Faith Community Responses to HIV/AIDS

Integrating Reproductive Health and HIV/AIDS for Non-Governmental Organizations, Faith-Based Organizations and Community-Based Organizations

Volume II

Faith Community Responses to HIV/AIDS

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	The AIDS Control and Prevention Project
CEDPA	The Centre for Development and Population Activities
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IGA	Income Generating Activities
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MSM	Men having sex with men
MTCT	Mother-to-Child Transmission
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV/AIDS
RH	Reproductive Health
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
TV	Television
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WCRP	World Council on Religion and Peace
WHO	World Health Organization

Acknowledgements

Headquartered in Washington, DC, The Centre for Development and Population Activities (CEDPA) is an international nonprofit organization that seeks to empower women at all levels of society to be full partners in development. Founded in 1975, CEDPA supports programs and training in leadership, capacity building, advocacy, governance and civil society, youth participation and reproductive health.

The Enabling Change for Women's Reproductive Health (ENABLE) project works to strengthen women's capabilities for informed and autonomous decision-making to prevent unintended pregnancy and improve reproductive health. Begun in 1998, ENABLE seeks to increase the capacity of NGO networks to expand reproductive health services and to promote a supportive environment for women's decision-making. ENABLE is currently implementing a faith-based initiative in Nigeria and Ghana.

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It is our hope that this manual will help faith-based groups to determine the best ways that they can address the HIV/AIDS pandemic, whether through the traditional roles of caring for widows, orphans, the sick and dying; offering counseling and spiritual guidance; or through more broad approaches, such as teaching HIV prevention to their congregations or advocating for the rights of people living with HIV/AIDS (PLWHA).

CEDPA works through organizations at the grassroots level and has many faith-based partners. This manual was developed for use with them and others in Africa, and was field-tested in Ghana, with both Nigerian and Ghanaian clergy and lay members of various Christian denominations. Special thanks go to Josephine W' Goro, Deputy Director Health & Social Services & Coordinator IRH (CEDPA), Church of Christ in Nigeria (COCIN) for her assistance in facilitation. We would also like to thank Reverend Attah Edu-Bekoe, Presbyterian Church of Ghana, who contributed a sample sermon and helped facilitate the Integrating Messages into Sermons session.

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Overview

The 1994 International Conference on Population and Development (ICPD) in Cairo was a watershed point for the field of reproductive health (RH). The ICPD brought about a major shift in thinking about population and development, from a focus on population control to an interrelated approach that considers population, sustainable development and economic growth and advances in women's education, economic status, and empowerment. Women's groups, non-governmental organizations (NGOs), faith-based institutions, and other members of civil society pressed for a new holistic interpretation of reproductive health that focused on the individual's needs and desires.

Given the call to action from Cairo, The Centre for Development and Population Activities (CEDPA) project, Enabling Change for Women's Reproductive Health (ENABLE), was designed "to strengthen women's capabilities for informed and autonomous decision-making to prevent unintended pregnancy and improve reproductive health." Through partner NGO networks, women would have greater access to high-quality, *integrated* reproductive health services and an enabling environment would be promoted.

Concurrently, the HIV/AIDS pandemic has created a crisis of unprecedented proportion, which greatly impacts society as a whole, but especially women and their reproductive health. Faith-based organizations everywhere are struggling to respond to it.

Many of CEPDA's partners are faith-based NGOs that have expressed a desire to become active in the fight against HIV/AIDS. Religious leaders have enormous influence in the community and can be powerful agents for change. Religious faith also plays a crucial part in the lives of people living with HIV/AIDS. The faith community and its leadership can play a pivotal role in ensuring the viability and sustainability of interventions that prevent the spread and mitigate the impact of HIV/AIDS. Therefore, religious leaders and institutions must define their roles in preventing HIV infection, supporting and prolonging the lives of people living with HIV/AIDS (PLWHA), and addressing both the stigma associated with HIV and the pandemic's root social causes.

This curriculum was developed to provide an overview of the HIV pandemic to Christian clergy, religious leaders, laity and church groups, and to sensitize participants of faith-based organizations on the current issues and challenges that PLWHA face. The curriculum provides an overview of the signs, symptoms, modes of transmission, and prevention of HIV/AIDS and can help to identify cultural and social factors that contribute to the pandemic's spread. It will orient participants to the various means by which faith communities can respond to HIV/AIDS, whether it is through care and counseling, education and outreach, or service delivery, along with helping participants to define what path to take to combat the pandemic. It will also assist participants in advocating and networking to reduce HIV/AIDS in their communities and churches. An additional benefit is the sensitization of clergy and their congregations regarding broader RH/family planning (FP) issues. CEDPA hopes that this curriculum will also be adapted for use with non-Christian groups.

The curriculum was designed to assist a trainer in delivering a five-day workshop. It is divided into seven chapters. Each chapter introduction provides background information for the trainer

about the topics covered. Activities have been designed to involve participants to the fullest extent possible.

Methodology

The curriculum uses several training methodologies to add variety and to engage all types of adult learners. The methodologies are—

- Demonstration
- Discussion
- Brainstorming
- Small Group Work
- Role-play
- Presentation/Lecture
- Guest Speakers

Evaluation

At the end of each day, participants will fill out three color-coded cards as follows—

- On the green cards, they will write one thing they learned that day
- On the pink cards, they will write one thing that they did not understand, or need more explanation on
- On yellow/blue cards, they will write one suggestion for improvement

Participant volunteers will then collect and summarize the cards and give the group feedback the following morning.

The training team will meet each day to evaluate the day's work and modify the program as necessary.

A final evaluation will be conducted with participants at the end of the workshop.

Learning Objectives

By the end of the training, participants will be able to—

- Explain why a religious response is needed to address HIV/AIDS
- Discuss the impact of the HIV/AIDS pandemic on society
- Differentiate between HIV and AIDS, state how it is transmitted, describe the signs and symptoms of AIDS, and state ways that HIV/AIDS can be prevented
- List current treatments for HIV/AIDS
- State cultural and social factors that contribute to the transmission of HIV/AIDS and list solutions to each factor
- Describe the steps of behavior change
- Describe five ways that clergy/churches can become involved in HIV/AIDS prevention, care, and treatment
- Demonstrate effective counseling techniques for use with people affected by HIV/AIDS
- Educate communities about HIV/AIDS
- Develop a sample sermon that integrates discussion of HIV/AIDS
- Demonstrate basic knowledge of advocating on HIV/AIDS

How to Use This Manual

This manual is designed to be flexible. It contains basic information about HIV/AIDS and different ways in which the faith community can respond including teaching, counseling, IEC, and advocacy. A prototype five-day training schedule is included for about 20 participants; the trainer will need to determine the needs of the specific group and plan accordingly. In order to help facilitate this process, there are additional or alternative activities to choose from in many chapters. For example, when using this manual with a women's church group, the trainer would not need to include sessions on Integrating Messages into Sermons.

For clergy, the training can be divided into two parts—

- A three and a half day training session that ends with the counseling session
- A follow-up training a few weeks later lasting two or three days that includes a debriefing for participants on using the counseling skills they learned previously and the rest of the sessions from the manual

Some faith groups may have doctrine that conflicts with parts of the content. The trainer should decide how to best use the materials and adapt them as needed. Remember that this manual is intended for use by a variety of faith groups with differing beliefs. There is a great need for the faith community to respond to the HIV/AIDS pandemic and that response can take many forms. Every effort will help.

Building a Training Team

Ideally, to facilitate the prototype five-day training used illustratively here, a team of at least three or more facilitators is needed. As team building is a process, facilitators should meet prior to the training to familiarize themselves with the content and discuss it. The sessions that each facilitator will lead should also be decided and who will be the appropriate participants. It is important that the facilitators have a variety of skills to respond to the participants' needs and questions. It is also important for facilitators to meet daily to address concerns, assess progress, and make any modifications that may be needed in the training.

The facilitator for the technical sessions will need to have substantial knowledge and experience in the area of HIV/AIDS; this facilitator could be a health or medical professional. Another facilitator should have a solid background in counseling, such as a trained social worker or other professional counselor, to facilitate the counseling sessions. One of the facilitators should be a church member, either clergy or laity, to ensure that the spiritual sessions and issues are covered appropriately. And finally, someone with experience in community-based education, mobilization, and advocacy, perhaps from a local NGO, or even a PLWHA activist, would be useful for those sessions. Of course, it may be possible to find one person that has two or more of these skills.

How the Manual Is Organized

This manual is divided into seven chapters and is organized into a five-day training schedule (see prototype at the end of this section). The trainer can also take material from several chapters and arrange it to meet specific training needs. Each chapter covers one thematic area and but each is divided into similar sub-sections and contains uniform components to facilitate flexibility.

Each chapter may contain these sections.

Key Questions. This section highlights the major questions that the chapter addresses.

Introduction. This section introduces the major theme of the chapter major and orients the facilitator to the overall lesson plan.

Objectives. The objectives set the learning goals for the sessions in specific, clear, and measurable terms. They can be used to focus pretest/posttest material and to orient the participants to the focus of the sessions.

Overview. The overview contains important background information for the facilitator. It gives general and specific information that the facilitator can use in the lecture activities and to facilitate discussions.

Sample Lesson Plan. The sample lesson plan covers the time required, content, methodology used, materials needed, and a way to evaluate the participants' learning. It helps the facilitator to determine whether the content is appropriate for the audience and to make sure that everything is prepared for the session.

Important Terms. This section contains definitions of key words that are necessary to understand the session content. This section can be used as a handout to help participants learn new terms and can be kept as a reference.

Activities and Handouts. This section contains all of the activities included in the sample lesson plan. Each activity has learning objectives and step-by-step directions on how to conduct the class. Any handouts needed are included after the activity.

Notes to Trainers. This section gives facilitators helpful hints on how to teach the class based on CEDPA's experience and extra resources for the session.

Trainer Resources. This section contains examples or materials that trainers can use and adapt to fit various audiences.

Additional or Alternate Activities and Handouts. This section includes materials that the trainer or facilitator can add when adapting the sample lesson plan to better match the audience. It can also provide the trainer with ideas for additional activities.

Faith Community Responses to HIV/AIDS
Sample Training Schedule

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	
Total Time	*9 hours*	*9 hours, 10 minutes*	*8 hours, 35 minutes*	*8 hours, 5 minutes*	*8 hours, 50 minutes*

Chapter 1

Introduction to HIV/AIDS

"AIDS has become a full-blown development crisis. Its social and economic consequences are felt widely not only in health but in education, industry, agriculture, transport, human resources and the economy in general."

–UNAIDS REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC, 2002

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Chapter 1: Introduction to HIV/AIDS

Chapter 1: Introduction to HIV/AIDS

Key Questions

- Why is it important for religious groups to become involved in HIV/AIDS prevention, care and treatment?
- What are the signs and symptoms of HIV/AIDS?
- What is the difference between HIV and AIDS?
- What are some common myths about HIV?

Introduction

It is estimated that 40 million adults and children worldwide are currently living with HIV/AIDS.[1] The pandemic has reached every corner of the world, and in numerous countries, young people, and especially young women, are at greatest risk of new infections. Young people, aged 15–24, account for about 30 percent of those living with HIV/AIDS. Many don't know they are HIV positive; many more don't know how, or are unable, to protect themselves from infection.

[1] "UNAIDS AIDS epidemic update," December 2001

Estimated Adult HIV Prevalence by Region

Region	Prevalence
Australia & New Zealand	0.13%
Caribbean	2.11%
East Asia & Pacific	0.06%
Eastern Europe & Central Asia	0.21%
Latin America	0.49%
North Africa & Middle East	0.12%
North America	0.58%
South & South-East Asia	0.54%
Sub-Saharan Africa	8.57%
Western Europe	0.23%

UNAIDS, 2000, available from http://www.unaids.org/epidemic_update/report/Final_Table_Eng_Xcel.xls

Of the 40 million people infected with HIV, approximately 70 percent (over 28 million) live in sub-Saharan Africa, the most severely affected region. New infections are increasingly due to established patterns of risky sexual behavior. The devastating effects of HIV/AIDS are being seen as child and adult mortality rates increase, women and adolescents begin to show high infections rates, and households deal with decreased income due to the death of family members. Relatives of affected individuals, often women, struggle to care for the children left behind. Orphaned children, especially girls, often do not attend school or find their schooling interrupted. There is also an increased demand for health care from people with HIV-related illnesses that places stress on the already under-funded healthcare system. These patterns are starting to appear in other areas of the developing world as the pandemic spreads.

In light of these escalating issues, various religious organizations have expressed an urgent concern to get involved in fighting the pandemic. For religious leaders to become informed advocates in the fight against HIV/AIDS, they must have a basic understanding of its modes of transmission, signs, and symptoms and learn ways to prevent disease transmission. As the prevalence of HIV/AIDS continues to rise, more options must be explored for care and treatment of those already affected.

The first part of this chapter focuses on setting the workshop tone and atmosphere with formal introductions and exercises to ascertain participant's expectations and create group norms. Next, an introduction to the epidemic is provided, followed by a discussion of why it is important for faith-based groups to respond to the epidemic, basic HIV/AIDS facts, and how to talk about sexual issues.

Chapter 1: Introduction to HIV/AIDS

Section 1: Introductions and Workshop Structure

Objectives

By the end of this section, the participants will be able to—

- Introduce another participant to the group by name
- State several basic facts about another participant
- Place themselves in a group of their choice
- Discuss ways to provide feedback to facilitators
- List participants' expectations for the workshop
- List the group norms for the workshop
- Describe the workshop purpose and
- List at least two of the workshop objectives

Overview

When a workshop begins, it is important to assess the strengths and weaknesses of participants. It is also helpful to get an idea of what the participants expect to get out of the workshop to make the experience a good and productive one for all involved. This will also help the facilitator get to know the participants as well as the participants to be comfortable with each other. It is important to foster a sense of belonging within the group and to establish a set of ground-rules that all participants can agree to for the workshop duration.

To begin an HIV/AIDS discussion, the facilitator and participants must realize that everyone will not be immediately comfortable discussing matters that are very private and personal, including acts and behaviors of a sexual nature and subjects that are intimate and occur in private. Just the act of recognizing this discomfort often helps to create a more relaxed climate and openness amongst the group.

The Human Immunodeficiency Virus (HIV) causes Acquired Immune Deficiency Syndrome (AIDS).[2] HIV attacks the body's immune system. As a result, the body can no longer protect itself from infection. AIDS is associated with numerous opportunistic infections that cause death, such as cancers, tuberculosis, and pneumonia. AIDS can be found on all continents and is now considered a pandemic or global epidemic.

A person who is infected with HIV may show no visible symptoms, feel healthy, and appear normal for years. Despite this, an HIV-positive person can still transmit the disease. Eventually, a person living with HIV will begin to show symptoms of infection. Symptoms include enlarged lymph glands, fevers, night sweats, and severe diarrhea. As the immune system weakens, more serious conditions develop, leading to "full-blown" AIDS. People with AIDS may show signs of weight loss and mental impairment in addition to cancer and other opportunistic infections.

Social behavior has contributed to the spread of the disease. In infected people, HIV is only present in cells and human body fluids such as semen, blood, vaginal secretions, menstrual fluid, and breast milk. These specific body fluids contain live cells and thus pose a risk. (Fluids such as tears, sweat, saliva, feces, and urine contain very few live cells, and pose almost no risk). Although HIV is present in the body and in certain fluids, it cannot survive long outside the body. HIV cannot be transmitted through air, food, water, or a mosquito bite and is difficult to grow in a laboratory. HIV dies quickly if exposed to air, light, or soap and water and can only reproduce (survive) inside the body of its human host.

[2] Adapted from Hung Fan, Ross F. Conner and Luis P. Villarreal, *AIDS: Science and Society* (Sudbury: Jones and Bartlett Publishers, 1998), available from: www.jbpub.com/. Reprinted with permission.

HIV transmission occurs through transfer of body fluids from one person to another through blood, breast milk, sexual fluids, or the placenta. Transmission requires direct contact of this fluid with another person's cells. Transmission also requires a portal of entry, an opening in the skin that HIV can pass through or a "door" into the body. Examples include cuts, sores, the vagina, penis, rectum, or mouth.

HIV transmission may occur as a result of—

- Blood infected with HIV contacting another person's blood stream (examples, blood transfusions, injection through a syringe, or through direct contact of blood with open sores)
- Transmission between an infected mother and her growing fetus, or during the birthing process
- Transmission between an infected mother and her baby through breast milk while breastfeeding
- Intimate sexual contact with an HIV-infected person (examples, vaginal, anal and oral intercourse)

Those who engage in unprotected sexual intercourse risk exposure to HIV, as well as to common sexually transmitted infections (STIs), such as gonorrhea and chlamydia. A person with an untreated STI is at greater risk for both contracting and for passing on HIV during unprotected sex.

Casual contact is not associated with HIV transmission. Examples of casual contact are kissing, massage, shaking hands, hugging, sharing eating utensils, sharing towels, using the same toilet seat, etc. To avoid contracting or transmitting the disease, individuals must assess their personal risk. This will be covered in the next section. Evidence suggests that improved healthcare and STI treatment can help reduce HIV transmission.

