

Safe Love Club Community Facilitator's Training Curriculum

Guide to Training HIV Prevention
Community-Based Club Facilitators

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Table of Contents

Abbreviations and Acronyms	5
Purpose and Use of the Training Curriculum	6
Structure of the Curriculum	6
Module 1 - HIV and AIDS in Zambia.	8
UNIT 1: Overview of HIV and AIDS	8
UNIT 2: Basic Facts about HIV and AIDS	9
UNIT 3: Key Drivers of HIV	10
UNIT 4: National Response to HIV	13
Module 2 - Primary Prevention Strategies.	14
UNIT 1: Prevention of Mother to Child Transmission (MTCT)	14
UNIT 2: Abstinence, Being Faithful and Condom Use (ABCs of Prevention)	16
UNIT 3: Post Exposure Prophylaxis (PEP)	20
UNIT 4: HIV Counseling and Testing (HCT)	22
UNIT 5: Prevention with Positives (PWP)	24
Module 3 - Behavior Centered Programming (BCP)	25
UNIT 1: Introduction to BCP	25
UNIT 2: Stages of Change	27
Module 4 - The Safe Love Campaign.	30
UNIT 1: Goal and Objectives of the Safe Love Campaign	30
UNIT 2: Messages for Communities	32
UNIT 3: Safe Love Campaign Products	34
Module 5 - Facilitation Skills.	35
UNIT 1: Interpersonal Skills	35
UNIT 2: Role of Facilitators	37
UNIT 3: Giving and Receiving Feedback	39
UNIT 4: Working with Young People	40
Module 6 - Monitoring and Evaluation	42
UNIT 1: Data Collection and Documentation	42
UNIT 2: Reporting	44
Appendices	45
APPENDIX 1: Community Outreach Form	45

Abbreviations and Acronyms

ABC	Abstinence, Being Faithful and Condom use
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CSH	Communications Support for Health
CSOs	Civil Society Organisations
CT	Counselling and Testing
HCT	HIV Counselling and Testing
HIV	Human Immune Virus
IEC	Information, Education and Communication
MARPs	Most at risk populations
MC	Male Circumcision
MCP	Multiple Concurrent sexual Partnerships
MOT	Modes of Transmission Study
MTCT	Mother to Child Transmission
NGO	Non-Governmental Organization
PEP	Post Exposure Prophylaxis
PWP	Prevention with Positives
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
STIs	Sexually Transmitted Infections
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
ZDHS	Zambia Demographic and Health Survey

Purpose and Use of the Training Curriculum

The purpose of this training curriculum is to provide guidance on key issues and information to consider when training community based facilitators of HIV prevention programmes. The guide provides practical tools and methodologies that are in line with principles of adult learning and facilitation skills. It provides easy to follow instructions on how to conduct training sessions.

The users of this curriculum will be any individuals, Civil Society Organisations (CSOs) and NGOs that provide training to community based organisations for the implementation of evidence based HIV prevention programmes at community level. This manual is specifically designed for use by CSOs contracted by the USAID funded Communications Support for Health (CSH) Project to implement community based activities under the national HIV prevention campaign Safe Love. However, the manual may be adapted by other groups also conducting HIV prevention activities at community level.

Structure of the Curriculum

Each session will be organized by:

- Learning objectives
- Required preparation
- Learning materials to be used and distributed to learners
- Proposed teaching methodologies/techniques

Time	60 minutes
Learning Objectives	Orient participants on the current trends of HIV and AIDS in Zambia
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participant
Learning materials: these materials may help you present and share the information with your group	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies: choose the methodologies best suited to teach the participants the information from this lesson.	Small group discussion Brainstorming Facilitator's presentation Demonstration Role play Case study

Proposed teaching methodologies/Techniques

Small Group discussions

Participants are put in small groups to allow everyone to actively participate in a discussion about the task or topic. This methodology requires that the facilitator provides clear instructions on the task to be completed. The group will select a team leader and a reporter to capture the key points to be reported to the larger group at a later stage. The facilitators may choose to use this methodology for topics that require consensus or agreement over an issue with many viewpoints. This methodology also helps participants to fully process a new idea as well as share knowledge and experiences with each other.

Brainstorming

The facilitator may choose to use this methodology in order to process a new idea in a large group. It is a method that provides an opportunity to all participants to present various ideas on the topic according to their level of

understanding and experience. All ideas should be accommodated and no judgment is made in a brainstorm session. The facilitator should guide participants to stay focused on the topic and have one conversation at a time. A brainstorming session can start by asking participants what their understanding is of a key word or idea. Then participants can quickly take turns in sharing their understanding of the word or idea.

Presentation

The facilitator presents concepts and facts on the subject matter. The purpose of the presentation is to provide information that has scientific evidence. The presentation should not be too long and with too much technical jargon to keep participants from losing interest. A presentation can be given to sum up a brainstorm session or to conclude a group work session.

Demonstration

This method can be used to allow participants to have a practical experience of the concept taught. Usually follows a presentation. Demonstrations help participants to acquire skills on a particular topic or concept. For example, the facilitator may ask participants to demonstrate the use of a male or female condom to make sure they have understood the correct use following a presentation.

Role play

This technique is similar to demonstration. The facilitator may request participants to practice a concept presented in theory by acting it out. For example, steps in counseling can be acted out in a role play where participants take different roles (eg. client and counselor).

Case Study

The facilitator may choose this technique in order to show real life examples of a program/activity. A case study highlights how a program was done and what were the outcomes. This can be used to demonstrate the different results a program can have depending on how it is designed. Case studies can help program staff to make decisions on the best approach to use for better results. The method compares two or more scenarios.

Module 1 - HIV and AIDS in Zambia

UNIT 1: Overview of HIV and AIDS

Time	60 minutes
Learning Objectives	1. Orient participants on the current trends of HIV and AIDS in Zambia
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation

Definitions

What does HIV stand for?

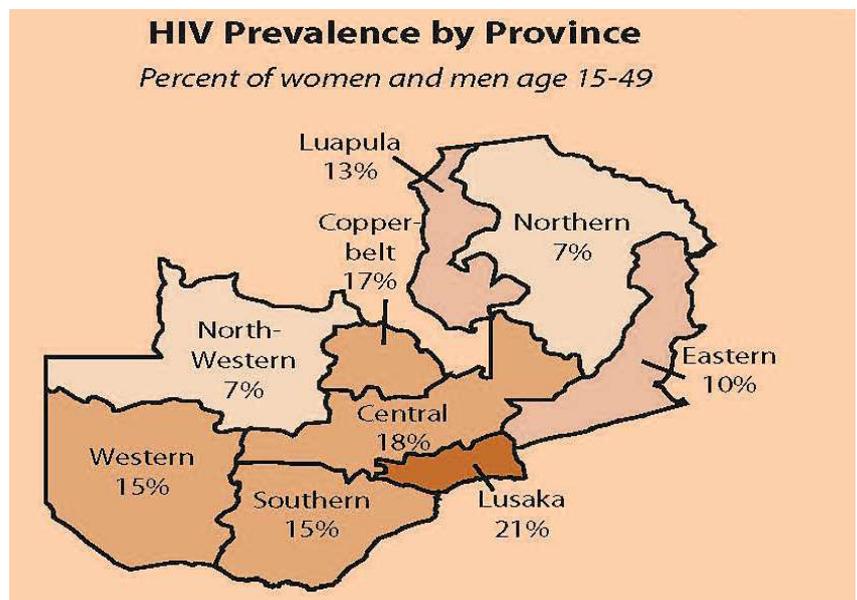
- HIV stands for Human Immunodeficiency Virus. This is the virus that causes AIDS.

What is AIDS?

- AIDS stands for Acquired Immunodeficiency Syndrome. This is when a person who is infected with HIV develops low immunity (the body's defence system) and can get other infections such as TB, pneumonia, diarrheal diseases, etc.

AIDS Prevalence in Zambia

- The prevalence of HIV in Zambia is about fourteen percent in the age group between 15 and 49 years old.
- More women than men live with HIV and AIDS in Zambia. The Zambia Demographic and Health Survey (ZDHS) of 2007, indicates that women living with HIV and AIDS are more than 16 percent, compared to men at about 12 percent.
- The urban provinces of Lusaka and Copperbelt have high HIV prevalence at 21 percent and 17 percent, respectively. Northern and North Western provinces have the lowest prevalence levels at seven percent.
- Prevalence is much higher among residents of urban areas than rural areas at more than 19 percent. Women who go to work or move around frequently were found to be more at risk than women who stay at home.



