participants and let each group report their findings in plenary. Supplement the discussion with information from the following examples of qualitative and quantitative tools.

Facilitator's notes

1. Quantitative monitoring tends to document numbers associated with the programme and tends to involve record keeping and numerical counts. This type of information is often obtained by review of service statistics and distribution records.

Quantitative methods	Quantitative tools
Reviewing BCC materials distribution	Distribution logbook/register
Periodic site visits	Checklist or questionnaire
Periodic review of implementation reports	Checklist, questionnaire, CHW activity sheet, client referral form
Periodic compilation of service statistics	Tally sheet

2. Qualitative monitoring (measuring quality) asks questions about how well the activities are being carried out. This type of information and feedback is often obtained by using such qualitative methods as in-depth interviews and focus group discussions. Qualitative methods and tools used in data collection help to assess the quality and effectiveness of the programmes. Below is an example of methods and tools used in qualitative monitoring.

Quantitative methods	Quantitative tools
Focus group discussion	Focus group discussion guide
Direct observation	Observation checklist
In-depth interviews with clients or target group (for instance, to monitor and track changes in questions emanating from target groups and audiences during the course of project implementation)	Interview guides
Content analysis of materials	Content analysis checklist
Pre-testing of materials with target population	Checklist

It is worth noting that similar tools may be known by different names. This exercise is designed to expose the participants to different types of forms, but the participants must be flexible about what these tools might be called.

Adopted from: FHI (2004): Monitoring HIV/AIDS Programs; A facilitator's training guide.

SESSION 8.3: Evaluation of BCC programmes

Objectives

By the end of this session, participants should be able to:
- Understand the basic elements of evaluation methods.
- Understand and apply the tools used in evaluation.

Materials

Pre-prepared and blank flipcharts, markers and pens

Method

Presentation, group discussions and brainstorming sessions

Duration: 45 minutes

Activity 1: Purpose of evaluation

Explain to the participants the purpose of evaluation using the notes below as a guide.

Facilitator's notes

Evaluation spans the life of a BCC programme. A programme begins with formative research or evaluation, progresses to monitoring, and closes with evaluation. The resulting findings help guide programme design, determine whether programme implementation is occurring as planned, suggest midcourse improvements, provide evidence that the programme influences behaviour, help guide the design of future programmes, and demonstrate accountability to partners and funding agencies.

In assessing the outcome and impact of a programme, evaluation should answer the following:
- Which indicators are we looking out for?
- What outcomes are observed?
- What do the outcomes mean?
- Does the program make a difference?

BCC programme evaluation is part of the overall HIV and AIDS prevention, care, and support programme. It is important that the evaluation questions to be used are included in the general programme evaluation plan. Questions should be based on and refer to the general programme BCC and behaviour change goals.

- Pick on any four session topics in this training manual, for instance, (a) Facts about HIV and AIDS, (b) Basics of HTC, (c) Condoms and condom use and (d) STI's and HIV.
- Divide participants into four groups. Each group to pick one topic.
- Let the groups brainstorm and discuss the BCC indicators that they would look out for when doing an evaluation on the above the topics. Give them 15 minutes for the exercise.
- Call them back to plenary and let each group present. Allow brief discussions from the floor on the responses from each group.
- Facilitator refers participants to the pre-prepared table on the flipchart as shown below, which can help them as programme implementers to measure progress towards objectives and which indicators to use.

Measuring progress towards objectives

Type of evaluation	Purpose of evaluation	Main questions answered	Indicators of success
Outcome Evaluation	Measures change in outcomes (for example, knowledge, self-efficacy, skills, attitudes, and behaviours) against BCC objectives. NB: Changes may or may not be due to the programme	• Did the desired changes in outcomes take place? • How much did knowledge, attitudes, and behaviour change?	• Percentage of audience who know of the recommended behaviour • Percentage of audience with a specific attitude (favourable or unfavourable) towards the recommended behaviour • Percentage of audience who are confident they could perform the recommended behaviour • Percentage of audience who practice the recommended behaviour
Impact Evaluation	Measures the extent to which programme activities changed outcomes (consistent with BCC objectives)	• Are changes in outcomes due to the BCC programme? • Did communities with the programme have better results than communities without the programme? • Did people with greater exposure to the programme experience better results than people with little or no exposure?	• Percentage of audience who know of the recommended behaviour • Percentage of audience with a specific attitude (favourable or unfavourable) toward the recommended behaviour • Percentage of audience who are confident they could perform the recommended behaviour • Percentage of audience who practice the recommended behaviour