Chapter 1, Section 1: Introductions and Workshop Structure

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
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Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
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Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
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Evaluation	*15 Minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 1: Introduction to HIV/AIDS

Section 1: Introductions and Workshop Structure

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**Introductions & Opening of the Meeting** An official may open the meeting, perhaps with a prayer or a speech. "Fruits of the Spirit"	Official Opening by Community Leader Introduction of participants/trainers using peer interviews	Can include head table with flowers, water for the speakers, etc. "Fruits of the Spirit" word cards, cut in half	Ability to name facilitators and at least one participant
30 minutes	**Workshop Structure**	Discussion, brainstorming	Flipcharts with group sign-ups, blank flipcharts, markers, tape	Active participation in one of three groups; abiding by the group norms throughout the workshop
20 minutes	**Expectations, Goals & Objectives**	Discussion	Flipcharts, markers, tape	Goals, Objectives & Expectations completed by the end of the workshop
20 Minutes	**What We Know about HIV/AIDS**	Written test	Pretest questionnaire	Number of correct answers

Chapter 1: Introduction to HIV/AIDS

Section 1: Introductions and Workshop Structure

Activities and Handouts for Introductions and Workshop Structure

- **Fruits of the Spirit**
- **Workshop Structure**
- **Expectations, Goals & Objectives**
- **What We Know About HIV/AIDS**

Activity Fruits of the Spirit

Objective By the end of the activity, participants will be able to—

- Introduce another participant to the group by name
- State several basic facts about another participant

Time allotted 30 minutes

Preparation Prepare word cards with one of the "Fruits of the Spirit" on each card, (i.e., Joy, Temperance, Peace, Love, Long-suffering, Gentleness, Goodness, Faith, and Meekness. Similar words can be added, depending on number of participants).

Cut each word card in half and mix the cards up. Prepare a flipchart with directions for participants. (This activity is good to use with groups of participants who don't know each other. Other "ice breaker" or introductory activities can be used with groups that are more familiar with each other.)

Facilitation steps

1. Hand out one-half of a word card to each participant. Do not refer to the "Fruits of the Spirit."
2. Explain that they will need to locate the person with the other half of their card. When they have found their "other half," they will take turns interviewing their partner.
3. The interviewer should find out their partner's name, the name they prefer to be called by during the workshop, their position title (if applicable), personal data (age, marital status, number of children, etc.), likes/dislikes, etc.

   After about five minutes, the participants should switch roles. The facilitator(s) may also wish to participate. (Depending on the size of the group, you may want to limit the amount of information the interviewer should get from the interviewee to reduce the time of interviews.)
4. After about 10 minutes, invite volunteer partners to introduce each other to the group and tell the word that binds them.

Wrap-up After everyone has been introduced, ask if anyone knows what the words on the cards signify. Someone should recognize them as the "Fruits of the Spirit" from Galatians 2:22.

Activity Workshop Structure

Objective

By the end of the activity, participants will be able to—

- Place themselves in a group of their choice
- Discuss ways to provide feedback to the facilitators
- Set and agree on the norms that will guide the group's work
- Set the overall workshop norms

Time allotted

30 minutes

Preparation

Prepare three flipcharts with the names of groups, for example—

- Set Up Climate Group
- Learning Synthesis Group and
- Feedback/Evaluation Group

Prepare cards in three colors and write on each—

- One thing you have learned today
- One thing you did not understand or need more explanation about
- One suggestion or improvement

Materials needed: blank flipcharts, markers

Facilitation steps

1. The facilitator introduces the three learning groups and explains each group's role.

   The three groups are—

   - **Climate Setting Group** is responsible for keeping track of the feelings of the participants, (e.g. when they are tired, the Climate Setters should suggest an energizer exercise)
   - **Learning Synthesis Group** will prepare a summary of the day's learning, keep track of any outside news that has relevance to the workshop, and report/review to the whole group the next morning

- **Feedback/ Evaluation Group** is in charge of distributing/collecting the feedback cards, analyzing them, and presenting a summary for the group the next morning

2. Explain the importance of feedback for the facilitators and that the daily evaluations will give an opportunity to share learning and participant concerns with everybody.

3. Introduce the way that the daily evaluation will be done using color-coded cards—

    - On the green card, the participants will write one thing that they have learned

    - On the pink card, the participants will write one thing that they did not understand or an issue they need more explanation on

    - On the yellow/ blue card, the participants will write one suggestion or improvement for the training

4. Lead a group brainstorming session on the workshop's ground rules. List suggestions on a flipchart.

5. As participants offer suggestions, the facilitator should seek agreement from the rest of the group before noting the norm on the flipchart. Examples of norms the group might suggest include; we should all be on time; we should encourage everyone to participate; smoking in the training room is not allowed; etc.

Wrap-up

The facilitator invites the participants to sign up for one of the three groups.

At this time, each group should meet and assign roles immediately or not later than the end of the evening session. The roles are—

- Facilitator of the discussion in the group
- Reporter (i.e., person who takes notes and reports back on the discussion progress)
- Timekeeper

The people assigned to each role could change everyday; the facilitator encourages the participants to do so, so that each one has an opportunity to play each role.

Activity Expectations, Goals, & Objectives

Objective

By the end of the activity, participants will be able to—

- Name one important workshop outcome for themselves
- Describe the purpose of the workshop
- List at least two workshop objectives

Time allotted

20 minutes

Preparation

Materials: three "category" flipcharts, blank flipchart, markers, and tape

Using the three flipcharts, write "Expectations" at the top of one, "Workshop Goal" on the next and "Workshop Objectives" on the third.

Facilitation steps

1. Refer to the "Workshop Goal" flipchart. Read and answer any questions participants might have.

2. Start by acknowledging that each participant has hopes, ideas and expectations about the workshop. Ask the participants to choose the most important thing that they want to take away from this workshop. Ask each person to give one expectation. Record each response on the "Expectations" flipchart.

3. Next, refer to the "Workshop Objectives" flipchart. Compare it with the list of expectations to see if all the expectations will be covered in the process of meeting the objectives.

Wrap-up

Ask participants to refer to the workshop schedule.

Summarize the expectations listed and indicate which sessions are likely to address these expectations. If there are unexpected topics listed, use this time to negotiate with the participants regarding a time or means to include that topic in the workshop if appropriate, or to clarify if a topic does not fall within the scope of this workshop. Tape the flipcharts from this session on the walls so that people can refer to them throughout the workshop.

Activity What We Know About HIV/AIDS

Objective By the end of the activity, trainers will be able to—

- Assess the base knowledge of participants regarding HIV/AIDS

Time allotted 20 minutes

Preparation A pretest/posttest questionnaire and the answer key are located in Appendix III. Make enough copies of the questionnaires for all the participants. Some participants may not be familiar with a written test format, so the trainer will have to adapt the questionnaires to meet their needs. Questionnaires should be based on the training. If the trainer modifies the content, the questionnaires will need to be modified as well to reflect the changes.

Facilitation steps

1. Sometimes participants feel intimidated by the idea of testing, so it is best to introduce this as a tool for the trainer to—

   - Assess how well the trainer presents the information in the workshop;
   - Get a sense of what participants already know; and,
   - Help the trainer to tailor the training to the participants' needs.

   Assure the participants that it is okay if they do not know everything on the questionnaire.

2. Distribute the questionnaires and instruct participants to answer all the questions to the best of their ability, without any discussion among themselves.

3. When everyone is finished, collect all the questionnaires.

Wrap-up Explain that the trainers will look over the questionnaires and they will not be returned. Emphasize that the information the participants provide on the questionnaires will help to improve the training and tailor it to the class.

Chapter 1: Introduction to HIV/AIDS

Section 2: Facts about HIV/AIDS

Objectives

By the end of this section, the participants will be able to—

- Differentiate between HIV and AIDS
- Discuss impacts of the HIV/AIDS pandemic globally and nationally
- Feel comfortable discussing sexuality and HIV/AIDS
- Clarify locally acceptable terminology
- Identify key facts about HIV/AIDS
- Discuss the way the virus works in the body
- Dispel common myths about HIV/AIDS

Chapter 1, Section 2: Facts about HIV/AIDS

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, continued *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, continued *1 hour* **Chapter 5** IEC — Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, continued *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, continued *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 1: Introduction to HIV/AIDS

Section 2: Facts about HIV/AIDS

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
90 minutes	**Overview of HIV/AIDS looking at the global, regional and local situations and the need for a religious response**	Lecture, Discussion	Flipcharts, markers, overheads, or PowerPoint	Application of information throughout workshop
60 minutes	**The Language of Sex, Becoming comfortable with terms that will be used in the sessions**	Group discussion/ brain-storming	Flipcharts and markers	Acceptable words used throughout workshop
45 minutes	**Facts and myths about HIV/AIDS and learning the difference**	Discussion	Large sheet of paper, scissors, tape, markers	Opinions/beliefs about AIDS, pre-post session

Chapter 1: Introduction to HIV/AIDS

Section 2: Facts about HIV/AIDS

Activities and Handouts for Facts about HIV/AIDS

- **Overview of HIV/AIDS and the Need for a Religious Response**
- **The Language of Sex**
- **Facts and Myths about HIV/AIDS**[3]

[3] Adapted from "The Life Skills Manual," Peace Corps, 2000

Activity HIV/AIDS Overview and the Need for a Religious Response

Objective By the end of the activity, participants will be able to—

- State HIV/AIDS statistics for the world, their region, and their country
- Come to a consensus on a religious response to HIV/AIDS
- Understand the meaning of the HIV/AIDS abbreviation
- Understand the way the virus works in the body

Time allotted 1 hour 30 minutes

Preparation Conduct research on—

- The latest statistical information on HIV/AIDS from UNAIDS (**Note:** When quoting statistics, be sure to include the date.)
- Your church's position on HIV and what response is called for and/or use information from the World Council of Churches (*Facing AIDS: The Challenges and the Churches' Response.* Also note that information can be found at its website at http://www.wcc-coe.org. See also the Trainer Resource on page 1-22 and 1-23 for information from the African Religious Leader's Assembly.)

Prepare a flipchart with statistical information or use the UNAIDS graphics on an overhead projector or in a PowerPoint presentation.

Prepare a flipchart with the abbreviation HIV/AIDS written out in full, (i.e. Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome).

Prepare a flipchart or overhead slides with the basics of HIV infection and AIDS. (See the Trainer Resource following this exercise on pages 1-24 and 1-25.)

Facilitation steps

1. Begin talking about the AIDS pandemic by reading the quote at the beginning of chapter 1 taken from the *UNAIDS Report on the Global HIV/AIDS Epidemic*. Ask participants what they think about the statement and how it relates to their own communities.

2. Present the statistical information about HIV/AIDS in the world, then specifically in the region, and finally in the country where the training is taking place. Be sure to include facts such as the ratio of women to men infected and the number of orphans. Ask participants what they think about the facts presented and if they can relate it to their own communities.

3. Present information on your church's policy or position on HIV/AIDS. Point out that religious leaders can be a key element in the fight against HIV/AIDS due to their influence and standing in the community. Ask participants to think of some ways that the clergy/church could respond to this situation.

4. Ask participants if they know what the abbreviation of HIV/AIDS means. Use the flipchart to go over each term and explain what it means.

5. Use flipcharts or overheads to go over the basic information on HIV infection and AIDS. (See the Trainer Resource on pages 1-24 and 1-25.) Be sure to talk about the immune system, how the disease progresses, and opportunistic infections.

Wrap-up

Although much of the information presented is very depressing and even overwhelming, remind participants that they are here to take the first steps in addressing the HIV/AIDS issue in their own communities. Change happens slowly, but by the end of the workshop, they will be better equipped to make that change.

Tools for Trainers

African Religious Leaders Assembly on Children and HIV/AIDS[4]

June 9-12, 2002
Nairobi, Kenya

On June 9, 2002, the World Council on Religion and Peace (WCRP) convened the African Religious Leaders Assembly on Children and HIV/AIDS in Nairobi, Kenya. This historic meeting brought together senior religious leaders, men and women, from more than 25 countries for the first-ever pan-African multi-religious gathering to address the impact of HIV/AIDS on Africa's children and families. The assembly was held as part of the Hope for African Children Initiative, a partnership of international NGOs dedicated to expanding community-based programs to address the needs of children affected by HIV/AIDS in Africa.

Plan of Action

In making HIV/AIDS a top priority in our religious communities, we pledge to carry out the following action steps to address the impact of HIV/AIDS on children. We commit ourselves to—

1. Promote and develop a theology of compassion, love, healing and hope that can break through the judgment, shame and fear so often associated with HIV/AIDS
2. Work tirelessly to reduce the discrimination and stigma faced by children and adults affected and infected by HIV/AIDS and to address social, religious, cultural and political norms and practices that perpetuate it. In particular, we will speak publicly at every opportunity, particularly from our pulpits, to counter such stigma and discrimination and affirm the God-given dignity of all persons, particularly children
3. Increase the human, material and financial resources that our communities devote to addressing the AIDS pandemic, and designate an HIV/AIDS focal point in each of our communities to assist in gathering information and developing program strategies
4. Actively involve persons infected and affected by HIV/AIDS as essential resources in our response to the impact of HIV/AIDS on children, families and communities, especially in worship, education, training, prevention, advocacy, and program development
5. Further recognize and strengthen the role of children, young people, and women in combating HIV/AIDS and caring for vulnerable children
6. Focus on the particular vulnerability of girls in the face of HIV/AIDS and give them special protection, and address gender roles and relations in our communities that contribute to the vulnerability of women and girls to HIV infection

[4] Available from: www.wcrp.org/RforP/NEWS_NAIROBIASSEMBLY_MAIN.html

7. Utilize the existing infrastructure and communications networks within our religious communities to disseminate information through accessible means relating to prevention, treatment, advocacy, and care of children affected by HIV/AIDS, and to build capacity to enable religious leaders to provide needed education and training in our communities on all aspects of HIV/AIDS

8. Develop curriculum that integrates HIV/AIDS into theological and religious education particularly on issues related to its social effects, discrimination and stigma and that strengthens moral education on healthy relationships and sexual integrity in the context of HIV/AIDS

9. Strengthen multi-religious collaboration at the local, national, regional and international levels to provide assistance and support to adults and children infected and affected by HIV & AIDS, and create mechanisms that can provide a unified voice of the religious communities in our advocacy for children

10. Advocate with all levels of government and their agencies to establish policy priorities and devote resources that adequately support and protect children, in particular we will push African governments and the international community to fulfill the commitments they have made through the Abuja Declaration, the Global Fund for AIDS, TB, and Malaria, and at G8 Summit meetings, as well as at United Nations General Assembly Special Sessions on HIV/AIDS (June 2001) and Children (May 2002)

11. Support greater partnerships between the religious communities, governments, UN and other international agencies, civil society and the business sector to increase capacity to care for and support children. Religious communities look to these partnerships to expand their capacity in areas such as program management, financial accountability, technical skills, and training

12. Endorse the five core strategies for intervention on behalf of children and the "Principles to Guide Programming for Orphans and Vulnerable Children" that have been developed by a wide range of international agencies, and apply these guidelines in all our work with children affected by HIV/AIDS

13. Support the role of the Hope for African Children Initiative and work as active partners in its mechanisms to increase the resources available to local community programs that care for children in need

14. Call on the World Conference on Religion and Peace to form under its auspices an African Religious Leaders Council to coordinate multi-religious collaboration in Africa, in particular overseeing the implementation of this plan and the ongoing involvement of religious leaders in efforts to care for children affected by HIV/AIDS

Tools for Trainers

HIV Infection[5]

HIV

HIV is a member of a group of viruses called ***retroviruses***. HIV is a particularly serious infection because it attacks and destroys cells of the ***immune system***—called ***T-cells*** or ***CD4 cells***—which are designed to fight infections and diseases. After HIV penetrates these cells, it takes over their machinery (or reprograms the cell) so that it begins to produce many copies of the virus, eventually destroying the immune cells. HIV has the ability to mutate (change itself), which makes it especially difficult for researchers to find an effective treatment or vaccine.

There are two types of HIV. HIV-1 is responsible for the vast majority of infection and cases of AIDS in the world. HIV-2 is the more common type in West Africa and has a slower course than HIV-1.

From the time a person is infected with HIV, the virus begins to damage the immune system. Although an infected person's immune system struggles to fight back—and can do so for as many as 10 years or more in an otherwise healthy adult—the virus continues to destroy these defenses until the immune system is too weak to fight off infections.

A person can be infected with HIV and not know it because HIV symptoms or illnesses related to it may not occur for many years after the initial infection. Most people lead healthy and productive lives after being infected with HIV—in fact, many people are not aware they are infected because they feel fine. Unfortunately, even if the infected person feels fine, he or she can pass the virus on to others.

AIDS

AIDS is an advanced HIV infection—the late stage of the infection when the immune system is weakened. Advanced HIV infection weakens the immune system to the point that it cannot fight off infections as it can in a healthy state. The individual becomes more prone to a variety of infections (called ***opportunistic infections***) and other conditions (e.g., cancer). Eventually, the infected person may lose weight and become ill with such diseases as constant and severe diarrhea, fever, tuberculosis, pneumonia, or skin cancer. Opportunistic infections are known as such because they take advantage of a weakened immune system to cause illness. Other AIDS-associated conditions include invasive cervical cancer, Kaposi's sarcoma, and lymphoma.

[5] Adapted from EngenderHealth Online Minicourse *HIV/AIDS* 2002

HIV Infection, continued

According to the U.S. Centers for Disease Control and Prevention, an AIDS diagnosis constitutes—

- Any one of a number of conditions indicating severe suppression of the immune system
- HIV infection in an individual with a CD4 (T-cell) count less than 200 cells per micro-liter (less than half of what is considered to be the bottom of the normal range)

Persons living with AIDS often have several infections, neurological disorders, extreme weight loss, diarrhea, and cancers. Although an infected person generally dies as a result of complications of these infections, conditions, and malignancies, living with AIDS is like living with other chronic diseases—sometimes the person feels sick and at other times he or she feels fine and can go about normal activities.

Remember

> No one dies from AIDS or HIV; rather, a person with AIDS dies from an infection or condition that his or her weakened immune system can no longer fight off.

In the U.S. and Europe, the average time from HIV infection to the development of AIDS is more than 11 years. In developing countries, the average time is shorter, which is probably due to multiple factors including a higher level of pre-existing infections; less access to care including treatment to prevent opportunistic infections (prophylaxis); and poor nutrition. The infection generally progresses much faster in infants than in adults.

Activity The Language of Sex[6]

Objectives By the end of the activity, participants will be able to—

- Feel more comfortable discussing sexuality and HIV/AIDS
- Clarify locally acceptable terminology

Time 45 minutes

Preparation Prepare flipcharts with terms for each group.