ZDHS: 2007

UNIT 2: Basic Facts about HIV and AIDS

Time	40 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Orient participants on the basic facts of HIV and AIDS 2. Orient participants on the modes of transmission
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation

How HIV is transmitted

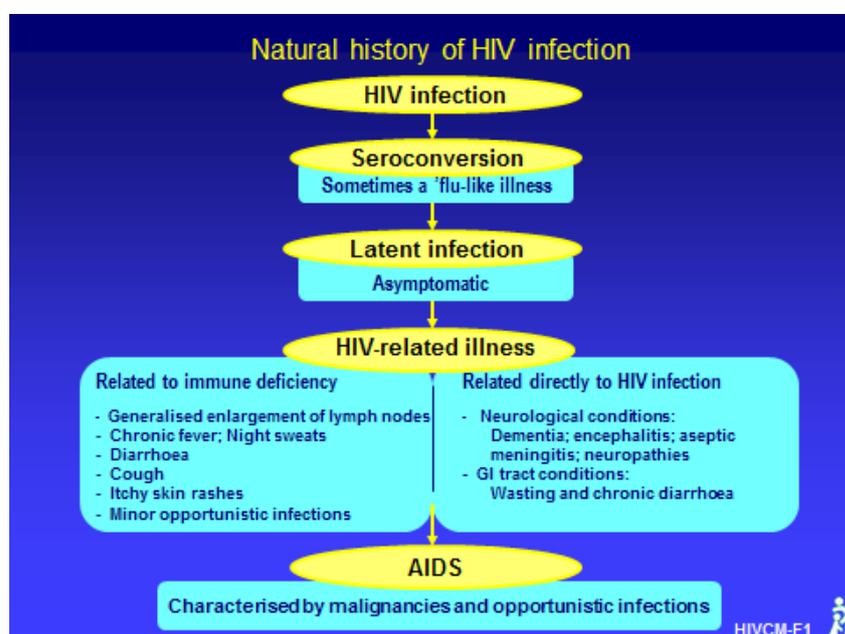
A person who has HIV carries the virus in certain body fluids, including blood, semen, vaginal fluids, and breast milk.

The virus can be transmitted only if such HIV-infected fluids enter the bloodstream of another person. This kind of direct entry can occur through any cuts or openings on the skin and linings of the vagina, rectum, mouth, and the penis or through intravenous injection with an infected syringe.

The most common method of transmission is through the following:

- **Unprotected sexual intercourse** (either vaginal or anal) with someone who has HIV. Anal sex (whether male-male or male-female) poses a high risk mainly to the receptive partner, because the lining of the anus and rectum is extremely thin and is filled with small blood vessels that can be easily injured during intercourse. Sexually transmitted infections that form sores also increase the risk of HIV transmission because of the breaks on the skin.
- **Infection during pregnancy, childbirth, or breastfeeding** (mother-to-child transmission). Any woman who is pregnant or considering becoming pregnant and thinks she may have been exposed to HIV—even if the exposure occurred years ago—should seek testing and counselling. Those who test positive are given drugs to prevent HIV from being passed on to a fetus or infant, and also receive counselling on feeding options. HIV can pass from mother to child during pregnancy, delivery, or breastfeeding.

The diagram to the right shows the progression of HIV infection.



UNIT 3: Key Drivers of HIV

Time	60 minutes
Learning Objectives	Orient participants on the key drivers of HIV
Preparations	<ol style="list-style-type: none"> 1. Read session carefully 2. Review relevant materials 3. Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation

Modes of HIV Transmission

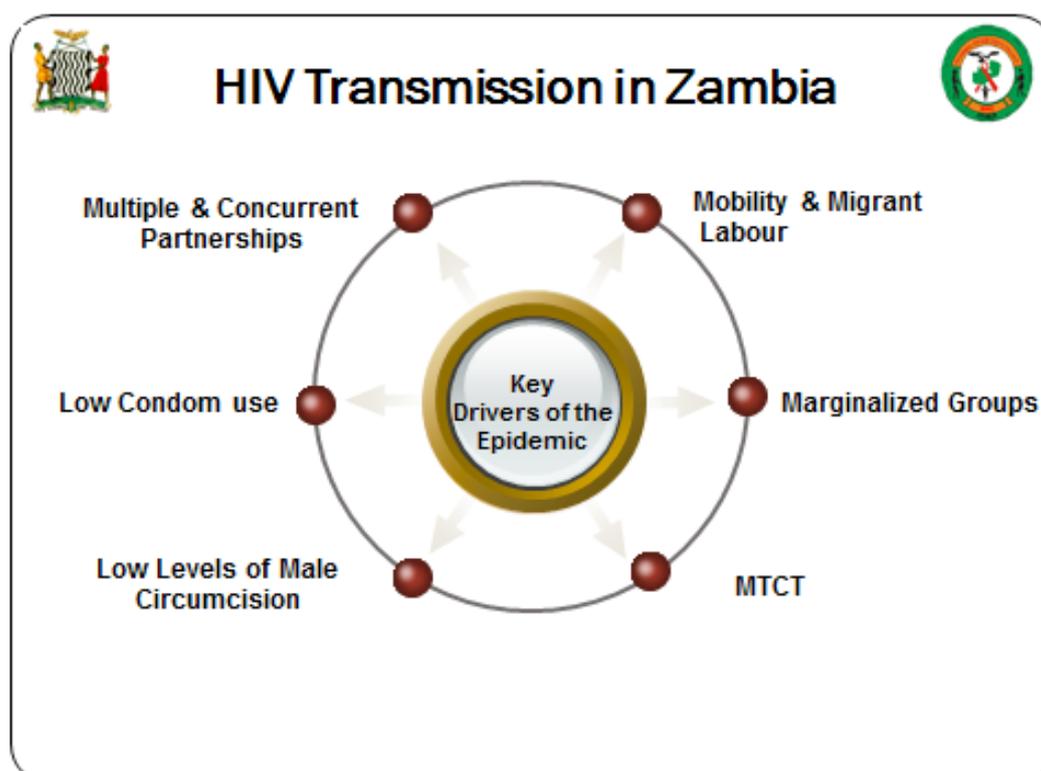
An estimated 90 percent of adult HIV infections in Zambia are caused by unprotected heterosexual (male-female) sex, making it the main mode of transmission in the country.

This includes sexual encounters with either:

- a casual partner
- a long-standing partner, or
- a concurrent sexual partner

HIV has the highest prevalence among people in stable relationships (15-16%); that is, those who are married or those who are living together in a long standing relationship. (MOT: 2009)

The diagram below shows the key drivers of HIV in Zambia



Multiple and Concurrent Sexual Partnerships (MCP)

- Multiple and concurrent sexual partnerships (MCP) refers to when a person (male or female) has more than one regular sexual partner at the same time. These overlapping sexual relationships create a network of people connected sexually.
- Factors that contribute to MCP are mainly socio-economic, and based on gender factors and perceptions. They include:
 - Lack of sexual satisfaction in primary relationships among both men and women
 - Financial and material gain, particularly women
 - Use of libido boosters among men
 - Seeking sexual adventure or variety
 - Sign of masculinity among men
 - Being away from the primary partner for a long time
 - Cultural and traditional norms that encourage male dominance
 - Alcohol and drug abuse (a person under the influence of alcohol and other drugs is more likely to make risky decisions)

Low levels of Medical Male Circumcision

- Medical male circumcision: a minor medical procedure that removes the foreskin of the penis.
- Voluntary medical male circumcision (VMMC) has been proven to provide up to 60% protection against HIV infection in men. In Zambia, VMMC remains low with only 13% of men aged 15-49 reporting (2007) having been circumcised. (ZDHS: 2007)
- Eastern (3.2 percent), Southern (4.4 percent) and Central (5.7 percent) provinces have the lowest levels of MC compared with North-Western (71 percent) and Western (40.2 percent) provinces that have among the highest levels of MC. These two provinces have tribes that practice circumcision as part of their culture and tradition of initiation that contribute to MC statistics.

Low, Incorrect and Inconsistent Condom Use

- Although positive changes in condom use have been reported from 1992 to 2007, lack of consistent and correct use, especially in steady and long term relationships and in multiple concurrent sexual partnerships (MCP), is a major source of concern.
- The most recent data shows that consistent condom use in the age group 15-49 stood at 37% for females and 50% for males (ZDHS 2007). Research has shown that correct and consistent use of male and female condoms can provide up to 95% protection against STIs and unintended pregnancies.

Mother to Child Transmission (MTCT)

- MTCT: the transmission of HIV from an HIV positive woman to her child. This can happen during pregnancy, child birth, or during breastfeeding.
- MTCT is reported to account for about 10% of all new infections in Zambia. Antenatal HIV prevalence was estimated at 16.4 % in 2008 and approximately 80,000 infants born of HIV positive mothers were at risk of contracting the virus.
- Although prevention of MTCT (PMTCT) services are readily available country-wide, uptake of ART by HIV positive pregnant women is still not high enough (61% as of 2009) to produce required impact. The PMTCT scale up plan aims to reach at least 90% of all HIV positive pregnant women with ART.