BCC evaluation

Possible BCC outcome evaluation questions
- What is the impact on the knowledge levels of the target/general population?
- What is the impact on attitudes and beliefs about HIV and AIDS?
- What is the impact on at-risk behaviours (e.g., sexual, drug abuse, needle sharing) among the target/general population?
- What is the impact on stigma against people living with HIV and AIDS?
- What is the impact on discrimination against people living with HIV and AIDS?
- What is the impact on service utilization (e.g., health, HIV and AIDS, legal, economic, social, psychological)?

Indicators

An indicator is a measure of the progress made towards meeting one of the programmes objectives. It is a factor that helps to show the status of a project or programme. Monitoring indicators give evidence of completion of events or activities. Evaluation indicators show achievements or lack of achievement of objectives.

Indicators should be measurable (magnitude & time), independent (measuring only one factor), factual (reflecting project/programme factors, and not external factors) and verifiable. For example, by the end of the second phase of Maanisha project in Mumias, Maanisha peer educators should have reached out to three quarters of the 7,000 sugar cane cutters in the farms with information on HIV and AIDS; 75 percent of sex workers

along the Malaba and Busia border should have decided to use condoms and; there should be 95 percent reach out to the tea leaves pickers in Kericho by the end of the programme. Typical BCC indicators include:

- Number of peer educators trained
- Knowledge of HIV transmission
- Attendance at regular meetings
- Knowledge of HIV and reproductive health services available
- Gender of trainees/peers and peer educators
- Use of available services
- Level of youth participation achieved
- Attitudes about using available services
- Number of outreach activities carried out in the month
- Intention to use condoms
- Number of educational materials distributed
- Risky sexual behaviours
- Number of implementing partners
- Number or percentage of target audience reached
- Referrals to other services
- Costs incurred in carrying out a peer education

Special considerations in evaluating behaviour change

- It is difficult to change peoples' behaviours.
- It takes several years of programme implementation before behaviour changes occur to the extent that they can be observed.
- It is difficult to measure behaviour change and collect data (sensitive questions about sexual behaviours, fidelity, illegal activities).
- It is difficult to link programme activities to observed behaviour change because of other, outside influences.

To conclude this session, emphasize to the participants that good evaluation can make difference:

- It is cost effective as it allows decision-makers to continue successful programmes and improve or abandon unsuccessful ones.
- It can provide support for future funding requests.
- It can contribute to the development of new programmes.
- If the evaluation shows a failure of the project, it can also explain why (for example, due to poor implementation of the project or unreasonable expectations).

APPENDIX 1: TRAINING TIMETABLE

BCC training workshop Time Table

Time	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
8.00 - 8.30	• Registration • Introductions • Expectations • Norms • Pre-test	Recap of Day 1	Recap of Day 2	Recap of Day 3	Recap of Day 4
8.30 - 10.30	• Analysis of BCC issues • What is BCC • Why BCC? • Theories on Behaviour change	• Dispelling myths about HIV and AIDS • Facts about HIV and AIDS	• TB and HIV • ART • HCBC	• RH rights in relation to HIV and AIDS • Human rights and HIV and AIDS	• Types of stigma • Self stigma and discrimination
10.30 - 11.00	**TEA**				
11.00 - 1.00	• Developing BC and BCC objectives • Analysis of risky sexual behaviour • Development of behaviour change messages • BCC Strategies	• Facts about HIV and AIDS • STIs and HIV and AIDS • STI Video -Silent Epidemic	• Mapping HIV services • Gender Inequality and HIV and AIDS • Gender concepts	• Human Rights and HIV and AIDS • Culture, Norms and Values • What is culture	• Coping with stigma • Monitoring and Evaluation • What is M&E?
1.00 - 2.00	**LUNCH**				
2.00 - 3.00	• Overview of drama strategy • Overview of PE strategy	Condoms in HIV prevention	Gender Concerns in HIV infections and Impact	helps and harms	Monitoring and Evaluation of BCC programmes
3.00 - 4.30	The Role of Community in BCC for HIV Prevention	Basics of HTC	• Human and legal rights • Understanding rights, legal rights and human rights	• Introduction to Stigma and discrimination • Naming the problem • Effects of stigma and discrimination	• Work Plan • Post-test and Final Evaluation
4.30 - 5.00	Day Evaluation and Departure	Day Evaluation and Departure	Day Evaluation and Departure	Day Evaluation and Departure	Departure