Materials Blank flipchart paper and markers for three groups

Facilitation steps

1. In our culture, we are brought up not to speak openly about matters related to sexuality and death. In the workshop, explain that participants will need to talk about things that most people feel embarrassed to discuss in public. A good way to overcome this embarrassment is to recognize that it is a universal feeling; we all experience it. Emphasize that our bodies are part of God's wondrous creation.

2. Explain that since there is no HIV vaccine or cure, the only way we have to prevent its spread is through changes in behavior and medical practices. Since sex is one of the main transmission routes, participants need to be able to talk about sexual attitudes, behavior, and safer sex practices.

3. Explain that the discussion will cover the sexual parts of the body and different sexual acts and will be graphic. Therefore the group needs to have a common agreement on locally acceptable words that all can use and understand. (These may be euphemisms, local language terms, or slang terms.)

4. Ask the participants to count off from one to three and to form three groups. Explain that each group will be given 5 to 10 minutes to brainstorm the terms below. List each group of words on a flipchart paper and give it to each group after you explain each category. Have the participants in each group list local terms under each heading.

    - **Group 1**: Consider local words for male genital organs, semen, pubic hair, female genital organs, and skin

[6] Adapted from "The Stepping Stones Manual," p. 75.

- **Group 2**: Consider local words for vaginal intercourse (penis inserted in vagina), vaginal fluids, anal intercourse (penis inserted into anus-male or female), and orgasm

- **Group 3**: Consider local words for masturbation (of self or partner); withdrawal (i.e. withdrawal of the penis from the vagina before ejaculation); oral sex (inserting penis into mouth or licking/sucking the female genitalia); breasts; thigh sex (i.e. mutual rubbing of the groin areas without penetration); and unprotected sex (penetrative sex of any kind without a condom)

Note: It may be necessary to explain some mechanics of the sexual acts. Make sure each term is clearly understood; the trainer should be able to explain each term, if necessary. (See Trainer Resource pages 1-28 and 1-31.)

5. After the discussion of local terms is complete, reassemble the larger group. Ask each group to report back on the words that they want to use, and make sure these words are acceptable to the group.

Wrap-up

Point out any words that were left out such as "oral sex." There may be denial that oral or anal sex takes place. Continue to use these terms during the workshop, explaining that they may be practiced elsewhere. If there are pastors in the group, it is important to emphasize that their flock is diverse and likely has more diversity of practices than one might guess. It is important to include them so participants know the risks involved in these practices.

Note to Trainers:

- Provide participants with contact information for health and religious professionals in their community that they can talk to outside of the workshop setting.
- When discussing body parts, emphasize that the human body is part of God's wondrous creation.
- Some people may find the exercise quite difficult and get angry or embarrassed and refuse to join in. Others may laugh. Or the participants may already know all the words involved. The exercise is useful anyway.

Sexual Practices[7]

What are people really talking about when they talk about "sex?"

Sometimes people assume that "sex" means penile-vaginal intercourse. But a much wider range of sexual practices exist, and practices can vary greatly among individuals.

Every person (whether a counselor or a parishioner) has attitudes, biases, and values about different sexual practices. Those attitudes, biases, and values can affect the way counselors talk with their parishioners. In addition, some sexual practices can have important health consequences.

What People Do…

Sexual practices between consenting adults can include a wide variety of behaviors. Depending on the individual, each parishioner may have different ideas about which practices they consider to be "sex."

As an exercise, ask yourself how you feel about the following practices—and ask yourself which of the following practices you consider to be "sex"—

- Hugging
- Kissing
- Masturbating
- Manually stimulating your partner
- Vaginal penetration
- Anal penetration
- Vaginal or anal penetration with objects
- Oral-genital stimulation
- Sexual excitement while looking at or reading pornography

No matter what your own feelings about these practices are, it is important to remember that parishioners may be talking about any of these—or about other practices not listed here—when they talk about "sex." Furthermore, if there are activities on this list that parishioners do engage in but do not classify as "sex," they may not mention them during discussion, depending on how your questions are phrased.

[7] Adapted from EngenderHealth Online Minicourse, "Sexuality and Sexual Health," 2002.

…Where and With Whom

In addition to individual attitudes toward different sexual practices, all people have attitudes, biases, and values related to the *circumstances* under which people engage in sexual practices.

For example, ask yourself if you feel differently about any of the above practices in the following situations when it is done—

- By a man and a woman
- By two people of the same sex
- By groups of people of both sexes
- When one partner is getting paid for it
- In a public place
- By two unmarried people
- By a young married couple
- By an old married couple
- When one person is married, but the other is not
- When one person has many partners
- When one person is much older than the other
- When the people do not know each other

No matter what your personal feelings are about these activities, it is important to give parishioners impartial, unbiased information—to help them without judging them.

Health Consequences of Sexual Practices

While not complete, the following list describes health concerns for some common sexual practices and lists activities that can mitigate health risks.

1. **Masturbation** is defined as manual or other non-penetrative stimulation of oneself or a partner for sexual pleasure.
    - Self-stimulation involves no risk of pregnancy or STIs/HIV/AIDS transmission.
    - In partner masturbation, there is a possibility of disease transmission from one person to another because body fluids and infections can be transmitted by contact with the hands or objects used. To maintain general hygiene, partners should wash their hands and any objects used with soap and water before and after masturbating themselves or each other.

Note: Masturbation should not be performed on a part of the body that has skin lesions, sores, or abnormal discharge, because there is a risk of spreading infection (e.g., herpes, syphilis) to other body parts.

2. **Vaginal penetration** is defined as penile-vaginal penetration, manual penetration of the vagina, or vaginal penetration with objects.

   - Because semen, vaginal fluids, and other body fluids are transferred between partners, unprotected penile-vaginal sex can result in pregnancy or, if one partner is infected, in STIs/HIV/AIDS transmission.
   - The best way to avoid transmission of HIV or other STIs is to practice abstinence or to be mutually faithful and engage in unprotected penile-vaginal sex only with an uninfected partner. Or, if the partner is known to be infected or the STI status is unknown, it is important to cover the penis with a new condom every time a person engages in penile-vaginal sex with an infected partner or any partners whose STI status is unknown. If available, female condoms can be used rather than male condoms.
   - "Dry sex" (using herbs, cloths, or other materials to dry out the vagina and increase friction) can be a painful and harmful practice. Lubrication provides the vagina with moisture to make penetration easier, while allowing for pleasurable friction from thrusting. Dry sex increases a woman's chances of experiencing tears, scrapes, or other damage to the vagina and may increase a woman's risk of contracting HIV or other STIs.
   - Objects used to penetrate the vagina should be clean and non-breakable, should have no sharp edges, and should not be shared with other people. Whenever possible, cover the object with a new, lubricated condom each time before it is put into the vagina. If a condom is not used, always wash the object immediately with soap and water before and after any act of penetration.
   - If anal penetration comes before vaginal intercourse, to avoid bacterial infection, change the condom on the penis or object after anal penetration and before putting the penis or object into the vagina. If a condom is not used, wash the penis or object with soap and water before putting it into the vagina.

3. **Oral-genital/oral-anal sex** is defined as stimulation of the male or female sexual organs or anus by sucking or rubbing or licking with the lips, mouth, or tongue.

   - These practices involve **no risk of pregnancy**.
   - Since body fluids and infections can be transmitted by oral-genital contact, STIs/HIV/AIDS transmission is possible. To reduce the infection risk, engage in unprotected oral-genital sex only with a partner who is not infected with a STI.
     - With a female partner who is infected or whose STI status is unknown, use a thin piece of rubber, latex dental dam (a thin piece of latex used to place over the female genitals during oral sex), female condom, or cut-open,

un-lubricated male condom, placing it between the mouth and the vulva before any oral contact is made.

- With male partners, cover the penis with an un-lubricated condom before mouth, lips, or tongue touch the penis.

- Avoid oral-genital sex with partners who have genital sores or abnormal discharge from the vagina or penis.
- During oral-anal contact, use a barrier (such as a thin piece of rubber, latex dental dam, or a cut-open un-lubricated condom) between the mouth and the anus to avoid the transmission of infection.

4. **Anal penetration** is defined as penile-anal penetration, manual penetration of the rectum, penetration of the rectum with objects.

   - Most STIs can be transmitted by anal or rectal contact. Anal sex is **especially risky for transmission of STIs such as HIV** because inserting and thrusting the penis or other objects in the anus can cause tears and bleeding in the rectum, making the transfer of blood-borne germs much easier. Infections of the gut and diarrheal diseases can also be transmitted by anal and rectal contact. (In areas where a girl's virginity is highly valued, young girls are at increased risk of engaging in anal sex.)
   - To reduce the infection risk, engage in unprotected anal or rectal penetration or stimulation only with partners who are not infected with a STI/HIV/AIDS. With all other partners, use latex or plastic gloves on hands that will come in contact with the anus or rectum, put a condom over the touching finger(s), or cover the penis or object with a condom.
   - The anus and rectum do not have natural lubrication, so **artificial lubricant should always be used before anal penetration**. To keep a condom from breaking during anal penetration, use a condom with extra **water-based lubricant**; after rectal penetration, change the condom before inserting the penis or object into the vagina or mouth. If a condom is not used, wash the penis or object with soap and water before putting it into the vagina or mouth.
   - Always wash hands with soap and water thoroughly before and after touching the anal or rectal area. Avoid putting fingers into the rectum if open sores are present on the hands or fingers.
   - Objects used to put into the rectum should be clean and non-breakable, should have no sharp edges, and should not be shared with other people. Cover the object with a lubricated condom before it is put into the rectum. Do not put the object too deeply into the rectum. Sometimes an object that is inserted in the rectum may break or may become stuck and cannot be retrieved. In these cases, medical help is needed to remove the object.

Activity Facts and Myths About HIV/AIDS

Objectives

By the end of the activity, participants will be able to—

- Recognize the seriousness of HIV/AIDS
- Identify key HIV/AIDS facts
- Dispel common HIV/AIDS myths

Time

1 hour

Preparation

Photocopy the worksheets at the end of this session (pages 1-34 to 1-36) and cut out the individual statements or make up statements true for your area, and myths that are common in your area. Fold statements and place them in a bowl or a basket.

Create two signs for the wall; one says "TRUE" and the other "FALSE."

Facilitation steps

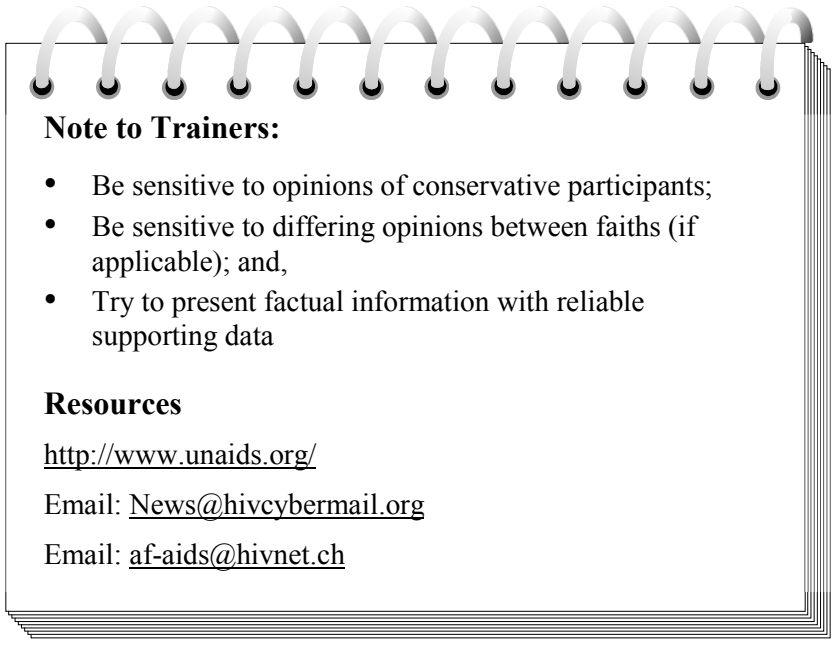
1. Explain to participants that the activity will help them to think about the HIV/AIDS problem in their communities and worldwide.
2. Recap the information covered in the last session with the participants.
3. Have participants raise their hands if they think AIDS is a serious problem in their community or if AIDS could be a danger to them or their family.
4. Have participants take a piece of paper out of the bowl and read it to themselves. Invite the participants to come to the front of the room one by one and read aloud the statement to the group, then say whether it is true or false. Ask if the group agrees and allow participants to debate the question. Clarify if the statement is true or false (see the "Questions and Explanations" handout), and have the participant place it under the appropriate sign before moving on to the next one.
5. After the statements are placed and questions answered (30 minutes), the facilitator leads the group in the discussion questions (30 minutes).

Discussion Questions

- What are some other things you have heard about AIDS that might not be true (myths)?
- Do you think that everyone who has AIDS knows he/she has it? Why or why not?
- What are some reasons people would hide the fact that they have AIDS?
- What might be some consequences in your community if someone revealed they have AIDS?
- Why do you think young girls are infected at a higher rate than young boys?
- What evidence do you see in your community of the effects of AIDS?

Wrap-up

Both before and after the session, have the participants raise their hands if they think AIDS is a serious problem in their community or if AIDS could be a danger to themselves or their family. Responses can be written anonymously on paper if preferred.



Note to Trainers:

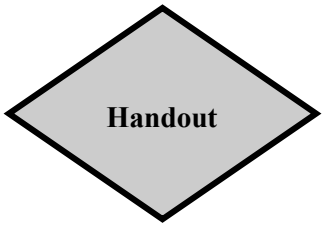
- Be sensitive to opinions of conservative participants;
- Be sensitive to differing opinions between faiths (if applicable); and,
- Try to present factual information with reliable supporting data

Resources

http://www.unaids.org/

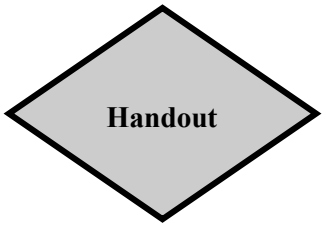
Email: News@hivcybermail.org

Email: af-aids@hivnet.ch



TRUE

- **AIDS has affected Africa more than any other part of the world**
- **As of the year 2001, approximately 28 million sub-Saharan Africans (adults and children) are living with AIDS**
- **Although treatments to slow the progression of AIDS exist, there is still no cure for AIDS**
- **More adolescent African girls have HIV than young boys of the same age**



FALSE

- **AIDS is an American invention to discourage sex**
- **Since everyone who has AIDS dies, it is better not to know if you have it**
- **You can be cured of AIDS by having sex with a virgin**
- **In our country, anybody who loses weight has AIDS**
- **Unlike the rest of the world, people in the United States have access to medicines that can cure them**
- **In our country, very few people have AIDS**
- **You always know by looking when someone has HIV**

- **Traditional healers in our country have cured AIDS**
- **You can cure AIDS by drinking local gin**
- **Religious people do not get HIV**
- **AIDS is a disease of immoral people, such as prostitutes**
- **AIDS is a plague that God has given to non-believers**
- **You can get AIDS by eating food sold or prepared by someone who has HIV**
- **If someone with HIV/AIDS breathes or coughs on you, you can get AIDS**

Questions & Explanations

True

1. AIDS has affected Africa more than any other part of the world
   - *According to UNAIDS, at least 28.1 million of the 40 million people estimated to be living with HIV in the world are living on the African continent. (UNAIDS, 2001)*

2. As of the year 2001, approximately 28.1 million sub-Saharan Africans (both adults and children) are living with HIV/AIDS
   - *UNAIDS, AIDS Epidemic Update, Dec.2001*

3. Although there are treatments to slow the progression of AIDS, there is still no cure for AIDS
   - *There are many treatments but there is no cure for AIDS. You can learn more about this in session number 4 of this chapter.*

4. More adolescent African girls have HIV than young boys of the same age
   - *According to the* UNAIDS Global Report on the HIV/AIDS Epidemic, *June 2000, young girls are more vulnerable to HIV/AIDS due to both physical and social factors. The genital tracts of young girls are more susceptible to infection during unprotected vaginal intercourse because they are not fully mature. Female genital tracts have a larger area of mucous membranes, which are more susceptible to infection. Women also have lower status in society at large and less power within sexual relationships. They often cannot negotiate condom use. Girls are also expected to be sexually naïve and thus are more likely to be uninformed about HIV.*

Questions & Explanations

False

1. AIDS is an American invention to discourage sex
   - *Americans did not invent AIDS. People from every race and nationality have been affected by HIV/AIDS. Its origins are in dispute, but it has existed in Africa for many decades. Where the disease originated is not relevant to our purposes here; we need to focus on how to stop the spread of the disease.*

2. Since everyone who has AIDS dies, it is better not to know if you have it
   - *Although people may believe that the stress of knowing one's HIV status can be a terrible burden, it is clear that knowing one's status can help prolong one's life by getting early treatment for opportunistic infections and taking care of one's general health. Also, knowing one's status can help us protect families and loved ones from infection and help people prepare for the future. People can live a long time with HIV/AIDS.*

3. You can be cured of AIDS by having sex with a virgin
   - *This statement is not true, and acting on this false belief can spread the infection to many young girls. Ask the group to explain why people might believe this myth. Discuss ways to dispel this myth.*

4. In our country, anyone who loses weight has AIDS
   - *There are many reasons why people lose weight. Other illnesses, such as cancer, can also cause weight loss.*

5. Unlike the rest of the world, people in the United States have access to medicines that can cure them
   - *People in the US do have access to medicines that are often not available in many developing countries, but these medicines **do not cure** AIDS. There is no cure for AIDS.*

6. In our country, very few people have AIDS
   - *UNAIDS estimates for prevalence by country should be used to refute this.*

7. You always know by looking when someone has HIV
   - *You cannot tell by looking if someone is HIV positive. People with HIV can remain healthy for many years before becoming ill.*

Questions & Explanations, False, continued

8. Traditional healers in our country have cured AIDS
   - *No one has found a cure for AIDS yet. It is possible that traditional healers have some remedies that may alleviate temporarily some HIV symptoms. Other practices, however, may cause HIV to progress more rapidly or increase the possibility of transmitting HIV if procedures involve sharing instruments with blood on them. It is important that medical doctors and traditional healers communicate to share what they have learned about the disease.*

9. You can cure AIDS by drinking local gin
   - *There is no cure for AIDS. People infected with HIV can live longer healthier lives by avoiding an excess of alcohol.*

10. Religious people do not get HIV
    - *Anyone can get HIV. There are many religious people who have been infected. It does not matter who a person is, HIV is transmitted by what a person does.*

11. AIDS is a disease of immoral people, such as prostitutes
    - *Since HIV is transmitted mainly through sexual activity, many people infected with HIV have been accused of being immoral, women in particular. UNDP reports that two-thirds of women with HIV worldwide report that they have had only one sexual partner, their husband. Other studies show that women who are prostitutes are not at greater risk than other women are unless they inject drugs. It is harder for women to negotiate condom use with their spouses than with casual sexual contacts.* ***If fidelity is to be used by women as their prevention method, it needs to include a way of determining if they or their partner is already infected with HIV.***

12. AIDS is a plague that God has given to non-believers
    - *God wills good for us that we should live abundantly and be blessed. People become infected with HIV through several means (unprotected sex, blood transfusion, mother-to-child, etc.). None of these is through God's will.*

13. You can get AIDS from eating food sold or prepared by someone who has HIV
    - *AIDS is not carried in food or water, so it cannot be passed on through food or water. The virus can only survive in the human body; it cannot survive in animals or insects. The virus also dies very quickly when exposed to air, light or soap and water. There have been no cases of HIV infection from an environmental source, such as transmission from touching dried blood on a table or dried semen on sheets.*

14. If someone who has HIV/AIDS breathes or coughs on you, you can get AIDS
    - *The HIV virus is not airborne and cannot be passed though breathing or coughing. HIV is only transmitted through unprotected sex, blood transfers (through shared needles transfusions, rituals), birth, and breastfeeding.*

Notes:

Chapter 2

HIV/AIDS Transmission, Prevention, Care, and Treatment

"We raise our voices to call for an end to silence about this disease - the silence of stigma, the silence of denial, the silence of fear. We confess that the Church herself has been complacent in this silence. When we have raised our voices in the past, it has been too often a voice of condemnation…. Our Christian faith compels us to include those who are living with HIV/AIDS, who are made in the image of God and are children of God."