Mobility and Labour Migration

- Mobility and labour migration refer to individuals who frequently travel away from home to work/do business both within and outside of Zambia. Common examples include cross-border traders, truck drivers, miners, students.
- Provinces with highly mobile populations and many migrant labourers, such as Lusaka, Southern, and Copperbelt, have higher HIV prevalence rates than provinces with less labour migration.
- Certain sectors such as trading attract more women migrants in particular.
- Informal cross-border traders – who are usually women - are highly vulnerable to exploitation and abuse, in

part because of their irregular migration status.

- Informal cross-border trade (ICBT) is estimated to make up about 30 to 40% of intra-Southern African Development Community (SADC) trade.

Other Factors Fuelling HIV Infections

- The spread of HIV is further increased by other structural factors that are underpinned by social and cultural norms, and limitations in service delivery. Among them are:
 - stigma and discrimination
 - gender inequalities
 - low levels of education
 - rural-urban differences in accessing services
 - inadequate focus on most at risk populations (MARPS), including women and girls and people with disabilities.

UNIT 4: National Response to HIV

Time	60 minutes
Learning Objectives	1. Orient participants on the national response to HIV and AIDS in Zambia
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation

Through the National AIDS Council (NAC), Zambia is currently responding through the 'three ones principle'. This means:

1. One coordinating National HIV/AIDS/STI/TB Council

NAC has decentralized structures at provincial (PATF) district (DATF), and community (CATF) levels.

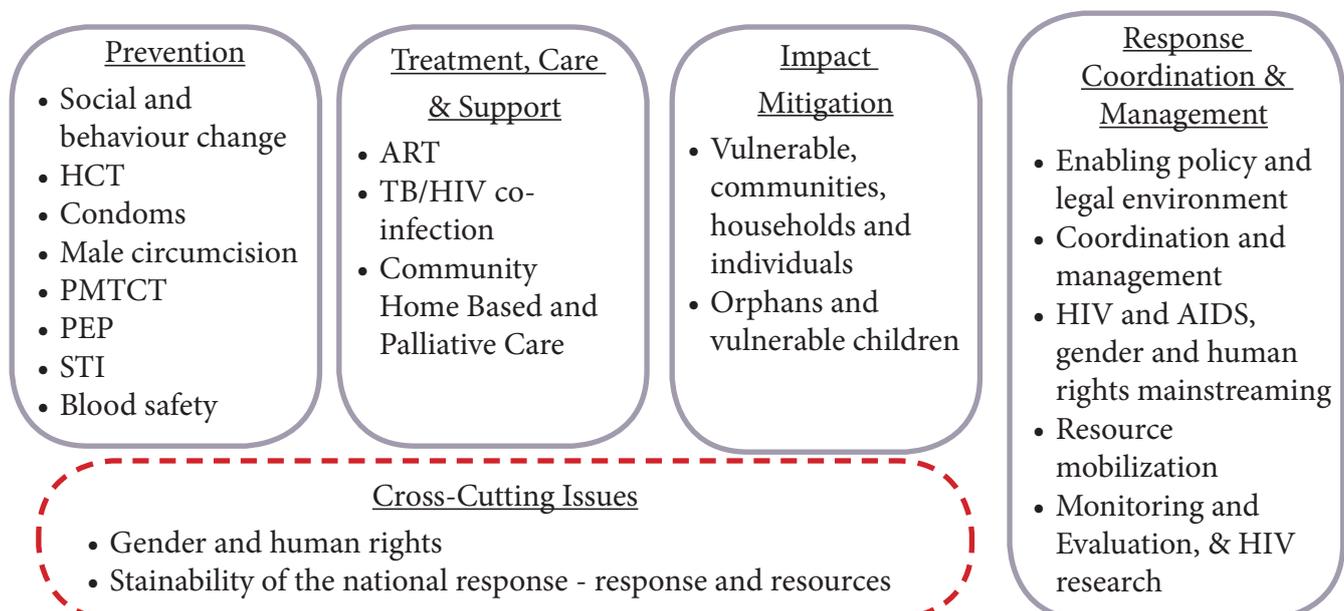
2. One monitoring and evaluation plan

All the information concerning implementation and impact of HIV/AIDS activities should be submitted to NAC using the National AIDS Reporting Forms (NARFs) for comprehensive country-wide monitoring and evaluation.

3. One National AIDS Strategic Framework (NASF).

The Zambia National AIDS Council's (NAC) framework to guide the country's response to HIV/AIDS is outlined in the diagram below:

NASF Priority Programmes



Module 2 - Primary Prevention Strategies

UNIT 1: Prevention of Mother to Child Transmission (MTCT)

Time	45 minutes
Learning Objectives	<ol style="list-style-type: none">1. Orient participants on the modes of Mother to Child Transmission of HIV2. Orient participants on strategies for PMTCT3. Discuss the role of the community in PMTCT
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation

Definitions

What is MTCT?

- This stands for Mother to Child Transmission of HIV. This is when an HIV positive mother transmits the HIV infection to her unborn baby or infant. Mother to child transmission of HIV accounts for 90% of all HIV infection in children aged 0-14 years.

What is PMTCT?

- PMTCT stands for Prevention of Mother to Child Transmission of HIV infection.

How does transmission of HIV occur from mother to child?

- During pregnancy through exchange of body fluids between mother and fetus.
- During delivery through exchange of body fluids between mother and baby.
- During breastfeeding through breast milk.

Risks that Increase Rate of Transmission

Ask participants to brainstorm about the risks that increase rates of transmission for topics below. Capture responses on a flip chart and be sure to highlight risk factors listed below.

During pregnancy:

An HIV positive woman is more at risk of transmitting HIV to her unborn baby during pregnancy if:

- She has infections such as STIs, severe malaria, or anaemia.
- She is involved in an accident that can cause internal bleeding through partial separation of the placenta causing mother and baby's blood and body fluids to mix.
- She is unaware of her HIV positive status, or has been recently infected during pregnancy.

During delivery:

An HIV positive woman is more at risk of transmitting HIV to her baby during delivery if:

- She is in labour for a long period of time beyond normal. This can lead to small internal bleeding and mixing of blood and fluids between mother and baby.
- She has cuts in her birth canal.
- She has ulcerative STIs on her vulva and birth canal.
- The bag of water where the baby lies breaks early before the onset of active labour.

During breastfeeding:

An HIV positive woman is more at risk of transmitting HIV to her baby while breastfeeding if:

- She has sores on her nipples.
- The baby has diarrhoeal diseases which can cause sores in the alimentary canal.
- The baby has sores in the mouth.
- The baby is given solid foods too early (before 6 months), before the stomach and intestines are strong and fully developed. The food can cause injury to the intestines or cause stomach infections which will make the baby more at risk of HIV infection.

Strategies to Prevent MTCT

As a counsellor, here are some ways you can prevent mother to child transmission of HIV in your community:

- Increase awareness of HIV prevention methods amongst women (including youths) through education and awareness programmes at workplaces, health centers, schools and community based activities.
- Encourage woman and couples to attend HIV counselling and testing.
- Promote family planning methods and services to women living with HIV to prevent unintended pregnancies.
- Encourage access to treatment, care and support for HIV positive mothers, their babies and families.
- Encourage uptake and adherence to ARVs to mothers who are HIV positive during pregnancy and labour.
- Encourage and increase awareness about screening and treatment for STIs during pregnancy.
- Encourage male involvement and participation in sexual reproductive health programmes.
- Encourage the promotion, distribution and use of male and female condoms.
- Encourage and increase awareness about exclusive breastfeeding of children up to 6 months.
- Encourage good nutrition among pregnant women.

The Role of a Community Facilitator in PMTCT Programmes

Conduct a brainstorming session with participants to think of ways a club facilitator can reduce MTCT in their community. Post the group's responses on a flip chart.

- Educate community on the benefits of early antenatal care including access to a full package of PMTCT services.
- Sensitize communities on the importance of delivering in a health facility with a skilled attendant.
- Sensitize the community on the dangers of untreated STIs and infections such as malaria and anaemia.
- Sensitize the community on the benefits of family planning.
- Sensitize the community on the benefits of HIV couple counselling and testing.
- Refer clients for PMTCT services.

Conclusion

Summarize key points discussed in the lesson as follows:

- Definitions of MTCT and PMTCT
- Risk factors for MTCT
- Strategies to prevent MTCT

UNIT 2: Abstinence, Being Faithful and Condom Use (ABCs of Prevention)

Time	60 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Orient participants on the ABC (abstinence, being faithful, correct and consistent condom use) approach to HIV prevention 2. Identify key barriers to implementing ABC 3. Discuss strategies for mitigating the barriers in the community 4. Orient participants on how to use male and female condoms
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation Demonstration

Definition

What do the letters ABC stand for?

- Abstinence – This refers to when a person does not engage in any form of sexual activity.
- Being faithful - This refers to when a person, who knows their HIV status, chooses to be sexually active with only one person whose HIV status they also know..
- Condom use - This refers to the use of male or female condoms correctly with every sexual act.