APPENDIX 2: GUIDE ON HOW TO USE THE MANUAL

Participation

Participation is the key to success of implementing this Training Manual. The facilitator must make sure that the participants are meaningfully and actively involved for maximum sharing throughout the training sessions. Certain approaches included in this Training Manual are essential in enhancing and promoting participation of community members and other actors in promoting sustainable behaviour change and subsequent contribution to widespread adoption of safe or healthy behaviours for reduction of HIV infection. Some of these approaches may include, but not limited to:

Using role plays and codes

Role-play including acting, singing and dancing is involved in many of the modules in this Training Manual. It is a good way to reveal thoughts and feelings about HIV and AIDS-related BCC issues covered in this Training Manual. Playing any role, demands more from people, than just talking about an issue. It involves going deeper into what they think and feel. This is critical because people's beliefs about some of the issues that influence HIV infection – sexuality, gender, stigma, socio-cultural beliefs and values - go very deep and are such a key part of who we all are as people.

Active listening

This means more than just hearing what is said. It means letting participants know that they are being heard and understood. Active listening encourages people to be more open in sharing their experiences, thoughts and feelings. This is crucial when it comes to encouraging groups to talk more openly about gender and sexuality which are key factors in HIV infection.
Active listening involves:

- Using body language and facial expressions to show interest and understanding.
- Listening not only to what is said, but also to how it is said – by paying attention to the speaker's body language.
- Asking questions of the person who is speaking – to show a desire to understand.

Facilitation and moderation

The cornerstone of effective workshop facilitation and moderating sessions is the effective use of appropriate adult teaching methodologies and approaches based on principles in adult learning as indicated in the table below.

Table 1: Principles of adult education and their implication for planning training

Adult education principles	Implications for the training plan
Adults learn best when they perceive learning as relevant to their needs	• Provide "real life" situations and emphasize the application of learning to real problems • Identify learners' needs and what is important to them
Adults learn by doing and by being actively involved in the learning process	• Provide activities which require active participation of learners • Provide activities which involve the learners as whole people: their ideas, attitudes, feelings, and physical being
Adults have unique learning styles. They learn in different ways, at different rates, and from different experiences	• Use a variety of training techniques • Establish an atmosphere of respect, understanding and tolerance of differences
Adult education principles	**Implications for the training plan**
Participants bring relevant and important knowledge and experiences to the workshop.	• Provide opportunities for sharing information and experiences. • Discuss and analyze participants' experiences • Use participants as a resource and encourage them to participate and share their experiences

Adapted from Guide to participatory training (Susan Purdin.1999)

Managing conflict

Often it is through disagreement with others that we come to better understand our own thoughts and feelings. But there may be situations when disagreement turns into conflict. When this is the case, people put their energy into defending their own positions rather than exploring the issues with each other. Helping the group to manage conflict is a key role for the facilitator. This will include helping people identify areas of agreement and shared concern –to create common ground to come together to work out a conflict.

Confidentiality

Making a clear working agreement on confidentiality is essential. Participants should not tell people outside the group details of what specific individuals in the group say. However, this agreement cannot be enforced and people should be careful about what they are willing to share and with whom they share it. The facilitator needs to note that it is safer to talk about 'people like us' rather than disclosing an event as a personal experience.

APPENDIX 3: PRE/POST TEST QUESTIONNAIRE

Pre/post test

This is to be filled out by participants

Name/Initial_____

Please circle the correct answer

1. What does AIDS stand for?
- Adabu Imeingia Duniani Sasa
- Acquired Immune Deficiency Syndrome
- Acquired Immunes Dental Sickness

2. What does HIV stand for?
- Highly Immune Virus
- Human Infectious Virus
- Human Immune Deficiency Virus

3. Can you get HIV from kissing?
- Yes
- Maybe
- No

5. "You can catch AIDS from sharing infected needles." Is there anything wrong with this statement?
- Yes
- No
- I don't know

If yes, explain what is wrong with the statement?