—A JOINT STATEMENT RELEASED BY THE ARCHBISHOP OF CANTERBURY, NOVEMBER 28, 2001[8]

[8] Available from: http://www.archbishopofcanterbury.org/releases/011128.htm

Table of Contents

Faith Community Responses to HIV/AIDS

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Key Questions

- What is the link between STIs and HIV/AIDS?
- How is HIV transmitted?
- What are the ways to prevent its transmission?
- What is voluntary counseling and testing?
- Why is it important to know your status?
- How can we care for and treat those affected by HIV/AIDS?

Introduction

Understanding how HIV is transmitted is the first step in learning how to prevent it. This chapter will begin with a discussion of how HIV/AIDS is transmitted and how STIs are linked to HIV transmission. In many places, people find it very difficult to speak about sexual matters or are unaware of STI symptoms and often fail to seek treatment for them. Women are at a particular disadvantage with regard to STIs because of several factors—

- A lack of education in sexual and reproductive health
- A lack of access to health care
- The common belief that pain and suffering in reproductive matters are "normal" for women
- The fact that many STIs show no symptoms in women

- The lack of power in sexual relationships that makes it difficult to refuse sex or insist on condom use
- The lack of economic resources or power that leads women to engage in risky sex or to be dependent on men who may engage in risky behavior

People with STIs are at higher risk for contracting and transmitting HIV/AIDS to others.

The ways that HIV can be transmitted are very clear, and participants will learn a very simple way to determine the transmission risk associated with any particular activity. Once a person knows the risk involved in an activity, one can decide whether to avoid doing the activity at all or can find some way to minimize the risk. The group will look at ways to prevent blood borne, sexual, and mother-to-child HIV transmission, and discuss some difficulties people may have in implementing prevention strategies.

Voluntary counseling and testing (VCT) for HIV is a powerful prevention tool. Once people know their HIV status, they are often motivated to reduce their risk behaviors if they are HIV negative or to protect others and take better care of themselves if they are positive.

Finally, this chapter describes how people living with HIV/AIDS (PLWHA) are cared for and discusses treatment options for the wellbeing of PLWHA.

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 1: HIV/AIDS Transmission, Prevention, and Risk Reduction

Objectives

By the end of this section, participants will be able to—

- Define "transmission"
- Identify five ways that HIV is transmitted
- Define "portal of entry"
- Relate HIV infection to infection with sexually transmitted infections (STIs)
- Identify five ways to reduce risk and prevent transmission (including through blood, mother-to-child (MTCT), and sexual)
- State the difficulties involved in talking with partners about HIV/AIDS
- Describe ways to negotiate for safer sexual behavior
- Explain what voluntary counseling and testing (VCT) means
- Describe the HIV testing process
- Name at least two things a person should know before deciding to have an HIV test
- Name at least two things that should be done in posttest counseling

Overview

This section builds on lessons learned in the previous chapter about HIV/AIDS facts and myths and how HIV is transmitted. We will look more in depth at the way that HIV is transmitted and give participants a simple tool for identifying whether any act puts them at risk of HIV transmission. Once participants have an understanding of how they can be infected with HIV/AIDS, they can begin to explore ways to prevent HIV transmission. The only way to prevent the transmission of HIV/AIDS is to change behavior. This section contains activities that will help the participants understand why it is important for people to change behaviors that put them at risk for contracting and then transmitting HIV and to take precautions that are *realistically* available to them.

To prevent HIV transmission, someone must first accept the fact that they are at risk for contracting HIV. They must have a clear idea of the risks involved with certain behaviors. That way, they can make choices based on fact. They must understand that HIV does not discriminate and that anyone can be infected. Most people with HIV do not know their status; they do not know they are infected with HIV.

Preventing Transmission of HIV through Sex

Sex is a natural part of life. Procreation ensures survival of the species. Sex is often enjoyed as a way to show you love someone. Sometimes people can choose to have sex, and others have no choice (i.e. rape, coercive sex within marriage).

How can one have sex without getting HIV? The HIV levels in someone's system may vary from time to time. This is what makes it possible for one person to become infected after one sex act, and another to have multiple sex acts with an infected partner and never be infected. Certain sex acts contain a greater risk for spreading HIV than others. As previously discussed, examples of these acts are vaginal and anal sex.

There are several **ways to avoid getting HIV through sex** [9]—

- Practice abstinence
- Have sex with only one partner who has no other partners (*monogamy*)
- Choose sexual partners carefully (i.e. know your partner well) and limit the number of sexual partners
- Ask partners to get tested for sexually transmitted diseases and HIV

[9] R. Granich and J. Mermin, *HIV: Health and Your Community, A Guide for Action* (Stanford: Stanford University Press, 1999).

- Have **safer sex** (such as kissing, hugging, massage, and masturbation, or oral, vaginal and anal sex with condoms)
- Use male or female condoms during sex

Choosing a sexual partner carefully involves honest communication between partners about their risk factors: past sexual history, whether he/she has had a blood transfusion, use of condoms, etc.

Barrier methods of contraception (male and female condoms) are used to prevent semen/vaginal fluid/blood from coming into contact with another person's body. If used correctly and consistently, they are **very effective in preventing HIV**. Condoms may sometimes break or slip off the penis if used improperly. In addition, condoms may be used for **dual protection**, i.e. to prevent both pregnancy and STIs/HIV. Women are not always able to ask their partners to use condoms or to get tested for HIV. The female condom is an option for a woman whose partner refuses to use a male condom. Other techniques they can use are having safer types of sex such as masturbation.

If there is a chance that one partner has been exposed to HIV, then they should be tested at least three months after the last chance of getting HIV. After a *second* test is found negative, the partners can be safe from HIV, as long as they remain faithful and don't have sex outside the relationship.

Sexual activity is a sensitive issue in any country. Challenges left to face include—

- Denial of the population that AIDS can affect them
- Lack of fidelity among married couples, especially men
- Customs of wife inheritance or ritual sex at funerals
- Reluctance to use condoms because they are perceived to reduce pleasure or because the couple is trying to get pregnant
- Reluctance (and fear) among women to suggest condom use
- Improper condom use
- Inconsistent condom use
- Lack of access to condoms

Linkages to STIs[10]

In efforts to reduce HIV risk for their clients, the relationship between HIV and other STIs is a particularly important factor for counselors or educators to consider. STI treatment and prevention can be an important tool in limiting the spread of HIV infection since—

- A person infected with a STI has a much higher risk of acquiring HIV from an infected partner
- A person infected with both HIV and another STI has a higher risk of transmitting HIV to another partner

For example, it is estimated that the presence of an ulcerative STI (such as herpes, syphilis, or chancroid) increases the risk of HIV acquisition from 10 to 300 times per exposure, while the presence of a non-ulcerative STI (such as gonorrhea or chlamydia) increases the risk from 3 to 10 times per exposure.

Although HIV can pass more easily through genital ulcers, STIs that do not cause ulcers also increase risk. This is because they increase the number of white blood cells (which have receptor sites for HIV) in the genital area and because genital irritation may cause tiny cuts or sores that can allow HIV to enter the body.

The "shedding" of HIV in genital fluids is increased by the inflammation related to STIs, making those who are infected with both HIV and other STIs even more infective (i.e. able to infect others). Studies have shown that treating STIs in men reduces the amount of HIV found in their ejaculate (the fluid that comes out of the penis at orgasm).

In addition, HIV infection may make the diagnosis and treatment of other STIs more difficult because HIV may change the disease patterns or clinical signs of certain infections. In people with HIV infection, STI symptoms may be more severe, the period when they are contagious may be longer, and normal treatments may fail.

Preventing HIV Transmission through Blood

Infected blood can be transmitted to others through injections, blood transfusions, and direct contact with infected blood. Injecting drug users spread HIV by re-using needles and other supplies. Health workers may also be exposed to blood during surgery or while assisting childbirth. HIV can spread if instruments and needles are used on more than one patient. A person may also come into contact with infected blood by sharing razors ("blades"), for example, if the same knife is used to perform female genital cutting on several girls.

[10] Adapted from EngenderHealth Online Minicourse "Sexually Transmitted Infections," 2002.

Blood and blood products are used around the world to save people's lives. If these products have not been screened (tested for the presence of HIV), a person could get several diseases, including HIV. The chance of getting HIV from a **blood transfusion** depends on the rate of HIV in your country. For example, if 25 percent of the donors have HIV, then 25 percent of the possible blood supply may contain HIV. Blood banks are now beginning to screen donors to identify those with specific HIV risk factors. The blood bank then asks these individuals not to donate blood. They also test all donated blood for HIV and discard any found to have the virus.

To prevent transmission by blood, people can check to see if the blood they are receiving through a transfusion has been tested for HIV. There may be blood banks that certify the blood to have been tested. In some areas, there may also be blood banks where a person can donate their own blood to be used only by them, specifically in cases of elective surgery. People can also avoid sharing razor blades and other objects that have touched blood. They can ask that health clinics keep a clean stock of needles and other instruments or that they sterilize needles between each injection. Health workers and birth attendants can wear latex gloves during medical procedures and make sure they sterilize instruments and wash their hands afterwards.

To prevent HIV transmission through blood, the challenges are the—

- Lack of testing facilities for donor blood
- Lack of medical supplies (needles, instruments, gloves)
- Lack of education on transmission among health workers

Preventing Mother-to-Child Transmission (MTCT)

HIV can be spread through pregnancy, birth, and breastfeeding. The chance of an infected mother transmitting the virus to her baby during pregnancy or birth is about 15-30 percent. The virus can pass from mother to baby through the placenta. During birth, blood and fluids from an infected mother can pass HIV to the baby. If a mother takes antiviral medications during pregnancy, there is a much lower chance of transmission. Antiviral medication can lower the amount of virus in her blood. The best way for a mother to prevent transmission to her child is to prevent herself from getting infected with HIV. If she already has HIV, she can choose to use contraception (birth control) to prevent pregnancy.

After birth, the baby will have many antibodies that its mother produced, including HIV. This does not mean that the baby has HIV. Children must be tested at 18 months to see if antibodies are still present. If they are still present at this time, the baby probably has HIV. Some babies with HIV die within a few years, and others can grow up and live many years with HIV.

Breastfeeding is important for a baby's health. Mother's milk contains many nutrients and protects the baby against disease. Unfortunately, breast milk from an infected mother can contain HIV. The estimated added risk of HIV infection from breast milk is about 15 percent for infants whose mothers have established HIV infections.[11] The current WHO/UNAIDS/UNICEF guidelines state that for HIV-positive mothers who choose to breastfeed, the safest choice is to breastfeed exclusively (that means no feeding the baby other food or liquids, even water, to reduce the risk that the gut may be damaged and transmission may become more likely) for three months and then stop early and switch to breast milk substitute or formula. Other options include breastfeeding in the generally recommended way, using heat-treated expressed breast milk, wet nursing (by an HIV-negative woman), or using replacement feeding with formula. This can be a problem because in many communities, healthy drinking water is not available to mix with the powdered formula. This dirty water can transmit other diseases to the baby and give it diarrhea. Formula is expensive and may not be prepared properly. And in areas where breastfeeding is the norm, a woman using formula may risk stigma and discrimination (though less after three months after breastfeeding than if using formula from birth). A mother with HIV must understand the risks of each method and decide which risk is greater for her personal situation: possibly passing HIV through breast milk or diarrhea and malnutrition from improperly prepared formula. (For HIV-negative women or women who do not know their status, long-term breastfeeding is still recommended.)

To prevent MTCT, the challenges include—

- Lack of awareness among people on this transmission route
- Women's unwillingness to be tested for HIV infection
- Lack of antiviral medications and high cost, if available
- Competing risks of breastfeeding and replacement feeding in areas with poor access to sanitary drinking water, affordable formula and education

HIV Testing for Prevention: Know Your Status

Many people are worried about contracting HIV/AIDS. They may understand that certain behaviors put them at risk for contracting HIV. HIV testing can be an important part of prevention efforts. A doctor may recommend a test based on the patient's behavioral history and/or clinical findings such as STIs. HIV/AIDS is a sensitive and emotional issue in many countries. Often, people with HIV are stigmatized in the community. **HIV testing should always be voluntary and confidential.**

[11] Ellen Israel and Douglas Huber, "HIV Transmission through Breastfeeding," Technical Guidance Series, No.1, Pathfinder International, December 1999.

HIV tests identify whether a person's blood contains antibodies to the virus. **Voluntary counseling and testing (VCT)** is a supportive process between a client and counselor, often a health provider. (In some testing services, counseling is not available or inadequate, and often people will go to their clergy for counseling either before or after testing, so it is important to understand the VCT process.) A person is counseled prior to being tested. The counselor—

- Determines the patient's HIV knowledge and corrects any mistaken beliefs on HIV/AIDS
- Assesses the person's risk by discussing past behaviors
- Explains the test and the meaning of test results, including how the results will be given (results should always be given in person)
- Gets the patient's consent or permission to give the test

After the test is given, the client and the counselor develop a personal risk reduction plan for the client. The counselor is also available to give psychological and emotional support and referrals as needed. Knowing their HIV status can motivate people to protect themselves from infection if they are negative and to prevent transmitting HIV to others if they are positive. A pregnant woman who knows she is HIV positive can then decide if she will take antivirals (if available) while pregnant, abort where legal, or breastfeed after birth.

In HIV testing, the challenges are—

- The fear that if one is tested, the results will not be anonymous (private)
- That if one tells one's family or partner they have HIV, there may be negative consequences, especially for women, including blame for the disease, violence or abandonment, or community stigmatization and discrimination
- Men may fear losing their jobs

HIV/AIDS is a difficult issue to discuss in many communities worldwide. The issue is particularly difficult in countries where transmission occurs mainly through heterosexual activity. Traditional cultural beliefs may prevent people from speaking openly about sex. Many educational campaigns have been effective in increasing HIV/AIDS knowledge in a community. Unfortunately, research has shown that **education alone is not sufficient to change the behavior of most people**. Researchers have found that because complex health behaviors such as sex take place in context, socio-cultural factors that the individual lives within must be well thought-out when planning prevention interventions.[12] In this chapter, the socio-cultural factors that influence behavior are discussed.