Activity 1

Divide participants in small groups to discuss the following:

- Strategies and benefits of promoting ABC programmes in the community
- Barriers/challenges to implementing ABC programmes in the community
- Strategies to mitigate the barriers.

Each group should report back in plenary.

Facts about Condoms

When used correctly and consistently, male and female condoms can provide up to 95% protection against unplanned pregnancies and STIs including HIV.

- Condoms are strong and reliable
- Condoms are available in health facilities, pharmacies and shops
- Condoms are safe.

10 Tips on Proper Condom Use

Brainstorm with the group on useful condom tips.

1. Admit you have sexual feelings.

2. Discuss sex with your partner and plan together. Who should buy the condoms? What brand do you prefer?
3. Buy condoms and check the expiry date on the condom package.
4. Keep condoms in a cool, dry place such as your bedroom. Do not keep condoms in your wallet or glove compartment of your car because the heat could damage them. Carry condoms in your purse or front pocket of your trousers.
5. Carry condoms whenever you think you will have sex.
6. If you have never used a condom, practice in private to reduce anxiety, nervousness or shyness.
7. Do not reuse a condom. Use a new condom every time you have sex.
8. Only use one condom for every sexual act.
9. If extra lubrication is desired only use water-based lubricants such as K-Y Jelly found in pharmacies and supermarkets. Never use Vaseline, lotion, or other oil-based products as this may cause the condom to break.
10. Remember, even if you think you trust your partner, it's important to use condoms because you never know who else your partner may be having sex with.

How to Use a Male Condom



1. Discuss and decide to use condoms with your partner.

2. Carefully tear the edge of the foil pack and open the package so that you do not damage the condom. Do not use teeth, nails, or sharp objects to open the package because this may rip the condom.



3. Place the condom on your erect penis before intimate contact. Hold the tip of the condom to allow room for the semen.

4. With the other hand, unroll the condom over your erect penis right down to the base. You are now ready for intimate contact with your partner.



5. After ejaculation (discharge), hold the condom at the base of your penis and pull out of your partner before the penis becomes soft. Slide the condom off the penis without spilling any semen.



6. Dispose of the condom immediately into a trash bin, pit latrine, burn or bury it. Do not put into a flush toilet.



Remember: use one condom for one sexual act!

How to Use a Female Condom

1. Carefully tear open the packet along the edge and remove the condom. Do not use teeth, nails, or sharp objects to open the package because this may rip the condom.

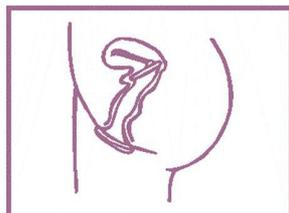
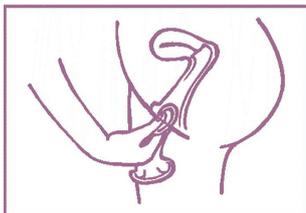
2. The female condom is a thin plastic sheath/tube with flexible rings at both ends. One ring is smaller and closed (inner ring) to facilitate insertion and keep the condom in place. This end of the sheath is closed to protect the cervix from contact with the penis. The other ring is larger and open (outer ring), and rests outside the woman's vagina. Hold the sheath with the open end hanging down.

3. With your hand on the outside of the condom, use your thumb and index finger to pinch the sides of the inner ring together to form a figure "8".

4. Find a comfortable position to insert the condom. You can stand with one foot on a chair, sit on the edge of a chair, lie down, or squat. Use your fingers to guide the sheath into the vagina.



5. Push the ring up the vagina using your index finger. Use the other hand to help widen the opening of the vagina. When your finger cannot push any further up the vagina, the condom is in place. Remove your finger. The inner ring will hold the condom in place inside of the vagina.



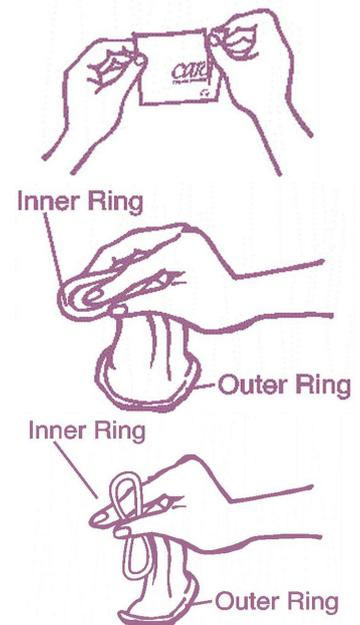
6. When you and your partner are ready for intercourse, secure the outer ring and ensure that your partner's penis enters the condom. Make sure that the penis enters into the female condom, not between the condom and the side of the vagina and that the outer ring remains flat against your outer vagina area. If you feel the outer ring being pushed into the vagina during intercourse, stop and pull the outer ring back into the original position.

Unlike the male condom, the use of the female condom does not rely on an erect penis. Therefore, your partner doesn't have to withdraw immediately after intercourse. You can remove the condom when it suits you both.

To remove the condom, twist the outer ring to keep the semen inside and gently pull the condom from the vagina. Use a paper or tissue to pull out the condom.

Wrap the condom in the paper/tissue and throw it in the bin, pit latrine, bury or burn it. Do not flush down toilet as it might cause blockage.

Remember: use one condom for one sexual act!



Demonstrate how to use male and female condoms. Allow participants to practice in pairs.

Conclusion

- Only condoms (both male and female) can protect you from both unplanned pregnancies and HIV at the same time.
- When used correctly condoms are a very safe and reliable way to prevent HIV infection from sexual intercourse.
- All sexually active people have a responsibility to use condoms to protect themselves when appropriate.

UNIT 3: Post Exposure Prophylaxis (PEP)

Time	45 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Orient participants on the role of PEP in HIV prevention 2. Identify key populations to be reached with information on PEP 3. Discuss the role of the community facilitators in promoting PEP
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials:	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies.	Small group discussion Brainstorming Facilitator's presentation

Definition

What is Post Exposure Prophylaxis (PEP)?

- Post Exposure Prophylaxis is a course of ARVs given to someone for a short period of time to reduce the risk of HIV transmission from an infected person.
- PEP is a service that is offered to all individuals who have been exposed to the risk of HIV.
- PEP is available to anyone who may come in contact with blood or blood products, or any other bodily fluid of a person infected with HIV (e.g. car accident, rape).
- This service should be accessed within 72 hours after exposure to the infected fluids.
- The prescription should be given by a qualified health worker at a health facility.

PEP is commonly used by:

- Health care workers
- Victims of sexual violence including rape
- Victims of assault and accidents

Who should be reached with information on PEP in your community?

Divide participants in small groups to answer the question above. Bring the small groups back together and ask each group to share their responses. Capture all responses on a flip chart and add to the list below:

- All health care workers
- All home based care workers
- Traditional healers
- Care givers
- Youths
- Traditional birth attendants
- Women who are raped, or forced to have sex

Discuss the role of a community facilitator in discussing PEP during Safe Love Club meetings.

- Raise awareness in the community on the importance of accessing PEP by all exposed persons.
- Raise awareness on the availability of PEP services and where they can be accessed in the community.
- Educate the community situations in which PEP is required.
- Sensitize the community on the importance of HIV counselling and testing before going on PEP.

Conclusion

- Question and answer session to wrap up and evaluate the session.

UNIT 4: HIV Counseling and Testing (HCT)

Time	45 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Orient participants on the benefits of HCT 2. Identify barriers to HCT in the community 3. Identify strategies for increasing uptake of HCT in the community
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies	Small group discussion Brainstorming Facilitator's presentation Role play

Importance of HIV Counselling and Testing (HCT) in HIV Prevention

- Getting tested for HIV is the only sure way to know one's HIV status.
- HIV testing should always be accompanied with some form of counselling before and after test results.
- HIV counselling and testing is available for free at most government clinics. HCT is also available at some mobile clinics and private clinics.
- Knowing your HIV status allows you to make informed decisions about your sexual reproductive health.
- For those who test HIV positive, they now have the opportunity to access treatment, care and support.
- Those who test HIV negative, they can receive advice on how to maintain their status.
- Currently national HCT uptake is at 15% (ZDHS 2007). This means about 85% of Zambians do not know their HIV status.

Ask participants to share some of the reasons why people do not access HCT services, especially in their communities. Take down responses on a flip chart paper.

Divide participants in small groups and ask them to identify some benefits of HCT. Groups report back to plenary and discuss the responses. Some of the benefits include:

- Better planning of sexual and reproductive health life, including family planning
- Provides peace of mind
- An entry point to treatment, care and support
- HCT provides guidance on whether an exposed person should be given PEP or not (In the event that a person is already infected with HIV before exposure, PEP will not be given; the person will be referred for ART instead)
- An entry point to access PMTCT services
- Reduces HIV stigma and discrimination in the family and community.