_____

_____

_____

_____

_____

5. Which of the following statements is correct?
- Women rights are human rights
- A widow has the legal right to inherit and own her late husband's property
- PLHIV have a right to life
- The law gives women and men equal rights to vote
- All the above

6. "In my community we have cultural practices that make us identify and relate to each other. Which one would you encourage us to continue practicing?"
- Wife inheritance and husband replacement
- Communal fish farming, smoking, selling and equal distribution of the profit to each participating household
- Female circumcision using the same ancestral knife for sisterhood
- Girls from poor families get married off between the age of 12 - 15 to polygamous elderly men in order to reduce the burden in their homes
- Male peers cut themselves on the palm and rub the cuts on each other as a sign of brotherhood and oath to remain so

7. Which of the following body fluids does not transmit HIV?
- Blood
- Sweat
- Semen
- Vaginal secretions
- Breast milk

8. Being assertive means all of the following except:
- Standing up for your own rights
- Dominating others by telling them what they should or should not do
- Expressing feelings in a positive way
- Respecting yourself

9. Which of the following can transmit HIV?
- Taking care of an PLHIV
- Sharing a public shower room
- Having unprotected sexual intercourse with a PLHIV
- Sharing plates, cups, or chopsticks with a PLHIV
- All of the above

10. What's the most effective way to protect you from a sexually transmitted infection?
- Waiting to have sex until marriage
- Remaining with the same sexual partner
- Using a condom
- Abstaining from sex

11. What term represents the ideas and expectations people, communities, and cultures have about men and women?
- Self esteem
- Sex roles
- Assertiveness
- Gender roles

12. Which of the following is not a sexually transmitted infection?
- Tuberculosis
- Herpes
- Syphilis
- HIV
- Trichomoniasis

13. Which of the following is a risky behaviour?
- Having unprotected sexual intercourse with person of unknown HIV status
- Having many sexual partners
- Not knowing how to use a condom correctly
- All the above

14. Window period is
- The time between when a PLHIV cannot transmit HIV and when he/she has enough HIV to be able to infect others
- The period between being HIV positive and the onset of AIDS
- The period between infection by HIV and the presence of enough HIV antibodies to be detected by an HIV test
- The distance between one window and another window

15. How can a person know whether they have HIV or not?
- When one starts losing weight, getting constant diarrhoea and losing hair
- By taking a HIV test
- By finding out his/her sexual partners status

16. One of the following statements is correct about condoms. Which one?
- Condoms are mainly made for prostitutes
- The more expensive a condom the more protection from infections
- Condoms can be effective in prevention of any infections and pregnancy when used correctly and consistently

17. Which of the following statements is a negative statement that would enhance stigma and discrimination in your community?
- If you care for PLHIV and give them the love they deserve and they will grow in strength
- People living with HIV and AIDS deserve love, care and hope. They can live long and productive lives
- AIDS is a punishment from God
- Don't point fingers, anybody can get HIV

18. Which of the following statements is true?
- Male HIV peer educators are better teachers than female peer educators
- A woman place is in the kitchen
- Men and women are equal and can carry out family duties together
- Because men are physically stronger than women they should be paid more money
- Taking care of children is a female duty

APPENDIX 4: OVERVIEW OF THEORIES ON BEHAVIOUR CHANGE

Summarized below are the various theories/frameworks for behaviour change that can be applied to HIV and AIDS BCC programmes.

1. Theories that focus on individuals (Psychosocial Theories)

These theories focus on how individuals can change their behaviour and have provided the foundation for most HIV prevention efforts. They can be categorized into three major groups; those predicting behaviour, those predicting behaviour change and those predicting maintenance of safe behaviour. Models of individual behaviour change focus on stages that individuals pass through while trying to change behaviour. However, they do not take into account the interaction of social, cultural and environmental issues as being independent of individual factors . Most of these theories state that behavioural changes occur by altering potential risk-producing situations and social relationships, risk perceptions, attitudes, self-efficacy, beliefs, intentions and outcome expectations. Although studies show the usefulness of these theories they do not fully explain why some people behave the way they do, why some populations have higher prevalence nor the complex interaction between contextual factors and individual behaviour. Some of the key psychosocial/individual-focused theories and models include:

i) Health Belief Model

Developed in the 1950s, it holds that health behaviour is determined by an individual's socio-demographic characteristics, knowledge and attitudes. According to this model, an individual must hold the following beliefs in order to change behaviour:
- Am I at risk for HIV infection? (Perceived risk)
- How hard would my life be if I was infected? (Perceived seriousness of the condition)
- Condoms are effective against HIV transmission. (Belief in effectiveness of the new behaviour)
- Witness AIDS-related death or illness of a close friend or relative. (Cues to action)
- If I start using condoms, I can avoid HIV infection. (Perceived benefits of prevention action)
- I do not like using condoms. (Barriers to taking action)

ii) Social Cognitive (Learning) Theory

The premise of this theory is that new behaviours are learned either by modelling the behaviour of others or by direct experience. It focuses on the role played by psychological processes and looks at human behaviour as a continuous interaction between knowledge, behaviour and environmental factors . Key elements of the theory are:
- Self-efficacy – the belief in the ability to implement necessary behaviour. (I know I can insist on condom use with my partner.)
- Outcome expectations – the belief that using condoms correctly will prevent HIV infection.

iii) Theory of Reasoned Action

This is based on the assumption that human beings are rational and make systematic use of information available to them. It argues that: (1) people consider the implications of their actions in a given context and at a given time before they decide to engage or not engage in a given behaviour and that most actions are voluntary . (2) a person's intention to act is determined by their attitude towards the behaviour and social influence.

iv) Stages of Change Model

It was developed in the early 1990s for smoking cessation by Prochaska and DiClemente and outlines six stages that individuals pass through when changing behaviour.
- Pre-contemplation – not considered using condoms
- Contemplation – recognizes the need to use condoms
- Preparation – thinking of using condoms in the next month/or in the next sexual encounter
- Action – use condoms consistently for less than 6 months
- Maintenance – Uses condoms consistently for 6 months or more
- Relapse – slipping with respect to condom use

V) AIDS Risk Reduction Model

Developed in the 1990s, it uses constructs from the Health Belief Model, Social Cognitive Theory and Diffusion of Innovation Theory to describe the process individuals/groups pass

though while changing their behaviour regarding HIV risk. It identifies three stages involved in reducing risk for HIV transmission:

- Behaviour labelling – Knowledge about HIV transmission, negative emotions, perceived susceptibility influence how people perceive AIDS.
- Commitment to change – Shaped by perception of enjoyment, self-efficacy, social norms and aversive emotions.
- Taking action - Negative emotions, sexual communication, help-seeking behaviour and social functions affect people's decision-making process.

2. Social Theories and Models

Overemphasis on individual behaviour change with a focus on the knowledge level has limited understanding of the complexity of transmission and control. Focusing on individual psychological processes ignores the interactive relationship of behaviour and thus omitting crucial determinants of behaviour. These theories argue that:

- Motivations for sex are complicated, unclear and may not be thought through in advance,
- Societal norms, religious criteria and gender power relations determine behaviour positively or negatively.
- Social models aim at changes at the community level.
- Social theories and models see individual behaviours as determined by their social and cultural context. They focus on social norms, relationships and gender imbalances that determine behaviour and behavioural change. These theories argue that efforts to effect change at the community level will have the most impact on individuals who are contemplating changes and on those who have made changes but need support to sustain those changes. Outlined below are some of the social theories on behaviour change.

i) Diffusion of Innovation Theory

It describes the dissemination of an idea in a community and has four elements – innovation, communication, social system and time. Exposure to a new idea takes place within a social network or through the media, will determine the rate at which various people adopt a new behaviour. The theory argues that people are most likely to adopt new behaviours based on favourable evaluation of the idea communicated to them by people they respect. Interventions using this theory identify how best to disperse messages within a community and which leaders can act as role models to change community norms.

ii) Social Influence or Social Inoculation Model

It is an educational model based on the concept that young people engage in behaviour including early sexual activity partly because of general societal influences but more specific from peers . It suggests that exposing young people to social pressures teaches them to examine and develop skills to deal with the pressures. It relies on role models such as older teenagers to present factual information, identify pressures, role-play responses to pressure, teach assertiveness skills and discuss problem situations.

iii) Social Network Theory

This theory examines behaviour as a social rather than an individual phenomenon but through relationships and recognizes that HIV risk behaviour, unlike many other health behaviours, involves two people . An individual's broader social networks of those who serve as reference people and who sanction behaviour are important for understanding individual risk behaviour Social norms are best understood at the level of social networks.

iv) Theory of Gender and Power

This is social structural theory that addresses the wider social and environmental issues surrounding women such as distribution of power and authority and gender specific norms within heterosexual relationships . The theory can help identify how a woman's commitment to a relationship and lack of power can influence her risk reduction choices.