[12] "Sexual Behavior Change for HIV: Where have current theories taken us?" UNAIDS, 1999. Available from http://www.unaids.org

Chapter 2, Section 1: HIV/AIDS Transmission, Prevention, and Risk Reduction

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 1: HIV/AIDS Transmission, Prevention, and Risk Reduction

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**HIV/AIDS Transmission and the Link Between HIV and STIs**	Demonstration and discussion	Large poster of body, cutouts of "fluids," tape, flipcharts, handouts	Match fluid to portal of entry
30 minutes	**What's the Fluid, Where's the Door?**	Problem solving, Discussion	Flipcharts, tape	Distinguish between activities that transmit or do not transmit HIV
60 minutes	**Prevention of HIV: Non-Sexual Transmission**	Case study, Discussion	Flipchart, markers	Level of understanding through discussion
60 minutes	**Prevention of HIV: Sexual Transmission, Discussing HIV/AIDS with Partners**	Discussion, Brainstorming, Role-play Problem solving	Markers, flipchart	Active participation in finding solutions to communication problems
60 minutes	**Understanding the HIV Test**	Brainstorming, Discussion	Flipchart with fisherman analogy, blank flipcharts, markers.	Level of understanding through discussion and application of information in counseling role-play

Important Terms

Acquired Immune Deficiency Syndrome (AIDS)	HIV syndrome caused by weakening of the immune system
Body Fluids	Substances produced by the human body which may or may not contain living cells
Human Immunodeficiency Virus (HIV)	A virus which attacks cells of the immune system
Immune System	The body's defense against infection. The immune system consists of specialized cells, called white blood cells, found in the blood and tissues that attack and neutralize foreign particles that can cause disease.
Opportunistic Infection	Infections by common germs that usually do not cause problems in healthy individuals. Opportunistic infections (OIs) are the major health problems for AIDS patients.
Pandemic Disease	An infectious disease that presents on many continents at the same time.
Portal of Entry	An opening in the skin that HIV can pass through, a "door" into the body; examples include tiny cuts, sores, the vagina, penis, rectum, or mouth.
Transmission	Passing (a virus like HIV) from one person to another

Anti-Retroviral Drugs (ARVs)	Medication that is designed to reduce the amount of HIV or destroy HIV cells in the blood.
Barrier Method	A contraceptive method that prevents body fluids from touching the mucous membranes of the sexual organs. Examples are the male and female condom.
Blood Transfusion	A process where donated blood is transferred to a person, often during surgery or after blood loss due to childbirth or accident.
Dual Protection	Use of a barrier method, such as a male or female condom, or a condom in addition to another contraceptive method, such as an IUD, Depo Prevera or pills, for the prevention of both STIs (including HIV) and pregnancy.
Monogamy	A sexual relationship in which the two partners do not have sexual contact with others outside the relationship.
Mother-to-Child Transmission	HIV transmission from mother to child during pregnancy, birth or breastfeeding (also called "vertical transmission").
Safer Sex	Sex that does not involve direct contact of infected bodily fluids with a mucous membrane. Examples are kissing, sex with a condom, and masturbation on to unbroken skin.
Voluntary Counseling and Testing	A way to find out if one is infected by HIV. Voluntary counseling and testing is a supportive process between client and counselor. A person is counseled prior to HIV testing, tested for HIV, and then counseled after the test, and encouraged to develop a risk-reduction plan. The counselor provides psychological and emotional support and gives referrals as needed.

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 1: HIV/AIDS Transmission, Prevention, and Risk Reduction

Activities and Handouts for HIV/AIDS Transmission, Prevention, and Risk Reduction

- **HIV/AIDS Transmission and the Link Between HIV and STIs**
- **What's the Fluid? Where's the Door?**
- **Prevention of HIV-Non Sexual Transmission (Blood borne and mother-to-child**
- **Prevention of HIV-Sexual Transmission: Discussion of HIV/AIDS with Partners**
- **Understanding the HIV Test**

Activity HIV Transmission & the Link Between HIV and STIs

Objective

By the end of the activity, participants will be able to—

- Differentiate between HIV and AIDS
- Define "transmission"
- Identify five ways that HIV is transmitted
- Understand the link between HIV and STIs
- Define "portal of entry"

Time allotted

30 minutes

Preparation

Prepare two flipcharts.

The first should read, "What's the fluid?" and have a colorful drawing of a drop of blood at the top.

The second should read, "Where's the door?" and have a colorful drawing of a door on the top.

Photocopy the Section 1 "Important Terms" pages 2-54 to 2-55, and "What Are STIs and RTIs?" and "Special STI Concerns for Women" handouts on pages 2-61 to 2-63 for each participant.

Facilitation steps

1. Introduce the session by asking participants, "What is the difference between HIV and AIDS?" Ask how the disease progresses and why it is fatal. Refer to the flipchart or overheads used in the "HIV/AIDS Overview" session and summarize the "Key Facts About HIV/AIDS."

2. During the discussion, refer to key terms such as HIV, AIDS, pandemic, opportunistic infection, and body fluids.

3. To introduce the concept of "transmission," read "Noni's Story" on page 2-60 to the participants (and, if time permits, this story can be acted out as a role-play). Ask participants to identify how HIV was transmitted to Noni and then on to her child. Ask the participants to come up with a working definition of transmission and write it on a flipchart, as illustrated below.

Transmission	Passing (a virus like HIV) from one person to another

4. Despite HIV myths, indicate that it is very clear how HIV is transmitted, and it is also clear how it can be prevented. Ask participants to brainstorm which bodily fluids can transmit HIV. Record the correct answers on the "What's the fluid?" flipchart. When incorrect answers are given, record them in a separate box at the bottom to be discussed later. The correct answers include **blood, semen, vaginal secretions, and breast milk**. (Also other secretions include amniotic fluid, synovial fluid, cerebral-spinal fluid, etc., but these will probably only come up if you are conducting a session with health workers.)

   Fluids that do not transmit HIV include vomit, saliva, tears, sweat, urine, and so on. After all of the correct answers have been given, be sure to indicate that, while fluids like vomit, saliva, tears, sweat, and urine do contain HIV, **the HIV concentration is very low in these fluids and therefore these fluids cannot transmit the virus from one person to another**.

5. Next, indicate that in addition to a fluid infected with HIV, one also needs a "door" into the body for HIV to pass through. This "door" is sometimes called—

Portal of Entry	A place in the body where the virus may enter

6. Ask participants to think of possible "doors" that may allow HIV into the body, and write the answers on the "Where's the door?" flipchart. Suggested answers can include cuts, sores, soft tissues of the vagina, tip of the penis, anus, mouth, eyes, or nose.

7. Point out that STIs can increase the risk of HIV transmission. STIs such as syphilis, chancroid and herpes are characterized by open sores that allow the virus to directly enter the bloodstream (a portal of entry or "door").

   In an HIV positive person, the HIV is concentrated in the areas where immune cells work, such as sores, making transmission much more likely. Other common STIs, such as gonorrhea and chlamydia, are also linked to higher rates of HIV transmission. (See the "STI Information" handout on pages 2-61 to 2-63.)

8. State that it is possible to figure out if HIV can be transmitted by asking two questions—

- What is the fluid?

  Is it one of the fluids that can transmit HIV present?

- Where's the door?

  Is there a portal of entry for the virus to pass through?

9. Ask participants to brainstorm some of the most common ways for HIV to be transmitted. These include—

   - Vaginal or anal sex
   - Possibly oral sex
   - Sharing needles or other sharp equipment such as razors
   - Through blood transfusions of untested blood (emphasize that most countries now test blood for HIV, so most sources are safe)
   - From mother to infant during pregnancy, during delivery, or through breastfeeding

Wrap-up

Summarize the activity by emphasizing that it is clear how HIV is transmitted. Review the fluids that can transmit HIV, and the "doors" through which it might enter.

Remind participants that they can now put any activity to the "What's the fluid?" "Where's the door?" test if they are unsure whether the activity may pose an HIV transmission risk.

In the next exercise, participants will practice this test by reviewing a number of activities that may or may not transmit the virus.

Distribute handouts on "Important Terms," "What are STIs and RTIs?" and "Special STI Concerns for Women."

Tools for Trainers

Noni's Story*

Owura worked at a mine about two hours from home and his girlfriend Noni. Because Owura was often away from Noni for long stretches, he became lonely. One evening, he found a woman to ease his loneliness. Soon after, Owura found a job back home and he and Noni married. Years later, Noni gave birth to her second child, Constance. She did not thrive like her older brother and died young. The doctors tell Noni that the baby died as a result of AIDS and suggest she be tested. The test is positive. Noni is afraid to talk to Owura about the situation, he may blame her, react violently, or abandon her; she feels numb. The doctor has urged her to come back to the clinic for counseling with her husband.

*Story adapted from R. Granich,and J. Mermin, *HIV: Health and Your Community, A Guide for Action* (Stanford University Press, 1999).

(**Note:** *Be sure to adapt this story to reflect a typical example in your culture.)*

Handout

What Are STIs and RTIs?[13]

Sexually transmissible infections (STIs)—also known as ***sexually transmitted diseases (STDs)***—are infections first and foremost passed from person to person by sexual contact.

Some STIs can be passed to a baby during pregnancy, delivery, or breastfeeding, causing serious problems. STIs are part of a larger group of infections known as ***reproductive tract infections (RTIs)***. RTIs include infections of the female reproductive system that—

- Are not caused by sexual contact, including infections caused by an imbalance of normal reproductive tract microorganisms (such as yeast infections)
- Are contracted during medical procedures (often when there is a failure in aseptic practices, for example during surgery, IUD insertion, or injection if the instruments are not properly sterilized)

STIs and other RTIs can lead to serious complications, including infertility (not being able to get pregnant), constant pain, and even death, especially if they are not diagnosed and treated early. No cure exists for HIV infection or AIDS, and infection usually results in death. STI infection greatly increases the risk of getting or passing on HIV.

STIs can be divided into two broad groups, curable and incurable—

- ***Curable STIs*** can be treated with medications, such as antibiotics or antimicrobials. These STIs include syphilis, gonorrhea, chlamydia, *trichomonas* infection, *lymphogranuloma venereum* (LGV), chancroid, *granuloma inguinale*, pubic lice, and scabies. If not diagnosed and treated in time, some of these curable STIs can have serious—even fatal—consequences.
- ***Incurable STIs,*** such as HIV/AIDS, hepatitis B, genital herpes, and human papillomavirus (HPV) infection, are caused by viruses. Although these diseases cannot be cured, in some settings they can be managed by preventing, relieving, or reducing their symptoms. (HPV infection can often be treated with no recurrence.)

A STI might lead to symptoms in the reproductive organs themselves, in the skin around the genitals or anus, or in the throat or mouth. Some STIs may lead to systemic symptoms that cause problems in other body parts or throughout the body, while others may cause no symptoms at all.

[13] Adapted from EngenderHealth Online Minicourse "Sexually Transmitted Infections," 2002

What Are STIs and RTIs? continued

Common STI symptoms include—

- Abnormal discharge from the vagina or penis
- Pain or burning with urination
- Itching or irritation of the genitals
- Sores, blisters, or bumps on the genitals
- Rashes, including rashes on the palms of hands and soles of feet
- Pelvic pain

It is important to remember that the symptoms associated with STIs and other RTIs can vary from none to minor to severe. It is not always evident if a person has a STI, and people without symptoms often transmit the infection to others unknowingly.

Handout

Special STI Concerns for Women

Although STIs affect both women and men, research shows that women are more prone to infection and are less likely to seek treatment than are men. The possible complications of untreated RTIs are more serious in women, and infections can be transmitted to the children of pregnant women as well.

Although the infection rates vary a great deal among and within countries, World Bank reports show that STIs are the second most important cause of health life years lost in women of childbearing age (after pregnancy-related problems).

Women are biologically more vulnerable to genital tract diseases than men are because—

- The lining of the vagina is a mucous membrane that is more porous to infection than the skin on the outside of the penis
- Women's genitals have more surface area through which infection can occur
- Lack of lubrication during intercourse or changes in the cervix during the menstrual cycle can make possible more efficient transmission of infection to women
- Younger women are particularly vulnerable because their cervical tissues may be less mature and more readily penetrated by organisms (e.g., chlamydia and gonococcus)
- Older women are more likely to get small tears in the vagina during sexual activity because of the thinning of the tissues and dryness that occur with age

Women who already have an infection (particularly one that causes genital sores) are more likely to get or transmit HIV, and since women are often asymptomatic (show no signs or symptoms) when infected with a STI, they are often not aware of this increased risk.

Although women are often perceived as being the "end of the line" of infection since they are less likely to pass on infection, many women are at risk for infection, particularly when their primary partners (husbands) have other partners. Social and economic vulnerability add to women's infection risk. For example, many women lack economic resources and are fearful of abandonment or of violence from their male partner. Therefore, they have little control over how and when they have sex, which in turn limits their ability to protect themselves from infection.

Activity What's the Fluid? Where's the Door?

Objective

By the end of the activity, participants will be able to—

- Determine whether or not HIV can be transmitted by specific activities
- List activities that can transmit HIV and activities that cannot transmit HIV

Time allotted

30 minutes

Preparation

Create cards with a number of different activities on them. (Suggested activities are listed at the end of this session on page 2-66.)

Ensure that there is one card for each participant.

Before the session—preferably before the day begins or during the break—tape the cards under the participants' chairs. Tape two signs at the front of the room, one reading "Can Transmit HIV," and one reading "Cannot Transmit HIV."

Facilitation steps

1. Remind participants of the transmission facts that they just learned and indicate that they will now practice using the "What's the fluid? Where's the door?" method.

2. Ask participants to reach under their chairs and pull out the activity cards taped there. Tell the participants that the cards were placed randomly and that the card they have has nothing to do with them personally.

   Give participants a moment to read their cards.

   Ask them to think about whether that activity might transmit HIV or not.

3. Invite participants to approach the front of the room, one-by-one, with their activity cards.

   Each participant should read his or her card, indicate what fluid is present that might contain HIV, and what door is present through which HIV might pass.

   The participant should then tape the card under the "Can Transmit HIV" or "Cannot Transmit HIV" section.

After the participant chooses, ask for feedback from the entire group.

Clarify any questions or incorrect answers.

4. Repeat this process until all participants have completed the exercise.

Wrap-up

Summarize the activity.

Suggest that participants can always tell whether or not an activity is a risk behavior for HIV transmission by using this simple test.

Remind participants that in the next session they will begin to discuss the ways that HIV can be prevented.

The "What's the Fluid? Where's the Door" session was adapted and reprinted with permission of the U.S. Peace Corps, from the U.S. Peace Corps "Life Skills Manual," pp. II-51 to II-55.

What's the Fluid? Where's the Door?

Tools for Trainers

Below is a list of activities for the "What's the Fluid? Where's the Door?" exercise. Write out one activity per card for each participant.

Can Transmit HIV

- Vaginal sex
- Direct blood transfusion of untested blood
- Sharing needles
- Contact with blood of an infected person
- Breastfeeding
- Mother to infant during delivery
- Mother to infant during pregnancy
- Contact with semen
- Contact with vaginal fluids
- Cleaning up blood spill without using gloves

Cannot Transmit HIV

- Living with a person with HIV infection
- Eating from the same dish as an HIV-infected person
- Hugging a person with HIV
- Kissing a person with HIV
- Shaking hands with a person with HIV
- Proper condom use during sex
- Eating a chicken raised by someone with HIV
- Sharing a drinking cup with an HIV-infected person
- Letting someone cry on your shoulder
- Stepping on a nail outside
- Cleaning up vomit with gloves on

Activity Prevention of HIV: Non-Sexual Transmission

Objectives By the end of the activity, participants will be able to—

- Understand the importance of not sharing body piercing/cutting instruments and taking precautions to use sterilized instruments to prevent blood borne HIV infection
- Understand the risks and concerns for an HIV positive person having a child, and understand the different options available

Time allotted 60 minutes

Background From a quick review of daily experience, participants will learn that a surprising number of "blood transactions" occur in everyday life, each of which could pose a possible HIV infection risk. How exactly and to what degree the infection risk works in each instance is a more technical matter, as are the protective behaviors.

Preparation The trainer should work to bring out the common sense that the participants will have about avoiding blood-borne infection risks.

Materials Flipcharts, markers

Facilitation steps

Blood to Blood HIV Infection (20 minutes)

1. Start with the idea that blood is the source and symbol of life. Unfortunately, blood-to-blood contact is also one of the ways HIV infection can be spread. The class will identify where blood-borne infection is possible.

2. Quickly review the fluids and portals of entry. Ask the group to identify all the possible blood transactions that could occur in everyday life. For purposes of this brainstorm session, a blood transaction is any occasion where blood from one person is exposed to another person's blood directly or to anything that can transmit HIV to another person. (Examples include blood brothers, male and female genital cutting, "false teeth," traditional healing, dirty needles and syringes, and blood transfusions.)

3. Record the discussion results on a flipchart and allow the participants to make comments or ask further questions.

4. Using the list, ask the group which blood transaction is high risk, medium risk, or low risk and why. As them what can happen and what would the result be.

   Transfer the list of high-risk activities to a new flipchart.

5. Summarize by identifying the blood transactions that pose the greatest HIV infection risk in their everyday lives.

6. Ask the group what the best **protective measures** are for avoiding the high risks and list them underneath the risks on the flipchart.

   Ask if it is possible to continue practicing any of these blood transactions if it were changed or adapted to fit the current situation. (For example, in a blood sharing ritual, the people would pour the blood into a common bowl instead of rubbing the blood on each other; circumcisions could be replaced with a non-cutting ritual, etc.)

HIV Infection and Childbearing (40 minutes)

1. Now guide the participants to explore the special risks and circumstances of childbearing for a couple with HIV.

   Review the ways in which HIV can be transmitted from mother to child (pregnancy, birth, and breast milk).

2. Discuss the following scenarios with participants and write their responses on a flipchart.

   - **Couple A** does not know their HIV status; what can they do to prevent HIV transmission to their child? (I.e. HIV testing, antivirals and avoid breastfeeding).

   - **Couple B** knows they are HIV positive; what influences might be involved as they decide whether to have children? (I.e. reasons for having children, expectations to have children from family, desired number of children, etc.)

3. Present the information in the text box below quickly and with authority, pausing to answer questions and respond to comments. If possible, present the information on an overhead.

The Impact of HIV Infection on Childbearing

On Pregnant Women

- Since pregnancy is stressful on a woman's body, a woman who is pregnant and whose immune system has been damaged by HIV may develop symptoms or more serious illness more quickly than she may have otherwise.
- HIV infection can lead to spontaneous abortion, either as a direct effect on the placenta or viral or bacterial infection due to damage to the mother's immune system.

On Children

- There is a 15 to a 30 percent chance that an HIV positive woman will infect her baby. There is no reliable way to tell in the womb or at birth whether or not the baby is infected, unless it is born with symptoms. Note that 80 percent of HIV positive babies die by the age of five.
- Children born to HIV positive women (whether the children are HIV positive or not) can have lower birth weights, be premature, fail to thrive, become malnourished due to problems in their gut, suffer from constant diarrhea, and be more likely to die than those children that are born to non-HIV positive women.
- There is evidence that suggests that the virus can pass from mother to baby through breast milk. However, the risk of death due to improper or contaminated bottle-feeding may be greater than the risk of a child getting the disease through breastfeeding.