Strategies to Increase Uptake of HCT in the Community

Sensitization on the benefits of HCT:

- Involve community and religious leaders in community mobilization and advocate for community involvement

- Establish male or female action community groups
- Promote couple counselling and testing
- Identify and recognize community role models to advocate for HCT

Brainstorm on common barriers to HCT. Be sure to include the following:

- Fear of a positive results.
- Stigma of going for testing.
- Denial of practicing risky behaviours.
- Fear of having to disclose to partner and deal with the consequences.
- Lack of awareness of access to support services (e.g. support groups and treatment).

Role Play: Ask small groups to get together and role play different situations that highlights the benefits and barriers of HCT.

UNIT 5: Prevention with Positives (PWP)

Time	60 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Orient participants on the role of ART in HIV prevention 2. Discuss the role of the community facilitator in promoting PWP
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies	Group discussion Facilitator's presentation

Definition

What is Prevention With Positives?

Prevention with positives (PWP), also known as secondary prevention, is a strategy that involves reaching out to HIV positive people and providing them with information on what role they can play in stopping the spread of HIV. An HIV positive person should be encouraged to:

- Access and adhere to their ART treatment.
- Use condoms correctly and consistently.
- Seek treatment for STIs and opportunistic infections.
- Reduce their number of sexual partners to just one or abstain.
- Disclose their status to their sexual partner(s)
- By following the above behaviours, there is a reduced chance of an HIV person infecting someone else.

Role of community facilitator in promoting PWP

Discuss the role of a community facilitator in promoting PWP in the community:

- Sensitize communities on the concept of PWP.
- Involve traditional, civic and religious leaders, traditional healers and lay counsellors in HIV and PWP activities such as condom use, partner reduction, treatment of STIs and opportunistic infections in the community.
- Involve PLHA in community HIV prevention sensitization meetings.
- Sensitize the community on the importance of disclosure of HIV status.
- Promote couples counselling, testing and disclosure.
- Create awareness on the availability of information, education and communication activities related to ART treatment and adherence in the community.

Conclusion

Wrap up with a question and answer session.

Module 3 - Behavior Centered Programming (BCP)

UNIT 1: Introduction to BCP

Time	60 minutes
Learning Objectives	1. Orient participants on Behaviour Centered Programming (BCP) approach
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies	Group discussion Brainstorming Demonstration Facilitator's presentation

Definitions

What is the Behaviour Centered Programming (BCP) approach?

- Behaviour centered programming focuses on using research to identify barriers and benefits of ideal behaviours, and using this research to develop behaviour change communication activities and products. Examples of behaviour change communication products include, a flyer indicating the benefits of condom use in HIV prevention.
- Behaviours are the centre piece of behaviour change communication in health programmes.
- Simply having the knowledge is not enough—there is a gap between knowing something and doing the right thing about it or even knowing HOW to act on it. For example, knowing that condoms prevent HIV infection is not enough. A person must also know HOW to use and condom and USE it in order for behaviour change to take place.

(continued on following page)

Defining Behaviour

Tell the group that the word “behaviour” has been used frequently in the discussion so far, but that no one has yet defined what is meant by “behaviour.” Let the group brainstorm on what behaviour is and capture answers on a flipchart. Ensure that there is general agreement on a definition that includes the following elements:

- A behaviour is an ACTION.
- A behaviour is specific, concrete, and measurable.

Next, show participants the following words and ask them to identify which are behaviours and which are not:

Word	Behaviour	Not a Behaviour
Think		X
Wash	X	
Attend	X	
Feel		X
Participate	X	
Explain		X
Know		X
Feed	X	
Put	X	
Give	X	

Ensure that the three statements “Put,” “Give,” and “Wash” are identified as behaviours, and that the reason is that they describe concrete, measurable actions, whereas the other four statements describe internal processes that cannot be measured or observed unless an action is carried out.

Conclusion

Why are behaviours the centre piece of BCP? Give an explanation on why we put behaviour first and ensure the following is covered:

- Individual or collective behaviours are critical to ensuring an intended health outcome.

UNIT 2: Stages of Change

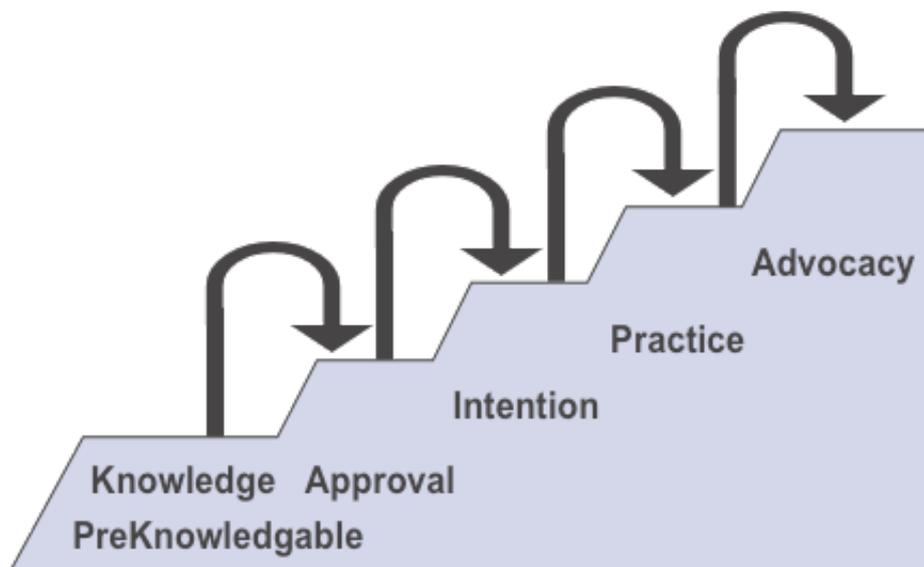
Time	60 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Learn the stages of resistance to change 2. Choose appropriate approaches receptive or resistant individuals
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies	Brainstorming Facilitator's presentation Case study

Stages of Change

Draw out the stages of change (SOC) theory diagram, seen below, on a flip chart so the participants can all see. Walk the group through the stages of change theory and give appropriate examples. The stages are as follows:

1. **Pre knowledge** - a person has a problem (whether she or he recognises it or not) but has no intention of changing. They also do not have adequate knowledge on the problem to support behaviour change.
2. **Approval** - A person receives information to raise awareness about the problem. The person recognises and accepts that there is a problem which needs to be addressed.
3. **Intention** - The individual recognises the problem and is seriously thinking about changing. Some behaviour change efforts may be reported such as inconsistent condom use. However the desired behaviour change has not been reached.
4. **Practice** - an individual has initiated action towards behaviour change. They begin to practice the new behaviour.
5. **Advocacy** - an individual maintains the new behaviour. They recognise the benefits and begin to talk about the benefits of the new behaviour to others.

* During all the stages of behaviour change, an individual requires support to deal with barriers they may encounter in the process of moving to the next stage.



Example of the Process of Change:

The target audience does not change just because of hearing a message in the media or seeing a poster. Often the person exposed to the message will first think about the message internally, counter check with others for approval, and finally make a decision to reject or adopt the message.

Ask participants to reflect on the theory and share any real life examples of how the theory was used to design a specific health product/message/program. Where there any challenges in changing the target group's behaviour? And how can they be avoided next time?

The Twister Game

The purpose of this game is to demonstrate the challenges a person can experience from passing from one stage of behaviour change to the next. In the first round, players will experience challenges in carrying out the required behaviour (e.g. unable to put a left knee on a square while keeping the left cheek on circle). In the second round, players will be coached on how to overcome the challenges and achieve the desired behaviour (e.g. the coach will instruct the player to remove their cheek from the circle so they can put their left knee on the square).

To start, draw out the shapes on large pieces of paper in the same pattern shown in the table below. Next, write each behaviour on a separate piece of paper (10 in total) and put them in a box.

Behaviours:

1. Right Cheek - Circle
2. Left Knee - Circle
3. Left Foot - Square
4. Right Elbow - Square
5. Head - Square
6. Nose - Triangle
7. Right Hand - Triangle
8. Head - Triangle
9. Left Ear - Diamond
10. Left Elbow - Diamond

To start, ask four participants to volunteer to play the twister game. The participant will be split into teams of two, each consisting of a player and a coach. Have the players stand at row 1. In the first round, the coach will draw one behaviour from the box at a time and read the instruction to the player. The player will carry out the instructions as best as possible to go from row 1 to row 10. Each new behaviour belongs in a new row, but a player cannot move his or her body from row 1 to achieve the new behaviour for row 2. If a player moves his or her body from a previous row to achieve a new behaviour they are eliminated. During this time, the coach is only allowed to read the instructions, no other help can be given to the player (e.g. row 1, left ear diamond; row 2 left foot square, etc.).

In the second round of the game, the coach will once again draw behaviours from the box and ask the player to carry out the behaviour. However, in this round, the coach is allowed to give the player extra information to help them carry out their behaviour from one row to the next (e.g. row 1, right elbow square; row 2, pick your elbow off of the square and move your face to row 2 to place your nose on the triangle). This will demonstrate how with IEC/BCC information targeting both knowledge and behaviours can help a person easily graduate through all 10 stages of behaviour change.