3. Community Level Theories

These theories view human behaviour as dependent on the community, organization, political and economic environment. They emphasize on linking the individual to the surrounding environmental systems. Interventions using these theories target organizations, communities and policy environment. The following are community level theories:

i) Theory for Individual and Social Change or Empowerment Model

It asserts that social change happens through dialogue that enables a critical review of social, cultural, political and economic factors that determine reality and taking action against repressive forces. Problem solving in a participatory style enables participants to understand the personal, social, economic and political forces in their lives in order to take action to improve their situations. Participants are included in the planning and implementation of activities.

ii) Social Ecological Model for Health Promotion

Patterned behaviour is the outcome of interest and behaviour determined by:

- Intra-personal factors – characteristics of the individual such as knowledge, attitudes, behaviour, self-concept and skills.
- Inter-personal processes and primary groups, formal and informal networks and social support systems including family, work group and friendships.

Whereas structural strategies seek to change the context that contributes to vulnerability and risk, and biomedical interventions block infection or decrease infectiousness, behavioural strategies attempt to motivate behavioural change within individuals and social units by use of a range of educational, motivational, peer-group, skills-building approaches, and community normative approaches. Noting that behaviour change has been responsible for HIV infection prevention success, it is clear that a mix of all the behavioural theories and models stipulated in the foregoing sections – psychosocial (individual), social and community level theories – will be applicable in meeting the objectives of this strategy. Strategies to modify risk behaviours need to remain a main priority for HIV prevention.

Behavioural strategies are those strategies that attempt to delay onset of first intercourse, decrease the number of sexual partners, increase the number of sexual acts that are protected, provide counselling and testing for HIV, encourage adherence to biomedical strategies preventing HIV transmission, decrease sharing of needles and syringes, and decrease substance use. Behavioural strategies to accomplish these goals will therefore focus on individuals, couples, families, peer groups or networks, institutions, and entire communities.

Table 1. Stages of BCC

Stages of behaviour change	Responsibility of BCC facilitator
Unaware	Provide basic information
Informed	Encourage them to adopt positive steps and present them with behaviour change option
Concerned	Tell them what to do next in changing their own behaviour, such as going to the clinic to receive STI treatment
Knowledgeable	Motivate the client to act, for example, by informing them of the benefits of using services
Motivated to change	Point or direct client to services and encourage their use
Ready to change	Tell client the benefit of using services
Trail/assessment of new behaviour	Provide an opportunity to practice new skills and reinforce what the client will do to continue the new behaviour
Sustained behaviour change	Tell the client they are doing the right thing. Create an environment that promotes the new behaviour

APPENDIX 5: SEXUALLY TRANSMITTED INFECTIONS

STI Questions TRUE/FALSE

i. A person can always tell if she or he has an STI
ii. Having an STI puts people at greater risk of contracting HIV
iii. Condoms are the most effective safeguard against the spread of STIs
iv. Using condoms will help prevent the spread of STIs
v. The most important thing to do if you suspect you have been infected by an STI is to inform your partner(s)
vi. With proper medical treatment, all STIs except HIV can be cured
vii. STIs can lead to serious health problems, especially if left untreated
viii. Women who have regular PAP smears will also find out if they have the most common STIs

Answers

i) A person can always tell if she or he has an STI
False. People can and do have STI without having any symptoms. Women often have STIs without symptoms because their reproductive organs are internal, but men infected with some diseases like Chlamydia also may have no symptoms. People infected with HIV generally have no symptoms for some time, even years, after infection.

ii) Having an STI puts people at greater risk of contracting HIV
True. Having an STI puts people at a greater risk for contracting HIV. If a person has an STI, it means they are having unprotected sex with a partner who may be having unprotected sex with other partners. This is a main route of HIV transmission. Some STIs cause sores around the genital, oral and anal areas. Open sores make it easier for HIV to enter the body.