Other Concerns: AIDS Orphans and Sick Children

- Even if an HIV positive mother gives birth to an uninfected baby, the real question is who will look after the baby after the mother dies? There is a big problem with AIDS orphans, both those who are HIV positive and HIV negative.
- What kind of care will the child/children receive? (A grandmother caring for six or more children will probably have a hard time providing the basic needs for these children.)
- Cost of sick children. Can family or society bear the costs of treatment (even palliative) for sick children?
- Who will care for the children when the mother has died?

4. **Identify childbearing options**: Ask participants to think of all the choices that there are for pregnancy and childbearing. State that the object is not to give them answers, but to let them know all the options available to be able to counsel individuals and couples.

   The list is a list of options for any couple that chooses to have or not have children. Record responses.

   Examples are—

   Sterilization

   Abstinence

   Contraception

   Having a child and giving it to a relative

   Having a child and keeping it

   Adoption

5. Ask participants to discuss their feelings about the various choices listed. The following questions can guide the discussion,

   - Which options do you consider realistic?
   - Which are not realistic?
   - If not realistic, why? (Religion, access, personal beliefs, etc.)

Wrap-up

Ask participants to privately consider what they might decide to do if they were infected with HIV and wanted to have children. Stress that **there is no right or wrong answer when counseling individuals or couples**; each individual must decide for himself or herself what is desirable for him or her.

Note to Trainers:

Having children is one of the most powerful of all human experiences. There are many reasons why people have children. Some of the reasons are conscious; some are not. There are always challenges associated with childbearing and parenthood that become more difficult when a couple is HIV-infected.

This session is not meant to be the only answer for the HIV-infected couple. Risk factors and options are presented so that members of faith-based organizations can use the information to fully inform individuals or couples when counseling.

Resources:

1. Dennis Klass, *The Spiritual Lives of Bereaved Parents* (New York: Brunner-Routledge, 1999).
2. Gillian Paterson, *Women, Health and the Challenge of HIV (*Geneva: World Council of Churches, September 1996).

Activity Prevention of HIV: Sexual Transmission, Discussing HIV/AIDS with Partners

Objective

By the end of the activity, participants will be able to—

- Identify ways to prevent sexual transmission of HIV
- Discuss the difficulties involved in talking with partners about HIV/AIDS
- Describe ways to negotiate for safer sexual behavior

Time allotted

60 minutes

Preparation

Prepare a poster of a man and woman to use as a visual aid. Prepare one flipchart page with discussion questions from step 5 below, one with "Helping Forces," and one with "Hindering Forces."

Materials

Blank flipchart, markers

Facilitation steps

1. To begin the session, ask participants to brainstorm the ways to prevent HIV/AIDS transmission through sexual activity. Remind participants to consult their notes from the transmission modes session. List the participants' responses on the flipchart. If any gaps exist, suggest them to the audience. Possible responses include monogamy, abstinence, "safe sex," male or female condom use. Correct any incorrect responses.

2. Ask each participant to think privately about how they would discuss HIV and AIDS with their sexual partner, or if celibate, how they would discuss it as a pre-marriage or marriage counselor.

3. Imagine that they are concerned about AIDS. Ask them to think privately about how they would go about discussing the issue or how they would counsel someone to discuss it with their partner.

4. Show the participants a picture of a couple and tell the participants to assume the couple in the picture is engaged to be married and have heard about AIDS.

5. Display the following questions on a flipchart and discuss them.

    - Do the topics of AIDS and sex normally come up?

    - Why is it important for two people to talk about AIDS?

- Why don't people talk about AIDS?

6. Brainstorm "Helping" and "Restraining" forces (see text box, below) by presenting the topic headings on separate flipchart pages.

   What are the helping and hindering forces in discussing AIDS with a potential sexual partner? Choose the top three forces that would be most effective for them if they were negotiating a discussion with an intimate partner.

   Forces Affecting Talking About AIDS

   Examples—

   Helping

   - Concern for others
   - Facts about AIDS
   - Fear of infection
   - Trust between lovers
   - Adult self-control
   - Moral obligation

   Hindering

   - Shyness about previous partners
   - Fear of losing new partner
   - Fear of signaling mistrust
   - Belief that a PLWHA is "bad" or "tainted"
   - Religion and other cultural beliefs
   - Power of passion hard to restrain
   - Difficulty using explicit language
   - Unequal power relationship
   - Effects of alcohol or other drugs
   - Fear of verbal or physical abuse

7. After you have recorded all the factors, divide participants into groups of six and have each group assign a recorder to take notes.

   Have the groups identify ways that the couple could successfully talk about the AIDS issue. Group members may want to do this through role-playing. Ask recorders to list the group's strategies on a flipchart. Examples may include—

   "Due to my concern for you…"

   "I am embarrassed too but we need to talk about this before we get married…"

   "AIDS is a dangerous disease that I think we should discuss"

   "Because I know we both want to have healthy children…"

Wrap-up Have the participants come together as a larger group and share their communication strategies. Participants may want to role-play, if time permits. As counselors, suggest that they may want to use role-play with their clients to build positive communication skills.

Note to Trainers:

- The facilitator needs to be comfortable with the words and sexual activities discussed. Be sensitive to the fact that religious leaders and some community members may not be comfortable discussing sexual activity between unmarried couples, other forms of sex, and prostitution. It is important for them to realize that these things do happen in their communities and they may have to talk about them to combat this disease.

- This session's purpose is to help the participants understand the helping or restraining factors that make it hard or easy to raise the AIDS issue with a sexual partner and to be able to counsel individuals or couples.

Activity Understanding the HIV Test

Objectives By the end of the activity, participants will be able to—

- Explain what voluntary counseling and testing (VCT) means
- Describe the HIV testing process
- Name at least two things a person should know before having an HIV test
- Name at least two things that should be done in posttest counseling

Time allotted 60 minutes or more

Preparation Prepare flipcharts prior to the activity.

Draw the fisherman analogy from Step 4 below on an overhead or flipcharts prior to the activity.

Prepare the "Pretest and Posttest Counseling" handouts on pages 2-79 to 2-83.

Facilitation steps

1. This session can be divided into three parts: before the test, the test, and after the test. It may be helpful to frame the session in this sense and have a discussion on each part.

   Begin the session by asking participants to list the reasons why someone would get an HIV test. List their responses on a flipchart. Their responses may include—

   - Experiencing symptoms
   - Multiple sex partners without protection
   - Contact with blood through a transfusion/cut/sore of infected person
   - Pregnant

2. **Before the test:** Point out that not everyone who wants an HIV test should have one. A person should consider if their *behaviors* put them at risk. People who are at high risk should be tested. The test must first be **available/accessible**. It should also be **voluntary** and **confidential** because often people who are HIV positive are stigmatized in the community. In particular, women are at high risk of negative social consequences if they test HIV-positive; they may be thrown out of their

home, have their children taken away from them, be beaten, or even killed. The client should give **consent** to be tested. They should have access to counseling prior to and after the test is done.

Display the following definition on a flipchart.

> **Voluntary counseling and testing (VCT)** is a supportive process between a client and a counselor. A person is counseled before HIV testing, tested for HIV, and then counseled after the test and encouraged to develop a risk-reduction plan. The counselor provides psychological and emotional support and gives referrals as needed.

- Ask participants if VCT is available in their communities. If not, ask what types of HIV testing services are available, (I.e. how accessible is voluntary testing and how confidential is it? Is counseling available pre- and posttest?) List their responses on a flipchart.

- Ask participants what a person would need to know before deciding to have an HIV test. List their answers on a flipchart.

- Answers should include basic HIV facts, such as what it is, how it is transmitted, and how it can be prevented. Myths should be discredited and mistaken beliefs corrected. Discuss past behavior to assess risk. The test and the meaning of the results should be explained including how the results will be given.

3. **The HIV Test**: Begin a discussion on an HIV test procedure by referring back to what was learned in section 1 of this chapter; people who are infected with HIV produce **antibodies** to the virus.

   Explain that the simplest and most widely used HIV tests (1) ELISA-enzyme-linked immunosorbent assay and (2) Western Blot, involve taking blood from a person and testing it for the presence of antibodies to HIV. Each test has its benefits and drawbacks, so they are usually used together.

   - Explain that test results are usually available within two weeks.

   - Some areas may have access to rapid serum HIV antibody tests, or saliva- and urine- based antibody tests. Results from these tests are usually available on the same day as the test. If a person tests positive with a rapid test, it is often confirmed by an immediate second test. The results are almost as reliable as the ELISA/Western Blot tests.

   - The ELISA test is very **sensitive**; it is good at finding those who are positive, but its downside is that it may identify people as

positive who are not (this is also known as a "false positive" result).

- The Western Blot test is highly **specific;** when it identifies someone as positive, that person is almost always positive. Therefore, the Western Blot test can be used to confirm a positive test that was done using the ELISA method. The downside is that this test is expensive.

4. **To explain the difference between sensitivity and specificity**, use the fisherman example.[14] If a fisherman is fishing for tilapia and uses a net, he may catch many tilapia but he may also catch other fish in the net. The net has high **sensitivity**, because it catches many tilapia. The ELISA test has high sensitivity, which "catches" almost everyone who has antibodies to HIV.

   On the other hand, a fisherman may use a fishing pole to catch tilapia. With a pole, he can use bait that *only* tilapia eat. This way, he can be sure that when he catches a fish, it is almost always a tilapia. This is similar to the Western Blot test, which has good **specificity** because almost everyone it identifies as positive has HIV antibodies.

5. **After the test:** Explain that HIV counselors and religious counselors can help people deal with the test results. Ask participants what kinds of things should be done in posttest counseling. List their answers on a flipchart.

   Answers should include the following.

   - If someone is found to be negative, they can put together a risk reduction plan to change behaviors and help them prevent future infection.

   - If someone is found to be HIV positive, they will need a risk reduction plan as well a way to avoid infecting others and re-infecting themselves, which can lead to faster destruction of the immune system and quicker death. They will also need psychological and emotional counseling. They may need support in deciding whether or not to reveal their status to their partner(s) or to others.

   - **It is *only* the individual who can choose to disclose his/her status to anyone else.**

Note: Some women have experienced negative outcomes from making known positive results to their partner, including blame, abandonment, physical harm,

[14] Rueben Granich, M. D., M.P.H. and Jonathan Mermin, M. D., M.P.H, *HIV, Health and Your Community: A Guide for Action* (Stanford: Stanford University Press, 1999), p.79.

and death. Counselors should ask the woman if there is a possibility of her partner becoming verbally or physically abusive and, if so, assist her to develop a safe disclosure plan or refer them to support services. Some men have lost their jobs when their positive status became public. Men and women will need a referral to other services to help them stay healthy.

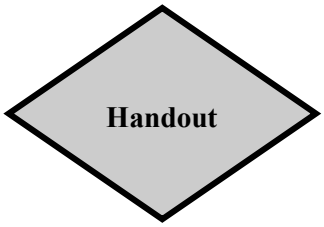
Wrap-up

Wrap up the discussion by asking if there are any other issues around HIV testing that were not discussed, such as—

- How often one should get tested if engaging in risk behavior (every three to six months)?
- What if the test is false positive or false negative?
- What are national testing policies?

Distribute the "Pre/Posttest Counseling" handouts.

Pretest and Posttest Counseling[15]



All individuals who are tested for HIV should have access to a counseling and education session before the test is done and then again once the test results are available.

Pretest Counseling

Pretest counseling provides an opportunity for counselors and clients to talk about the HIV testing process, the meaning of positive and negative test results, the client's potential risks, ways to reduce risk, and the client's intended action plan once he or she has received the test results.

Pretest counseling should not focus on getting the client to admit to various behaviors, which may be considered socially unacceptable or which he or she may feel uncomfortable discussing. The keys to HIV counseling are to discuss all the behaviors that may increase the HIV infection risk in a client-centered, nonjudgmental way and to discuss ways to reduce risk.

Pretest counseling and education will help both the provider and client assess the client's understanding of HIV/AIDS, testing, modes of transmission and prevention, and his or her ability to handle the results.

In addition, counselors should attempt to work with clients to develop personalized HIV risk-reduction plans, focusing on realistic, incremental steps toward behavior change. It is important to note that before taking an HIV test, a client should be aware that if the result is positive, he or she will have an illness that carries a social stigma. In some settings, people with HIV have been thrown out of their homes, fired from jobs, victimized in their community, and physically assaulted. Clients need to think through these possible problems before they decide to be tested.

Posttest Counseling

All individuals who are tested for HIV antibodies should have access to a posttest counseling and education session when they are given the test results. This session will help both the provider and the client assess the client's understanding of the test results. Test results should be given as soon as possible so that the client has time to absorb this information. When giving negative test results, remind clients that the results may not be accurate if the client has engaged in behaviors that put him or her at risk during the three months before testing or since the test was done. If appropriate, clients should be offered a repeat test at an appropriate time in the future.

[15] Adapted from EngenderHealth "HIV and AIDS Online Minicourse." Available from: www.engenderhealth.org/res/onc/hiv/diagnosis/hiv4p5.html.

When disclosing a negative test result, the counselor should disclose test results in a direct, neutral tone of voice and wait for the participant's reaction before proceeding. Explain what the test result means, answer any questions, address the client's emotional response, and discuss strategies for remaining HIV-negative. This could include further discussion of the client's risk-reduction plan.

Talking with Clients about Positive Test Results

If the test is positive for HIV, the counselor should disclose the test results in a direct neutral tone of voice and wait for the participant's reaction before proceeding. The counselor can then begin to help empower the client to participate in the many difficult decisions that HIV infection poses by providing clear, honest, factual information in terms the client can easily understand.

If a client tests HIV-positive, the counselor should explain what a positive result means, address the client's emotional response, answer any questions, discuss treatment options (if they exist) and self care, and discuss how the client can avoid transmitting the virus to others. Providers should refer HIV-positive clients to care and support services, wherever feasible, and address issues of stigma, disclosing HIV status to partners, and any personal safety concerns, threats of violence, or abandonment that the client may face after testing positive. Women who test positive should be counseled on options available to prevent mother-to-child transmission (MTCT) of HIV.

Recognizing Clients' Anxieties

Most clients who test positive for HIV are likely to have a high degree of anxiety, even before learning of the diagnosis. Many people at high risk have friends or acquaintances, who are currently living with HIV infection or who have already died from AIDS, and many may have misperceptions about HIV infection facts. Even clients who already have a good level of information about HIV infection in general will require personalized information about the infection regarding the specifics of their own individual case.

While giving information, providers should be aware that the anxiety and emotion that accompany a positive result are likely to have a profound effect on the client, and the client may need some time to come to terms with the results before being able to deal with more detailed information. For many clients, it might be more appropriate to wait for a little while to discuss treatment options, perhaps with the supportive presence of a friend or family member.

Talking About Clients' Prognoses

When discussing HIV infection with a newly diagnosed client, providers must walk a very thin line between the client's simultaneous needs for honesty, factual information, practical information, advice, and hope for the future.

After learning of the diagnosis, clients are likely to ask difficult questions, such as "How long will I live?" Honesty and realism are essential tools for providers when discussing a client's prognosis, but a realistic and spiritual optimism should be applied whenever appropriate.

While recognizing the seriousness of the diagnosis, providers should avoid speculating about a client's survival time, stressing that each individual case is different and that strategies to extend survival and new treatment therapies are being developed and tested at a rapid pace. This may offer little comfort in settings where treatment options are not readily available.

Referral for Counseling and Services

Newly diagnosed clients may require immediate assistance in attaining additional counseling for emotional distress, peer support, or assistance with financial concerns, future planning, child care issues, housing, or other practical concerns. Such clients also may require referrals to services related to MTCT prevention and family planning services. Where available, counselors should refer clients to appropriate community organizations, social agencies, peer support groups, and other resources.

Clients who test negative may also require referrals to family planning, health care, counseling, or social services. All clients, positive and negative, should be provided with condoms, counseling on prevention, and information about where to obtain additional condoms.

Partner Notification and Counseling

Notifying partners about HIV infection is important because it can help reduce the spread of HIV. When given to HIV-infected partners, risk-reduction counseling can help decrease the likelihood that they will transmit the infection to others; when given to uninfected partners, risk-reduction counseling can help reduce their chances of becoming infected. Partner notification allows for partners to be tested if they desire and if HIV testing is available; if they are infected with HIV, they may undergo medical evaluation and receive treatment if available. When referring to persons who are infected with HIV, the term "partner" includes not only sex partners, but also injection drug users who share needles, syringes, or other injection equipment.

Who Should Be Notified?

If possible, all sex and drug-sharing partners (as appropriate) of an infected client should be notified of their exposure to the infection and encouraged to visit a health care facility. If the partners have other partners, they should also be contacted.

The Importance of Voluntary Consent and Confidentiality

Partner notification should be a *voluntary process*, done with the client's *full consent*. All possible efforts must be made to protect the confidentiality of the client and his or her partner(s).

In addition, partner notification must be conducted with great sensitivity, taking into account social and cultural factors, such as the possibility of violent reactions on the part of partners.

Counselors should be aware of the impact HIV can have on a client's life. When a client tells a partner about the infection, the partner's reaction can cause problems. Providers need to minimize these kinds of problems by ensuring confidentiality and by ensuring that clients agree to help with partner referral voluntarily.

Partner Notification Strategies

The client, the counselor, or public health authorities can notify the client's partner.

- **Client notification:** The client accepts full responsibility for informing partners of their exposure and for referring them to appropriate services. This is the preferred method of partner notification.

  In some cases, clients may choose to notify partners in the counselor's presence to lend support and answer questions and address concerns.