Row 1				
Row 2				
Row 3				
Row 4				
Row 5				
Row 6				
Row 7				
Row 8				
Row 9				
Row 10				

After the game, hold a discussion with the participants. Ask the following questions:

- What was the goal of the game?
 - Answer: Following the given behaviours to get from one end of the other.
- In the first round, what were some of the barriers to achieving that goal?
 - Answer: It was physically challenging to carry out the behaviours, instructions were not clear, etc.
- How was it different from the second round?
 - Answer: The barriers were the same, but small intermediary steps were presented to help the player do each behaviour. The coach and player worked as a team, rather than the coach just instructing the player.
- Which round was more helpful to achieving the goal?
- How might this relate to your role as a club facilitator?
 - Answer: Instructions must be clear and feasible, and creating behaviour change must be a participatory process between the facilitator and club members. People also need a chance to try things out and figure out how it can work for them.

Conclusion

- Resistance to change is GREATEST when individuals do not recognize the existence of a problem.
- Resistance is LEAST when individuals are ready to advocate change.
- Individuals tend to oscillate (move up and down) along the scale of resistance..
- Change comes when individuals are helped to overcome their resistances. People change when they want and for their own reasons.

Module 4 - The Safe Love Campaign

UNIT 1: Goal and Objectives of the Safe Love Campaign

Time	30 minutes
Learning Objectives	1. Introduce participants to the Safe Love campaign
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies	Facilitator's presentation

Safe Love Campaign

- **Goal:** Contribute towards the reduction of the national rate of HIV infection
- **Behavioral Objectives:**
 - Reduce the number of people engaged in multiple and concurrent sexual partnerships (MCP).
 - Increase correct and consistent condom use.
 - Increase use of prevention of mother to child transmission of HIV services.
 - Increase the uptake of voluntary medical male circumcision (VMMC) services.
- **Important issues** to highlight that impact the behavioral objective:
 - Alcohol use
 - Gender based violence
 - Youth as a special target audience
- **Primary audience:**
 - The person or group of people who will directly receive, or use, the campaign messages, products, services or goods.
 - MCP, condoms use, MTCT: men and women in both rural and urban areas of reproductive age (ages 15-49)
 - VMMC: uncircumcised, HIV negative males in both rural and urban areas ages 15-49
- **Secondary audience:**
 - A person or group that may exert an influence on the primary audience, such as children, spouses, associates, friends, neighbors, traditional leaders, etc
 - MCP, condoms use, MTCT: Partners of all sexually active Zambians (ages 15-49)
 - VMMC: Parents and guardians of uncircumcised, HIV negative males age 15-17, parents and guardians of uncircumcised males ages 0-60 days, and female partners of uncircumcised, HIV negative males age 15-49.
- **Channels:** Multimedia (video, print, radio, internet)

Research

Share some of the following research to demonstrate why the campaign objectives were selected.

Why focus on multiple and concurrent sexual partnerships (MCP)?

- According to ZSBS 2009 and the PSI/SFH 2009 HIV TRaC. Generally, rural areas reported more concurrency (6.5% of rural Vs 3.8% of urban and 22.9% of rural Vs 22.6% of urban) than the urban areas except that urban males engage in more concurrency than their rural male counterparts.
- Levels of MCP in Zambia are generally high as reported to be high (5.5%, 23%) as reported by ZSBS 2009,

and PSI/SFH TRaC 2009, studies respectively. MCP is higher among males (36%) than females (8.2%) (Source: PSI/SFH TRaC 2009)

- The 2009 ZSBS report that among sexually active male, 11% of single versus 5% of the monogamously married, had concurrent partners
- According to ZDHS; 2007, MCP is higher among single (38%) and formerly married (52%).
- Rates of MCP are the same in both rural (22.9%) and urban (22.6%) areas, but more urban men (38%) compared rural men (36%) Source: PSI/SFH TRaC 2009
- MCP is high (43.9%) among males aged 25-39 years. [ZDHS; 2007]
- MCP is high among females aged 15-25 years at and 34-39 years. [ZDHS; 2007]

Why focus on incorrect and inconsistent condom use?

- Among men 14% (19% in urban, 10% in rural) used a condom at last sex.
- Among women 11% (14% in urban, 9% in rural) used a condom at last sex.
- Marital condom use is very low in both urban and rural areas.
- In rural Zambia 26% of those who have multiple partners used a condom at last sex as compared to 17% in urban areas.
- 10% of men in concurrency used a condom at last sex with each of the partners.

*According to ZSBS 2009 and the PSI/SFH 2009 HIV TRaC

Why focus on mother to child transmission?

- HIV prevalence among pregnant women is 13.9%. [Joint United National Program on HIV and AIDS; 2009]
- About 80,000 infants become infected with HIV in the absence of PMTCT interventions. [Joint United National Program on HIV and AIDS; 2009]
- 3% of women testing negative at first ANC became infected before delivery (average 100 days after the first ANC). [Joint United National Program on HIV and AIDS; 2009]

Why focus on voluntary medical male circumcision (VMMC)?

- MC provides partial protection for men against HIV and some other sexually transmitted infections (STIs) such as herpes, syphilis, chancroid, and human papilloma virus, as well as cancer of the penis.
- MC can make it easier for a man to clean and maintain good hygiene of the penis.
- MC can reduce the risk of getting and passing-on the virus that causes cervical cancer in women.
- MC for male children can reduce the risk of urinary tract infections.
- MC does not provide 100% protection from HIV and other STIs; a circumcised man can still get HIV and other STIs.
- MC should not replace other HIV and STI preventive methods such as abstinence, mutual fidelity, & correct and consistent condom use.

Conclusion

Discuss the following with participants:

- What are the key focus areas of the Safe Love campaign?
- How would you identify club members?
- How do you help club members identify other people to share safe love messages with?
- Who can influence behaviour change in your community?
- Who is hindering change in your community?
- Who are possible advocates for safe love in your community?

UNIT 2: Messages for Communities

Time	60 minutes
Learning Objectives	1. Orient participants on the broad messages of Safe Love health objectives
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Handouts
Methodologies	Facilitator's presentation

Remind the participants about the focus areas of the Safe Love campaign (MCP, low and inconsistent condom use, MTCT, and VMMC). Now share the broad messages the campaign promotes for each of its four focus areas.

Messages on MCP

- MCP is a major driver of HIV in Zambia.
- Know your HIV status and you partners' too.
- Stick to one faithful sexual partner whose HIV status you know.
- The more people you are having sex with, the larger your sexual network and the higher your risk of getting HIV.
- Whenever one person in the network gets HIV, it spreads quickly to everyone in the network who is having unprotected sex.
- Having fewer sexual partners reduces the risk of HIV infection.
- Correct and consistent condom use reduces the risk of HIV infection.
- Even having one extra partner who is unfaithful to you can put you at high risk of HIV.
- Trust alone is NOT enough to protect you from HIV.

Messages on Condom Use

- Condom use reduces the risk of HIV Infection.
- Talk to your partners about using a condom.
- Condoms are safe.
- Condoms are available and accessible in shops, clinics and pharmacies.
- Condoms help prevent unwanted pregnancies.
- Only condoms can protect you from both unplanned pregnancies and STIs.
- Check the expiration date on the condom package before use.
- Store condoms in a cool, dry place.
- Use a new condom every time you have sex.
- Use only one condom for every sexual act.
- Women should NOT be afraid to talk about or use condoms.
- If you are sexually active, it is your responsibility to carry and use condoms.

Messages on PMTCT

- Go for ANC as soon as you know you are pregnant (before three months) to have a healthy pregnancy and baby.
- You and your partner should get tested for HIV when you are planning to get pregnant or as soon as you

know you are pregnant.

- It is possible to have healthy children even if you are HIV positive. Talk to your counsellor about how to get pregnant safely.
- If you are HIV positive and pregnant, access PMTCT services at your clinic to have a baby born free of HIV.
- Using family planning methods can help you avoid unwanted and unplanned pregnancies.
- Planning your pregnancies can greatly reduce the chance of having children infected with HIV.

Messages on VMMC

- MC provides partial protection for men against HIV and some other sexually transmitted infections (STIs) such as herpes, syphilis, chancroid, and human papilloma virus, as well as cancer of the penis.
- MC can make it easier for a man to clean and maintain good hygiene of the penis.
- MC can reduce the risk of getting and passing-on the virus that causes cervical cancer in women.
- MC for male children can reduce the risk of urinary tract infections.
- MC does not provide 100% protection from HIV and other STIs; a circumcised man can still get HIV and other STIs.
- MC should not replace other HIV and STI preventive methods such as abstinence, mutual fidelity, & correct and consistent condom use.

Ask participants to pick their favourite message from the lists above and give a brief five minute talk about why this message is important.