iii) Using condoms will help prevent the spread of STIs
True. Condoms can help prevent the spread of STIs but they must be used correctly.

iv) The most important thing to do if you suspect you have been infected with an STI is to inform your partner(s)
False. The most important thing to do is to seek immediate medical treatment. Symptoms of an STI may never appear, or may go away after a short time, but the infection continues inside the person's body. One can suffer serious physical damage and can continue to infect others. Once medical treatment is begun, the person or a health care provider can inform sexual partners. In the meantime, it is also important for the infected person to abstain from any sexual contact until the treatment has been completed.

v) With proper medical treatment, all STIs except HIV can be cured
False. Many STIs can be treated but Genital herpes which is caused by a virus cannot be cured.

vi) STIs can lead to serious health problems, especially if left untreated
True. Many STIs, if left untreated, can cause serious reproductive health problems for men and women. Some lead to sterility in men and infertility in women or death.

vii) Women who have regular PAP smears will also find out if they have the most common STIs
False. The PAP smear is a test specifically designed to detect cervical cancer (or pre-cancerous cells).

APPENDIX 6: UNIVERSAL DECLARATION ON HUMAN RIGHTS

Article 1
All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2
Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it is independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3
Everyone has the right to life, liberty and security.

Article 4
No one shall be held in slavery or servitude. Slavery and the slave trade shall be prohibited in all their forms.

Article 5
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6
Everyone has the right to recognition everywhere as a person before the law.

Article 7
All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8
Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted to him/her by the constitution or by law.

Article 9
No one shall be subjected to arbitrary arrest, detention or exile.

Article 10
Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him/her.

Article 11
(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which she/he has had all the guarantees necessary for his defence.
(2) No one shall be held guilty of any penal offence on account of any act or omission, which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12
No one shall be subjected to arbitrary interference with his/her privacy, family, home or correspondence, nor to attacks upon his/her honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13
(1) Everyone has the right to freedom of movement and residence within the borders of each state.
(2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14
(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.
(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15
(1) Everyone has the right to a nationality.
(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16
(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to start a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
(2) Marriage shall be entered into only with the free and full consent of the intending spouses.
(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17
(1) Everyone has the right to own property alone as well as in association with others.
(2) No one shall be arbitrarily deprived of his property.

Article 18
Everyone has the right to freedom of thought, conscience and religion. This right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19
Everyone has the right to freedom of opinion and expression. This right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20
(1) Everyone has the right to freedom of peaceful assembly and association.
(2) No one may be compelled to belong to an association.

Article 21
(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
(2) Everyone has the right of equal access to public service in his country.
(3) The will of the people shall be the basis of the authority of government. This will shall be expressed in periodic and genuine elections, which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22
Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23
(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
(2) Everyone, without any discrimination, has the right to equal pay for equal work.
(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24
Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25
(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26
(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27
(1) Everyone has the right to freely participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28
Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29
(1) Everyone has duties to the community, in which alone, the free and full development of his personality is possible.
(2) In the exercise of his/her rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30
Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Other relevant international human rights laws include:
- Charter of the United Nations
- International Covenant on Economic, Social and Cultural Rights
- International Covenant on Civil and Political Rights
- Covenant on Elimination of All Forms of Discrimination against Women
- United Nations Convention on the Rights of the Child
- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
- African Charter on Human and People's Rights
- Convention on Worst Forms of Child Labour
- Discrimination (Employment and Occupation) Convention
- Declaration on Elimination of Violence against Women
- United Nations Declaration on the Right to Development
- Universal Declaration on the Eradication of Hunger and Malnutrition
- United Nations Declaration of Commitment on HIV/AIDS
- United Nations Fourth World Conference on Women and Beijing Declaration

Relevant national laws include:
- The Law of Succession Act
- The African Marriage and Divorce Act
- The Marriage Act
- The Matrimonial Causes Act
- The English Married Women's Property Act
- The Penal Code
- The Criminal Procedure Code
- The Children's Act
- The Evidence Act
- The Employment Act
- The Insurance Act
- The Transfer of Property Act
- The Civil Procedure Act
- The HIV/AIDS Control Bill
- Common Law

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HIV and AIDS Behaviour Change Communication

A Facilitator's Training Manual for Community Empowerment and Social Mobilization

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