- **Counselor/public health authority notification:** With the infected client's consent, the counselor or a health care worker takes responsibility for confidentially notifying partners of the possibility of exposure.

- **A Combined Strategy:** Often, more than one strategy may be used to notify different partners of the same infected client, depending on the client and partner circumstances. For example, a client may feel that he or she is in a better position to notify a main partner, but would prefer that a health care worker notify other partners. The decision about the type of notification to use should also be based on program priorities and program staffing levels.

In some countries, HIV requires mandatory contact tracing. In such cases, public health workers actually track down and inform the client's contacts and make referrals to appropriate services.

It is important to note that research indicates that a fear of violence can discourage some women who receive VCT from telling partners about their test results. Based on a Tanzania study that explored the links between HIV infection, disclosure of HIV status and partner violence among women attending a VCT clinic, researchers recommended the following actions to address women's fear of violence.

- Train counselors to engage in a dialogue with clients about potential partner violence and to develop "safe disclosure plans" with clients.
- Develop community-based interventions to raise awareness and change norms about violence. This is particularly important for church leaders to address.
- Enact and enforce laws against domestic violence that punish abusive partners and help women leave violent relationships.

Confidentiality Issues

In addition, there are concerns about maintaining the confidentiality of test results, in part because of the stigma attached to HIV infection in many settings and the potential for discrimination against, violence toward, and community rejection of individuals who test positive. Also, coercion into test taking is a concern in some settings. That is why testing must **always be voluntary and based on the client's informed consent**. As such, counseling is an integral component of testing.

It is essential to prevent the exposure of personal information regarding a client's test results (or even that fact that they had an HIV test) to unauthorized persons. Private client information must not be made accessible to other clients or community members through careless record storage, lack of private space for confidential counseling, or inappropriate discussion of client information inside or outside the counseling setting.

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 1: HIV/AIDS Transmission, Prevention, and Risk Reduction

Alternate Activities and Handouts for HIV/AIDS Transmission, Prevention, and Risk Reduction

- **HIV-Infection Risk Estimates**

Handout

HIV-Infection Risk Estimates[16]

Activity	Precautions	Risk Estimate
In health care settings: Laboratory work culturing	Avoid use of sharps, avoid skin contact, and take special care with blood products	High Risk
Venipuncture	Care when the needle is out of the patient	Significant Risk
Childbirth	Wear gloves, avoid splashes of blood and amniotic fluids	Significant Risk
Placental removal	Wear gloves; avoid splashes with fluids; dispose of placenta by burning or burying	Significant Risk
Suturing	Wear thimbles and gloves; use forceps	Moderate Risk
Waste disposal	Avoid skin contact, beware sharps	Moderate Risk
Injection	Take care with needle afterwards	Minimal Risk
Dentistry	Avoid skin contact, aerosolized blood splatters	Minimal Risk
Cleaning blood spills	Avoid skin contact	Minimal Risk
Cleaning used instruments	Wear gloves when handling; disinfect before handling if possible	High Risk
Laundry	Avoid skin contact with wet body fluids, beware sharps	Minimal Risk
Examining, feeding, and nursing patient	None	Minimal Risk
Washing patient	None (as long as there are no open sores)	No Risk

[16] "TOT in AIDS Education," Save the Children, 1991.

HIV-Infection Risk Estimates, continued

Activity	Precautions	Risk Estimate
At Home:		
Unprotected sex (especially during menstruation)	Use condoms and refrain from sex during menstruation	High Risk
Childbirth	Wear gloves; avoid splashes with fluids; dispose of placenta by burning or burying	Significant Risk
Food preparation	Use care when handling sharp instruments	Minimal Risk
Shared use of razors, toothbrushes	Don't share	Minimal Risk
Yard work, falls, other accidents where blood is spilled	Exercise caution as appropriate	Minimal Risk
At Work:		
Cuts, abrasions	Wear heavy gloves; use care when handling sharp tools	Minimal Risk
Other accidents	Exercise caution as appropriate	Minimal Risk
In the Community:		
Ritual Scarring	Sterilize or clean needle or blade between clients; wear gloves	High Risk
Circumcision	Sterilize or clean needle or blade between clients; wear gloves	High Risk
Tattooing	Sterilize or clean needle or blade between clients; wear gloves	Significant Risk
Piercing	Sterilize or clean needle or blade between clients	Significant Risk
Traditional healing practices (when shared cutting implements are used)	Sterilize or clean needle or blade between clients	Significant Risk

HIV-Infection Risk Estimates, continued

Activity	Precautions	Risk Estimate
For substance abusers: Substance abuse, including alcohol and injectable and non-injectable substances	• Carry condoms at all times • Try to use condoms consistently • Limit number of sexual partners • Avoid sex if you or your partner has a STD or symptoms of one (sores, painful urination, painful sex, etc.)	High Risk
Shared use of injection equipment	• Don't share injection equipment • Handle equipment carefully • Use clean/sterile equipment for each person • Sterilize needle	High Risk

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 2: HIV/AIDS Care and Treatment

Objectives

By the end of this section the participants will be able to—

- Describe the special needs of people living with HIV/AIDS (PLWHA)
- Identify ways to care for PLWHA
- Distinguish between "cure" and "treatment" and give at least five examples of treatment strategies available in their area
- Indicate why early detection and treatment is better than "not knowing" about your status

Overview

This section will address the current care options and treatments available to people with HIV/AIDS and explores the wellbeing cycle.

Many people are under the impression that no HIV/AIDS treatment is available; this is not correct. Although there is currently no **cure** for HIV/AIDS, care and treatment can help those who are infected to lead full and healthy lives. People with HIV must deal with medical problems and emotional and social problems. Having HIV can be isolating. When people find out that they have the virus, they will feel fear, anger, and pain. Some people cannot talk to their partner, friends, or family members about the disease for fear of abandonment. They may lose hope for the future. They can become depressed and cannot cope with their feelings. Others may become courageous and focus on what is important to them. Knowing they have a fatal illness may help them change their behaviors. Some see having HIV as a challenge to overcome, and they work to stay healthy and help others stay healthy. This kind of "positive living' can help them to live longer, healthier, more fulfilling lives.

There are several stages of coping with HIV (Granich, 1999) from denial to acceptance.

1. In the first stage, there is **denial** and **isolation**. People may not believe the positive test results and think the doctor or laboratory is wrong.

2. The second stage is **anger**. People feel it is unfair that they have become infected, they resent that others are healthy.

3. The third stage is **bargaining**. HIV-infected people will bargain with themselves, God, spirits and religious figures, promising to be faithful if they will be cured of HIV.

4. The fourth stage, **depression**, is when people feel despair about caring for their families and themselves. It may get worse as pain and the disease worsen.

5. The final stage is **acceptance**. The person accepts that they have HIV, and they may have more energy and a new will to live their lives to the fullest. They may be more peaceful.

Religious leaders can play a key role in helping someone through the coping stages. Depending on the stage, a supporting, accepting, and counseling role can help people overcome their denial, anger, and depression. Care can take the form of support groups, social support, or home care.

Support groups can help those with HIV come together to discuss common problems. Also, family and friends of people with HIV often need support and to talk to each other about HIV/AIDS and how it affects their families. They need someone to talk to about losing a loved one to AIDS. Families, the government, or the community can provide social support. In many places, special programs exist that provide services for people affected by HIV/AIDS. This may take the form of counseling, advice from health workers, or provision of food, medicines, and transportation services.

Most sick people are cared for at home, but some people are afraid to care for loved ones due to fear of being infected by HIV. Education on how HIV is transmitted and how to prevent infection can make home care possible. People with HIV are at a greater risk of catching other diseases from household members when cared for at home. Colds and flu can be serious for someone with AIDS. Some tips for home-based caretakers are to—

- Always wash hands with soap and water before and after cooking
- Wash dishes in hot soapy water
- Wash foods as well, especially if they have dirt on them
- Be sure to wash hands with soap and water after going to the bathroom

Some tools to help care for someone with HIV/AIDS include a bedpan, walker, urinal, facemask, and gloves.

Because many developing countries do not have access to drugs that attack the virus itself, most medical treatments focus on treating the most common opportunistic infections. Major HIV/AIDS signs include weight loss, frequent diarrhea, and constant or occasional fever. Other signs include persistent cough, itching skin, **herpes zoster (shingles), oral thrush**, worsening **herpes simplex** infection, and lymph node swelling. Common infections that are found in people with suppressed immune systems include **tuberculosis, pneumonia, cervical cancer,** and **meningitis**.

People with access to medical care can find treatments for most opportunistic infections. Diarrhea is an infection symptom. To avoid getting these infections, the person with HIV/AIDS should always drink clean water and eat clean foods that are cooked thoroughly. Most infections that cause diarrhea are treated with antibiotics. Tuberculosis is a serious infection in people with HIV/AIDS, but treatment is available.

In addition to treating opportunistic infections, it is beneficial for a person with HIV/AIDS to get plenty of rest and fluids, eat a nutritious diet, and avoid alcohol, smoking, and drugs.

Chapter 2, Section 2: HIV/AIDS Care and Treatment

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, continued *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling continued *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support , and Counseling, continued *1 hour* **Chapter 5** IEC — Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, continued *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, continued *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, continued *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 2: HIV/AIDS Care and Treatment

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**Overview of Care and Treatment**	Discussion, Brainstorming	Flipchart, markers	Participants will be able to explain the difference between cure and treatment.
60 minutes	**Wellbeing and Treatment**	Discussion and group activity	Wellbeing handouts, 3 x 8 cards	Level of understanding and active participation in discussion

Important Terms[17]

Cervical Cancer	Cancer of the cervix (the lower end of the uterus which dips into he upper part of the vagina), which is caused by a certain type of the human papilloma virus.
Cure	To restore to health
Herpes Simplex	Viruses that cause cold sores (type I) and genital sores (type II)
Herpes Zoster (Shingles)	Painful blisters on the skin common in people with weakened immune systems. Caused by the same virus that causes chicken pox (*varicella zoster*).
Meningitis	Infection of the lining of the brain
Oral Thrush	Infection of the mouth by *candida albicans* (yeast).
Pneumonia	Infection of the lungs
Treatment	A medicine or intervention used to cause the disease's symptoms to become less pronounced or disappear completely.
Tuberculosis	A bacterial infection that attacks the lungs

[17] H. Fan, "AIDS, Science and Society,"1997.

Chapter 2: HIV/AIDS Transmission, Prevention, Care, and Treatment

Section 2: HIV/AIDS Care and Treatment

Activities and Handouts for HIV/AIDS Care and Treatment

- **Overview of Care and Treatment**
- **Wellbeing and Treatment**[18]

[18] Adapted from "Life Skills Manual," U.S. Peace Corps, 2000.

Activity Overview of Care and Treatment[19]

Objectives By the end of the activity, participants will be able to—

- Distinguish between "cure" and "treatment"
- Give at least five examples of treatment strategies that are available in their country

Time allotted 30 minutes

Preparation Be thoroughly familiar with the overview of this section and the special needs of people who have HIV/AIDS (includes medical, spiritual, and emotional challenges and needs). Prepare suggested flipcharts prior to the activity. Have a blank flipchart available. Make copies of the Important Terms on page 2-93 for participants.

Facilitation steps

1. Begin by stating that "There is no **cure** for HIV/AIDS."

   Display the following on a flipchart.

   > **Cure:** To restore to health

2. Ask participants to imagine that they have just learned they are infected with HIV/AIDS. Then ask them to think privately for five minutes and identify some challenges that they will face in coping with the disease, in light of the fact that there is no cure.

3. After five minutes, ask participants to share responses and write them on a flipchart. As the responses are discussed, group them into medical, spiritual, and emotional needs on the flipchart.

4. Explain that this section explores the options for care and treatment of HIV and AIDS.

   Display the following on a flipchart.

   > **Treatment:** Using a medicine or intervention that causes a disease's symptoms to become less pronounced or to disappear completely. The symptoms *may* recur at a later date.

[19] Adapted and reprinted with permission of the U.S. Peace Corps from the "Life Skills Manual," pp. II-81- II-85.

5. HIV is unique in that it attacks the cells and uses the material of the cells to make copies of itself. There is not yet a way to kill the virus without killing the cell. So currently, there is only treatment, not a cure, for HIV.

6. Explain that the definition of treatment can be expanded not only to include treatment of disease, but treatment of the person's emotional and spiritual being. Thus "treatment" can mean any intervention that helps improve any aspect of a person's wellbeing. There are many strategies that can be used to prolong life and improve its quality even if a person is HIV-infected.

Wrap-up

Call on individuals to explain the differences between a cure and a treatment. Have participants brainstorm examples of HIV/AIDS treatments that are available in their community. Hand out Important Terms.

Activity Wellbeing and Treatment[20]

Objective By the end of the activity, participants will be able to—

- Identify ways to care for PLWHA
- Justify why early detection and treatment is better than "not knowing"

Time allotted 60 minutes

Preparation Make a copy of the wellbeing chart for each participant.

Supply 3 x 5 cards or post-it notes.

Copy the Wellbeing Chart from page 2-99 onto a flipchart or overhead, but only the inner circle with the main topics should be filled in.

Facilitation steps

1. Display the wellbeing chart on a flipchart or overhead.
2. Ask the group to describe what each sector of the wellbeing chart means to them.
    - Which sections of the circle do they see as being the most important for maintaining and restoring their health?
    - Who are people in the community who would help support their wellbeing in different sectors?
3. Invite participants to brainstorm the kinds of elements in each section that could improve the health status of someone living with HIV/AIDS. Help elicit responses similar to the following and write the suggestions in the outer circle of the diagram or have participants write them on cards or post-it notes to put on the chart. (The trainer may want to start with an example for each sector.)
4. Ask for a show of hands of how many believe that treatments are available for those with HIV/AIDS in their community. Discuss what and where they are available. List these treatments on a flipchart.

[20] Adapted and reprinted (with permission of Peace Corps), from the "Life Skills Manual," pp. II-81 to II-85.

Health and Wellbeing

- **General Health Maintenance** includes nutrition, rest, exercise, avoiding infections, and avoiding drugs and alcohol. Studies have shown that these things strengthen our immune system.
- **Psychological wellbeing** means having a positive attitude, building self-esteem, counseling, and reducing stress.
- **Spiritual wellbeing** involves having faith or a belief system, practice prayer, or meditation.
- **Social wellbeing** means having spousal or family support, peer support, a social system that protects one from discrimination, or continuing productive work or advocacy. Studies have shown that women with breast cancer who were involved in support groups lived twice as long as those who were not.
- **Physical wellbeing** includes at least three types of medical interventions.

    1. Treatments to strengthen the immune system, which could include traditional remedies like herbs and acupuncture
    2. Treatment to prevent or alleviate symptoms and cure opportunistic infections like TB, pneumonia, diarrhea, skin conditions
    3. Anti-retroviral therapies and other treatments are often not available in the developing world, except for treatments to reduce risk of perinatal transmission

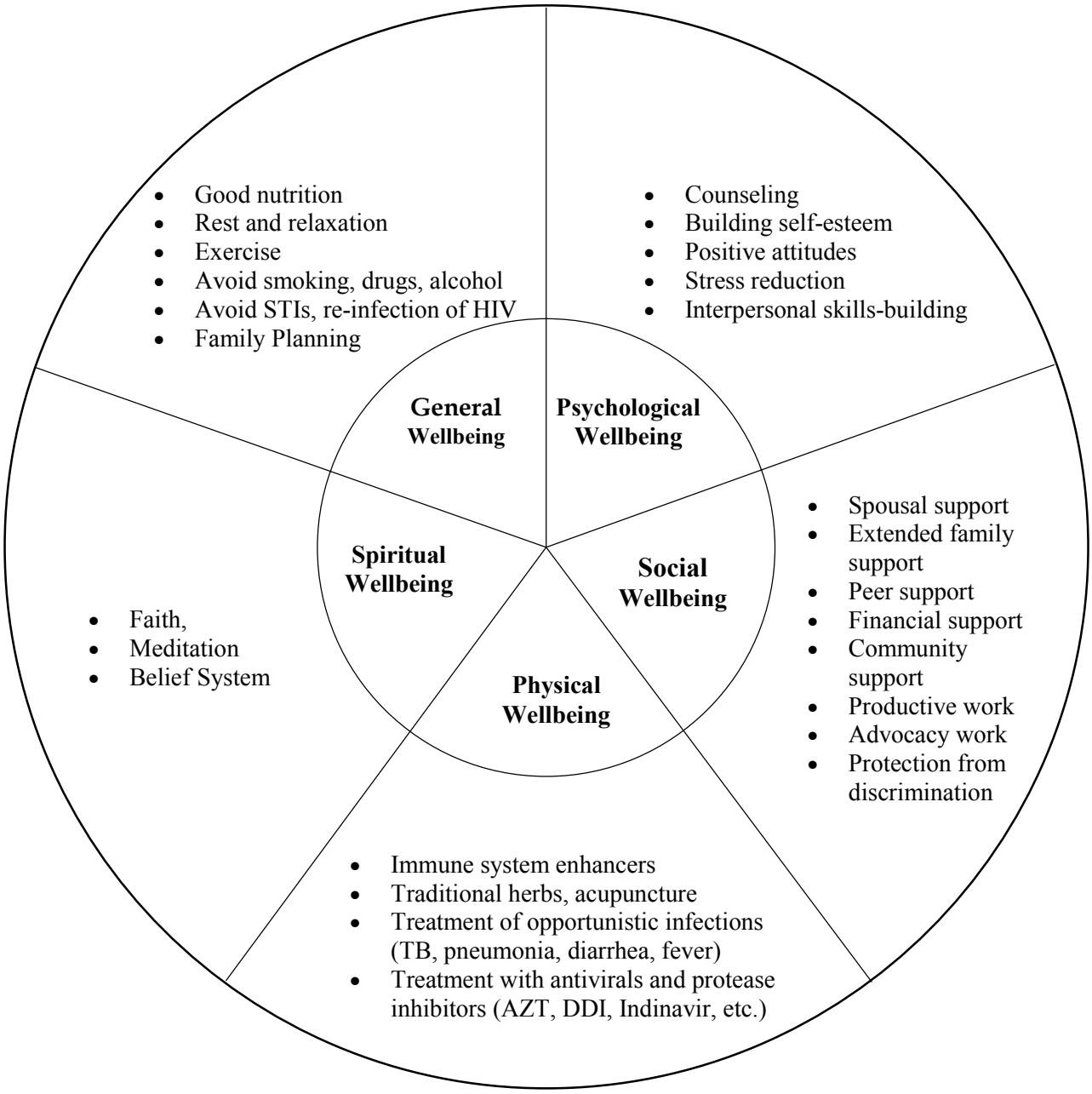
Wrap-up

Ask for a show of hands of how many think it would be good to find out early if a person has HIV.