Conclusion

Now that all participants are familiar with the Safe Love campaign and key messaging, ask them to state their definition of what it means to be a safe lover. The definition should include:

- Use a condom every time you have sex.
- Know your HIV status.
- Know the HIV status of each person you have sex with.
- Have sex with only one person whose HIV status you know.
- VMMC

UNIT 3: Safe Love Campaign Products

Time	60 minutes
Learning Objectives	1. Introduction to Safe Love products 2. How to use the products in a Safe Love Club meeting
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip chart/flip chart stand Notebooks Pens Markers Bostik Safe Love Campaign products
Methodologies	Facilitator's presentation Group discussion

Safe Love Campaign Products

Share with participants the list of current Safe Love campaign products:

- Safe Love campaign fact sheet
- Teaching aid poster and flyer on risks of having multiple sexual partners (male and female version)
- Teaching aid poster and flyer on condom use
- Teaching aid poster and flyer on how to be a safe lover
- Teaching aid poster and brochure on HIV testing
- Teaching aid poster and flyer on HIV and pregnancy
- Teaching aid poster and flyer on caring for your baby if you are HIV positive
- CDs and discussion guide for Life at the Turnoff
- DVDs of Love Games
- Safe Love Club Discussion Guide

IEC/BCC Materials

Explain the issues to consider when using IEC/BCC materials:

- Target audience
- The objective of using a particular material
- The barrier(s) to be addressed
- The tone of the message on the material
- The format in which the material was presented
- Creative consideration for each material.

Now divide participants into small groups. Distribute various campaign products to each group to discuss the following about the materials:

- Who is the target audience?
- How should the material be used?
- Where should the material be placed?

Bring the small groups back together and share what each group discussed in a plenary session.

Conclusion

- Wrap up with a question and answer session.

Module 5 - Facilitation Skills

UNIT 1: Interpersonal Skills

Time	60 minutes
Learning Objectives	1. Equip community facilitators with interpersonal communication skills 2. Learn to deliver tailored HIV prevention messages
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip charts/flip chart stand Markers Reference materials Training Handouts
Methodologies	Group Discussion Brainstorm Role Play Facilitator's presentation

Definition

What are interpersonal skills?

- Interpersonal skills are the life skills we use every day to communicate and interact with other people, individually and in groups. Interpersonal skills include not only how we communicate with others, but also our confidence, and our ability to listen and understand.

Ask participants to brainstorm on their understanding of “interpersonal skills,” include examples of specific skills (e.g. listening, body language, voice tone, vocabulary) Following the discussion, share the above definition of interpersonal skills with the group. Now that you have established what interpersonal skills are, discuss why they are important and how they could enhance or hinder interpersonal communication.

Listening

One particularly important interpersonal skill for facilitators to have is to be a good listener. A good listener will not only listen to what is being said, but also to what is left unsaid, or only partially said. Listening involves observing body language and noticing inconsistencies between verbal and non-verbal messages.

For example, if someone tells you that they are happy with their life but has tears filling their eyes, you should consider that the verbal and non-verbal messages are in conflict. Listening requires you to pay attention to verbal and non-verbal communication.

Have the group brainstorm on what it takes to be a good listener. Make sure the following good listening tips are included.

- Remove distractions: Focus on what is being said: don't shuffle papers, look out the window. Avoid unnecessary interruptions.
- Empathize: Try to understand the other person's point of view. Look at issues from their perspective. Let go of preconceived ideas.
- Be patient: A pause, even a long pause, does not necessarily mean that the speaker has finished. Never finish a sentence for someone.
- Avoid personal prejudice: Try to be impartial. Don't become irritated and don't let the person's habits or

manner distract you from what they are really saying.

- Listen to the tone: Volume and tone both add to what someone is saying.
- Listen for ideas, not just words: You need to get the whole picture, not just isolated bits and pieces.
- Wait and watch for non-verbal communication: Gestures, facial expressions, and eye-movements can all be important.
- Do not jump to conclusions about what you see and hear. You should always seek clarification to ensure that your understanding is correct.

Conclusion

Summarize the session on interpersonal skills by highlighting the following important points:

- Learn to listen and listen to learn.
- Be sensitive to other people's feelings and opinions.
- Understand what factors impact the success or failure of effective interpersonal communication.
- Relax.
- Clarify.
- Be positive.
- Empathize.
- Understand stress.
- Learn to be assertive.
- Reflect and respond.
- Respect other people's opinion.

UNIT 2: Role of Facilitators

Time	60 minutes
Learning Objectives	<ol style="list-style-type: none"> 1. Equip community facilitators with facilitation skills 2. Develop skills and capacity in managing the day-to-day aspects of a community meeting/activity training
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip charts/flip chart stand Markers Reference materials Training Handouts
Methodologies	Group Discussion Brainstorm Role Play Facilitator's presentation

Role of Community Facilitators

Ask the participants what they understand as the role of a Safe Love Club facilitator to be. Ensure the following points are covered:

- Planning for community meetings.
- Managing the day-to-day details of implementing community activities including preparing all materials.
- Facilitating all community group meetings, discussions and other learning activities.
- Ensuring that learning objectives of each session are met.
- Ensuring that all questions of participants are answered.
- Serving as a point of contact for any future questions or support needed by the community.

Facilitating Adult Learning

Introduce the principles of adult learning to the facilitators. As facilitators in a club primarily made up of adults, learning these principles will help facilitator successfully relate to and interact with their club members.

Principles of Adult Learning:

- Create a supportive learning environment: For example, be sure that group members feel confident that their contributions will be received respectfully.
- Build trust with participants and demonstrate that you are equally committed to the topic and are willing to share your own experience.
- Provide opportunities for group members to practice what they are learning and to address feelings and ideas that arise.
- Build team work and a sense of group belonging by encouraging active participation.
- Create a culturally sensitive and respectful learning environment by becoming familiar with local customs and values and understanding the local context.

Learning Approaches

Keep these various learning approaches in mind when interacting with your club members. Participants learn best through:

- **Doing** - identifying their own strengths and weaknesses as group members when discussing and solving common problems, analysing different topics, and applying concepts to their own life situations.
- **Small Groups** - the “doing” takes place in small groups. Members work together in buzz groups, task groups, skills practice groups and other types of small groups to discuss, analyse, solve problems, practice and plan. The small groups make it easier to maximize participation and sharing.
- **Trying it out** - group members are given lots of opportunity to practice different skills. After each practice session the performer is given supportive feedback to show him/her how to improve, e.g. condom demonstrations.

Also keep in mind that **adult learning is most effective** when it is

- Relevant
 - Learning experiences should relate directly to the learner’s real life experiences.
 - Learning acknowledges and takes advantage of the wealth of experience adults bring (facilitators and group members learn from each other.)
- Participatory
 - Learners are actively involved in the learning.
 - Learning is pleasant and involves a low level of stress (may include having a comfortable environment, free from distractions).
- Based on positive feedback
 - Learning goals are clear and progress is measurable.
 - Corrections are based on constructive criticism and delivered in a positive way.
- Built on clear and appropriate expectations
 - Facilitator should make sure their expectations for club members are realistic in relation to members’ current understanding and abilities.
 - Participants have opportunities to practice their new skills.
 - Objectives are clear, so that progress can be assessed by the facilitators and learners themselves.
- Communicated using appropriate language/vocabulary
 - Present information in a clear and logical way using language familiar to participants. This will allow them to easily talk about the topic on their own, away for the group.
 - If you need to introduce new vocabulary, take the time to make sure participants clearly understand the meaning. Choice of words, technical or non-technical will have a significant impact on what your learners can achieve.

Ask participants to brainstorm different ways they can discuss key Safe Love behaviours using appropriate vocabulary and learning approaches.

E.g. multiple and concurrent sexual partnerships (MCP) → having sex with more than one person at the same time (vocabulary); role play how to talk to your partner about going for HIV testing (learning approach; participatory)

UNIT 3: Giving and Receiving Feedback

Time	20 minutes
Learning Objectives	1. Understand principles of giving and receiving feedback
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip charts/flip chart stand Markers Reference materials Training Handouts
Methodologies	Group Discussion Brainstorm Role Play Facilitator's presentation

Principles of Giving and Receiving Feedback

Ask participants to brainstorm on what makes good or bad feedback and how to receive or give useful feedback. After the brainstorm, discuss the list below with participants.

Giving Feedback

- Giver needs to want to help receiver develop.
- Feedback should be well intentioned and given to help the presenter.
- Always give constructive criticism, trying to give both positive and negative feedback with possible solutions to weaknesses.

Receiving Feedback

- Listen carefully to the feedback.
- Be receptive to feedback and see it as helpful.
- Accept both negative and positive feedback.
- Avoid arguing or being defensive.
- Ask questions to clarify and seek examples when needed.
- Acknowledge the giver of feedback and show appreciation for his or her contribution. The feedback may not have been easy to give.
- Don't feel like the giver is your enemy.
- Reflect on negative feedback and identify areas for improvement.
- Try to keep feedback sheets/information together.
- Do not let negative feedback upset you, use it to improve.
- Try not to be defensive and make excuses for weaknesses.
- Consult whenever necessary; accept that you do not know it all.

Conclusion

- End this session by asking participants to mention some principles of giving and receiving feedback. Responses should include principles discussed earlier in the lesson.

UNIT 4: Working with Young People

Time	30 minutes
Learning Objectives	1. How to engage young people 2. How to be a youth as peer educators
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip charts/flip chart stand Markers Reference materials Training Handouts
Methodologies	Group Discussion Brainstorm Role Play Facilitator's presentation

Why work with young people?

Ask participants to brainstorm why it is important to engage young people in Safe Love Club activities. Make sure the following are included:

- All members of a community, including young people, are affected by HIV/AIDS.
- Youth are important decision makers and stakeholders in a community.
- Young people are concerned about many issues ranging from understanding how their bodies work and change, HIV and AIDS, politics, religion, socialization and the environment, just to mention a few.
- Allowing young people to discuss the issues, to develop a deeper understanding and voice their concerns can be a positive, fulfilling experience both for you and for them.
- Educating young people will help them develop valuable skills and knowledge and help them to make informed decisions about their health.

How to Engage Young People

Decide which youth you are going to target, for example in-school or out-of-school. Next, identify where you can find these individuals and visit the locations, for example visit schools, youth clubs, and colleges. Try asking teachers and club coordinators if you can make presentations about joining your Safe Love Club during their meetings/classes to encourage club membership.

Peer Educators

It is encouraged for Safe Love Club facilitators to be around the same age as their club members, in order to encourage open and relevant discussion during club meetings. Club members are more likely to open up about their experiences and concerns when talking to someone they perceive to be a peer. This is particularly important amongst youth. If a Safe Love Club facilitator happens to be much older than their club members, they are encouraged to identify someone within the club that may act as a peer educator.

Key qualities of a youth peer educator:

- **Be a role model:** Role model positive behavior.
- **Be an educator:** Educate friends and peers about the “cool stuff” they learn that can help them make good choices.
- **Recognize and refer:** Recognize young people who need help and refer them to services, like the clinic, community HIV/AIDS clubs, economic empowerment clubs, etc.

- **Community Support:** Support the community by advocating for resources and services; taking on community service activities, and raising awareness of important issues affecting youth.

Ask youth participants what they understand their responsibilities to be as peer educators. Ask participants to state their contributions in the following way, “As a peer educator I ...” Write down all their contributions. Discuss each role proposed. In consolidating the lesson, share with them the additional roles below and check how it compares with their contributions.

- Have a passion to lead by example.
- Am willing to be a servant leader, always putting other people first and serving those around me.
- Want to build my community, country and continent.
- Know what I think about different issues.
- Am reliable and trustworthy.
- Am willing to work with many different people.
- Have a vision for my future.
- Am able to communicate well with others.
- Have the strength of character to influence other peers.
- Am willing to work to look at different choices and challenge myself to make decisions which enhance my health and impact positively on my future.
- Will represent my class, grade or community.
- Will be trained and given skills in the area of HIV and AIDS, sexuality, reproductive health and life style issues.

Conclusion

Have a final question and answer session.

Module 6 - Monitoring and Evaluation

UNIT 1: Data Collection and Documentation

Time	60 minutes
Learning Objectives	1. Build data collection and documentation skills for programme monitoring
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip charts/flip chart stand Markers Reference materials Training Handouts
Methodologies	Group Discussion Demonstration Brainstorm Case Study Facilitator's presentation

Data Collection

Start the session by reading the following statement:

“Data collection is a core component of any monitoring system. After you have identified the questions you need to assess the impact of your program so far, you must be able to collect data to answer the questions. Instead of us telling you about the process of data collection, we want you to tell us. There is a wealth of experience in this room, and now we are all going to become facilitators for this session. “

Divide participants into small groups, and give each team one of the following questions about data collection:

- Why do we collect monitoring data?
- What monitoring data do we collect?
- How do we collect monitoring data (methods and tools)?
- Who collects monitoring data?
- What are some of the challenges in collecting the data, and how do you overcome them?

Each team will select one facilitator for their question and spend 10 minutes brainstorming their answers and writing them on the flip chart. At the end of the 10 minutes, all participants can regroup and have the facilitator present to the plenary their group answers.

Next, the facilitator can move on to present established monitoring systems/practices/methodologies:

Data Collection Methods

There are various methods that can be implemented to monitor and evaluate programmes. A common way to distinguish between methods is to classify them as either quantitative or qualitative.

- **Quantitative methods** are those that generally rely on structured or standardized approaches to collect and analyse numerical data. Almost any evaluation or research question can be investigated using quantitative methods, because most phenomena can be measured numerically. Some common quantitative methods include surveys, provider-client observations, and client exit interviews. This methodology is best used when you want to collect information about a large group of people to draw conclusions about certain behaviours/practices.

- Qualitative methods are those that generally rely on a variety of semi-structured or open-ended methods to produce in-depth, descriptive information. Common qualitative methods include focus group discussions and in-depth interviews.

Quantitative methods and qualitative methods can be used in a complementary fashion to investigate the same phenomenon.

- One might use open-ended, exploratory (qualitative) methods to find out what issues are most important and the language to use in a structured questionnaire.
- Alternatively, one might implement a survey and find unusual results that cannot be explained by the survey, but that might be better explained through open-ended focus group discussions or in-depth interviews of a subgroup of survey respondents.
- In addition, one might implement qualitative and quantitative methods simultaneously to gain both numeric and descriptive information about the same topic.

Data Collection Tools

Ask the group which method of data collection is generally used to collect monitoring data. However, tell the group that we are not that interested in the “methods” that we use for collecting monitoring data, rather we are interested in the specific “tools,” or instruments, that we can use.

- Whereas a method refers to the design or approach to a monitoring, evaluation, or research activity, a data collection tool refers to the instrument used to record the information that will be gathered through a particular method.
- Tools are central to quantitative data collection because quantitative methods rely on structured, standardized instruments such as questionnaires. Tools such as open-ended questionnaires are often also used in qualitative data collection as a way to guide a relatively standardized implementation of a qualitative method.
- Tools may be used or administered by trained community members. Clients may fill in the answers on the tool. If tools are to be self-administered, there should be procedures in place to collect the data from clients who are illiterate. Space, privacy, and confidentiality issues should be observed.

Data Quality

Break the participants into small groups and presents each group with a scenario. There are three projects working to improve condom distribution and promoting consistent and correct condom use with one catchment area. The groups can review this scenario for 10 minutes and identify how to avoid double counting in maintaining attribution.

After 10 minutes, ask each group to give a 5 minute presentation on their group’s methodology and tools. Once each group has presented, discuss the solution as a whole and decide as a group on a final methodology and tools.

UNIT 2: Reporting

Time	20 minutes
Learning Objectives	1. The goal of this learning session is to build the skills of participants in reporting
Preparations	Read session carefully Review relevant materials Prepare lesson materials for participants
Learning materials	Flip charts/flip chart stand Markers Reference materials Training Handouts
Methodologies	Facilitator's presentation

Reporting Requirements

- **Multiple stakeholders are involved in collecting and reporting data for programmes with varying roles and responsibilities** including collecting data, reporting data on a monthly or quarterly basis, encouraging and supporting the collection of data, and sharing findings with the community.
- Data can only be successfully reported if data sources are well identified. **Data sources are the resources used to obtain data for monitoring and evaluation activities.** There are several levels from which data can come, including client, program, service environment, population, and geographic levels. Regardless of level, data are commonly divided into two general categories: Routine and Non-routine.
- **Routine data sources provide data that are collected on a continuous basis**, such as information that clinics collect on the patients utilizing their services. Although these data are collected continuously, processing them and reporting on them usually occur only periodically, for instance, aggregated monthly and reported quarterly.
- Data collection from routine sources is useful because it can provide information on a timely basis. For instance, it can be used effectively to detect and correct problems in service delivery. However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.
- **Non-routine data sources provide data that are collected on a periodic basis**, usually annually or less frequently. Depending on the source, non-routine data can avoid the problem of incorrectly estimating the target population when calculating coverage indicators. This is particularly the case with representative population-based surveys, such as a Demographic Health Survey (DHS).
- Reports should be **submitted at an agreed time frame** to donors and to stakeholders.
- The format of reporting should be appropriate for the audience.

Data Reporting Cycles

- Data reporting follows two different reporting cycles for stakeholders: **monthly and quarterly.**
- **Monthly reports** are submitted to CSH by CSOs and are due by the 10th working day following the end of the reporting month. For example, reports which include data for the month of January would be due on the 10th working day of February.
- **Quarterly reports** are generated by CSH and shared technical teams and feedback is provided to CSOs on program performance.

Refer to the Monitoring and Evaluation instruction manual for the HIV CSOs