Lead a discussion about the reasons why this might be true; be sure to emphasis "positive living."

Handout

Wellbeing Chart



Notes:

Chapter 3

Cultural Issues Concerning HIV/AIDS

"God didn't come into our experience to discriminate; God came to set free, and to end feelings of hopelessness and separation."

—*LARRY MCGUIRE*

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Faith Community Responses to HIV/AIDS

Chapter 3: Cultural Issues Concerning HIV/AIDS

Chapter 3: Cultural Issues Concerning HIV/AIDS

Key Questions

- What makes people vulnerable to HIV infection?
- What are the practices and beliefs in your country that contribute to the spread of HIV?
- What are the practices and beliefs in your country that can be used to prevent the spread of HIV?
- How does HIV affect the whole community?
- What prevents people from discussing HIV in the community?
- What are the consequences of disclosing one's HIV status to family and community members?
- What can religious leaders do to combat stigma in their communities?

Introduction

People's decisions about their behavior and lifestyles do not occur in the absence of a social, cultural, and economic context. One's surroundings often influence the choices people make and can explain why some people cannot make healthy choices about their sexual behavior.

Many factors influence people and can make them vulnerable to HIV infection, or to suffering once they are infected. Examples include discrimination, stigma and intolerance, denial of the existence of the epidemic, the lower status of women, abuse of power by older or wealthier individuals or the opposite sex, scarcity of testing and counseling services, scarcity of condoms

or lack of skill in their usage, lack of care and support for those infected or affected, poverty or trafficking that leads to prostitution, domestic violence and rape, military conflict, and labor migration which can split up families. These factors will vary from place to place. This chapter explores the cultural and social factors that can make people more vulnerable to HIV infection. It also examines the positive factors that help prevent the spread of HIV. And finally, the participants will learn how stigma about HIV affects their communities and stands in the way of preventing HIV, and how they can use this information for counseling individuals and couples.

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 1: Cultural, Social, and Economic Issues and HIV/AIDS

Objectives

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

- Identify feelings and attitudes associated with sex and sexuality, and identify which attitudes are *helpful* to prevention of AIDS and *harmful* to the prevention of AIDS
- Classify harmful and helpful attitudes by social, economic, or cultural basis
- Recommend how to deal with cultural and social practices that increase risk
- Identify common gender stereotypes
- List some common expectations for men and women in this community
- List at least five reasons that men can be vulnerable to HIV/AIDS due to their expected social roles
- List at least five reasons that women can be vulnerable to HIV/AIDS due to their expected social roles
- List at least two aspects of the expected social roles of men and women that can be used to help in the fight against HIV/AIDS

Overview[21]

AIDS has spread silently throughout the world, but especially in sub-Saharan Africa. Since HIV was identified in the early 1980s, fear, stigma and denial have surrounded the disease. In Africa and other areas where the virus is spread mainly by heterosexual contact, the infection carries a stigma associated with "immoral" sexual behavior. This fear of discrimination and stigmatization prevents many people with HIV from disclosing their status and taking measures to prevent transmitting the disease to others. The fear of HIV is great, and the knowledge that there is no cure prevents many people from getting tested. Sexual behavior is a private act, not easily discussed openly, even between married partners. Furthermore, individuals with HIV often appear healthy, since the time lag between infection and apparent disease can last up to 10 years.

For many years, many governments denied the disease was present in their countries and did not implement prevention and treatment services. As a result many people were not educated early on about HIV transmission and prevention. Community and government support for education and testing services was lacking. Marginalized populations (for example, sex workers, immigrants, migrant workers, drug users, men who have sex with men, and the economically disadvantaged) are less likely to have access to information and services.

Women of all ages, particularly young women, are more likely to become infected with HIV during unprotected intercourse. The reproductive tracts of young girls are not fully mature, which makes them biologically more vulnerable to infection. Girls are more likely than boys to be coerced, raped, or enticed into sex by someone older or richer. The gap between the ages of sexual partners also increases risk. Older men have been sexually active longer than younger men and tend to be more heavily infected. Sexual initiation is occurring at earlier ages.

Women and girls are also susceptible to violence, rape, and sexual abuse. Women may fear violence, thus it is difficult for them to refuse unsafe sex or suggest condom use with their partners. Married women may also find it difficult to refuse unsafe sex with their husbands for fear of divorce, due to the total economic dependence on their husbands. The laws in many countries do not support the prosecution and conviction of sex offenders and spouse abusers and thus much of the abuse goes unreported or un-prosecuted.

Despite these daunting facts, many countries did act early to prevent HIV. In the United States, the gay community mobilized to educate their members as to how the disease spread and to promote condom use. In Senegal, the government acted early to promote counseling and testing and to provide services to those infected with HIV. In Thailand, where prostitution is illegal, the government instituted and enforced a "100 percent condom use" policy for sex workers and their clients, which resulted in millions of averted infections.

[21] Most of the overview information is from the June 2000 UNAIDS "Report on the Global HIV/AIDS Epidemic."

To design appropriate prevention interventions that lead to changes in human behavior, one must understand the social, economic, and cultural context where the harmful and helpful behaviors occur. Understanding and advocating against stigma can also help to open communication on HIV/AIDS and improve access to services for individuals with HIV.

Culture is simply the values and behavior shared by individuals. Culture can span across ethnicity, religion or race. Culture can be determined by age, gender, lifestyle, or socio-economic status (Granich 1999).

Chapter 3, Section 1: Cultural, Social, and Economic Issues and HIV/AIDS

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, continued *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling continued *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, continued *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, continued *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, continued *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, continued *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 1: Cultural, Social, and Economic Issues and HIV/AIDS

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
45 minutes	**Identifying cultural, economic, and social issues surrounding HIV/AIDS**	Discussion	Flipchart, markers	Ranking the most harmful and most helpful practices/norms
5 minutes	**Gender toss**	Game	Ball Flipchart Markers Tape	Active participation in the exercise
75 minutes	**Social vulnerability to HIV/AIDS**	Brainstorming, discussion	Flipchart paper Markers Tape	Level of understanding reflected in lists created by groups

Important Terms

Culture	These are the values and behavior shared by individuals. Culture can span across ethnicity, religion, or race. Culture can be determined by age, gender, lifestyle, or socio-economic status.
Discrimination	Discrimination occurs when a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. For example, a person living with HIV/AIDS may be denied health services or have their employment terminated on the grounds of their HIV status. Discrimination is stigma in action.
Stigma	This is a mark that is a token of disgrace, infamy, or reproach. HIV/AIDS-related stigma builds on and reinforces existing prejudices. It also plays into and strengthens existing social inequalities especially those of gender, sexuality, and race. Ultimately, stigma creates and is reinforced by social inequality.

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 1: Cultural, Social, and Economic Issues and HIV/AIDS

Activities and Handouts for Cultural, Social, and Economic Issues and HIV/AIDS

- **Identifying Cultural, Social, and Economic Issues Surrounding AIDS**[22]
- **Gender Toss**
- **Social Vulnerability to HIV/AIDS**

[22] Rakai, "PE Training Manual," 1993.

Activity Identifying Cultural, Social, and Economic Issues Surrounding HIV

Objectives By the end of this activity, participants will be able to—

- Identify feelings and attitudes associated with sex and sexuality, and cultural, economic, and social barriers to HIV/AIDS prevention
- Identify which attitudes are helpful to prevention of AIDS and harmful to the prevention of AIDS
- Classify harmful and helpful attitudes by social, economic, or cultural basis

Time allotted 45 minutes

Preparation Prepare to take notes on a flipchart.

Facilitation steps

1. Remind participants of the discussion in chapter 1 on HIV/AIDS prevention. Remind them of the discussion on the married couple and how they could talk about AIDS.

2. Ask participants to think in a larger context. Point out that many times, the ease in discussing AIDS and taking preventive measures is influenced by a person's environment. Many cultural, social, and economic factors can influence a person's behavior.

3. Explain that this session will examine these factors in the context of the participants' culture and identify which factors are helpful to preventing AIDS and harmful to AIDS prevention efforts.

4. Start the session by asking the participants the following questions.

    - When did you first learn about HIV/AIDS?
    - How did you learn about it (i.e. in school, through a friend, on TV)?
    - What was the response of our government to the AIDS epidemic?
    - How easy is it to discuss sexuality in our culture?

5. After getting initial responses, ask participants to give examples of some social, economic, and cultural attitudes and beliefs and realities that are

harmful to AIDS prevention. Write their responses on the flipchart. Examples may include the following.

Social	Cultural	Economic
People are reluctant to discuss sexuality, past sexual history.	Wife inheritance	Poverty may lead to prostitution.
Premarital sex is more common now among youth.	Female circumcision	Poverty may make young girls more accepting of older sexual partners.
Many men have sexual partners outside of marriage.	Polygamy	Poverty may prevent people from purchasing condoms.
Low status of women, inability of women to refuse sex or suggest condom use even with husbands.	Acceptable for men to have many sexual partners	Poverty prevents people from attending school, where they may learn about HIV/AIDS prevention.
Denial that AIDS is real	Ablution of the dead	Poverty may lead to poor nutrition and health.
People are not educated on HIV/AIDS transmission and prevention.	Fatalism, AIDS is a disease sent by God as punishment.	Anti-retrovirals are not always available (cost too much).
If someone has AIDS, he is outcast from the community.	Some churches frown on condom use.	

6. After participants have exhausted the examples of the harmful beliefs, attitudes and realities ask them to repeat the exercise to identify *helpful* beliefs, attitudes and realities that aid in HIV/AIDS prevention.

Social	Cultural	Economic
Presence of NGOs doing HIV/AIDS interventions	Strong extended family structure	Programs that assist families to care for AIDS orphans and provide supplementary income
Supportive government policies on HIV/AIDS	Compassionate care by religious organizations	Availability of low-cost, good quality condoms
Laws to prevent sexual and spousal abuse	Religious beliefs that encourage virginity at marriage and fidelity to spouse	Employment programs for out-of-school youth

Social	Cultural	Economic
Availability of counseling and testing services in some areas		Government subsidized anti-retro-viral treatments
HIV/AIDS curriculum in schools		A conscious effort by governments through policy to get girls in school and keep them there.
High self-esteem and confidence to talk about HIV and prevention behaviors among people of all ages.		

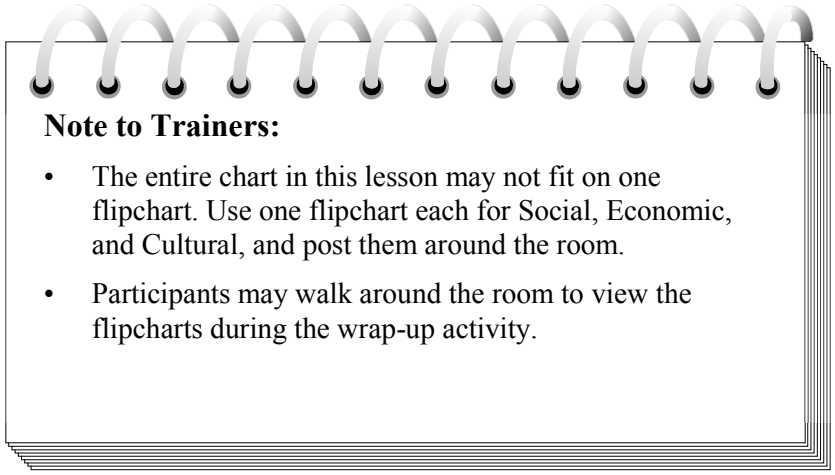
7. Explain that these lists will help us in future sessions when the participants will decide what types of interventions they plan to do related to HIV/AIDS.

Wrap-up

Distribute a blank note card to each participant.

Have participants **rank** the three most helpful and harmful are from each list on the note cards.

Ask participants to share their rankings with the group.



Note to Trainers:

- The entire chart in this lesson may not fit on one flipchart. Use one flipchart each for Social, Economic, and Cultural, and post them around the room.
- Participants may walk around the room to view the flipcharts during the wrap-up activity.

Activity Gender Toss

Objective By the end of this warm-up, participants will be able to—

- List common stereotypes about men and women in this community

Time allotted 5 minutes

Preparation Provide a ball, or a bunch of scrap paper balled up and covered in tape. Create a flipchart with two columns, "Men" and "Women." Ask a volunteer to record the responses of participants under the appropriate column once the warm-up begins.

Facilitation steps

1. Remind the participants that they have spent some time discussing some major facts and issues surrounding HIV/AIDS. Indicate that no matter how much they know about HIV/AIDS, sometimes the ability to act on that knowledge can be influenced by other factors in our environment, for example, by the society's cultural and social roles expected of us because of our gender.

   For this reason, the discussion will now focus on exploring gender's impact on HIV/AIDS. The discussion will cover the impact of social roles on a person's abilities to prevent HIV infection or mitigate the effects of HIV/AIDS in his or her life.

2. Indicate that the session will begin with a short warm-up.

   State that you will toss a ball to different participants, while calling out one of two sentences, either "Women are…" or "Men are…." When the participant catches the ball, he or she must immediately complete the sentence and then toss the ball back to the facilitator.

   Stress that the exercise must go very fast, so the participant who catches the ball should say the first thing that comes into his or her head and then toss the ball back to the facilitator.

   As the group plays the game, a volunteer will record what is said on the flipchart.

Wrap-up

After the activity, review the words or phrases listed on the flipchart with the participants. Look for any common themes among the words listed to describe men and the words listed to describe women. Ask participants why they said what they did to describe men and women. You may want to probe the more controversial answers.

Ask that the group keep this exercise in mind as the session moves on to talk about some reasons that people can become vulnerable to HIV infection.

Activity Social Vulnerability to HIV/AIDS[23]

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

- List some common expectations for men and women in the community
- List at least five reasons that men can be vulnerable to HIV/AIDS due to their expected social roles
- List at least five reasons that women can be vulnerable to HIV/AIDS due to their expected social roles
- List at least two aspects of the expected social roles of men and women that can be used to help in the fight against HIV/AIDS

Time allotted 75 minutes

Preparation Prepare flipchart paper and markers for each group before the session. Clear a large space of wall for posting flipcharts as groups report out. (The words "roles" and "expectations" are used somewhat interchangeably here.)

Facilitation steps

1. Referring back to the Gender Toss game, suggest that every culture and community ascribes certain roles to people based on whether they are male or female. In addition, roles and expectations can be assigned depending on a person's age.

2. Divide participants four, mixed-sex/age groups. Provide each group with an ample supply of flipchart paper and markers.

3. Indicate that each group will get about 20 minutes to discuss the roles and expectations that their society or culture places on a specific age/sex group. Assign each group of participants one of four sex/age topics One group will talk about social expectations of older men. One will talk about social roles of older women, one about social expectations of girls/ young women. One group will talk about social roles of boys/ young men. They should list these ideas on a flipchart.

   In addition, they should think about how the age and sex of their assigned group makes people of that age and sex particularly vulnerable to HIV. They should list these ideas on a flipchart as well.

[23] Adapted and reprinted with permission of U.S. Peace Corps from the "Life Skills Manual," pp. II-63 to II-68.

4. After about 20 minutes, provide each group an opportunity to briefly report their ideas to the larger group. Post all the flipcharts on the wall as the groups report out.

5. Lead a discussion around these vulnerability issues based on cultural and social expectations. Attempt to make a link between the expectations that participants list and the list of vulnerability to HIV. For example, the expectation that women should accept male authority may lead to an inability to negotiate safe sex or VCT.

6. Depending on the community, the following issues might be relevant to the groups of women and girls. If these issues do not come up, and you feel that they may still be pertinent, ask the participants if these are issues in the local area.

    - Women do not have as much decision-making authority as men, and sometimes may not be able to make the decision whether or not to have sex; whether or not to use a condom; whether or not to get pregnant; and whether or not to get tested for HIV or other STIs.

    - Fear of violence from men, which may keep a woman from getting tested for HIV or from reporting her test results to her partner.

    - Sexual violence against women, including trafficking in women and rape.

    - Girls' initiation rites that may include female circumcision or sexual initiation by an older male.

    - Taboos related to speaking about sex.

    - Men's preference for dry sex, which may encourage women to put drying agents in the vagina and can cause tearing.

    - Bride price or marriage rites that give women a property value.

    - Denial of homosexuality or bisexuality, which may cause men who have sex with men to continue to have sex with wives/girlfriends to protect themselves from censure/disclosure.

    - Early marriage for girls.

    - In areas where great importance is put on virginity, girls may engage in anal sex to preserve their virginity.

    - Extreme poverty that encourages the exchange of sex for money, school fees, or food.

- Inheritance laws that deny women land or resources when their husband dies.

- The expectation that women should care for others before themselves may lead to lack of treatment seeking for STIs/HIV/AIDS.

- Lack of economic resources/power that may lead to inability to purchase condoms.

- Lack of education for women about sexual and reproductive health issues.

- Wife inheritance/funeral customs that include sexual relations with the brother of the deceased.

- Acceptance of multiple partners for men and/or women.

- Lack of availability of female-controlled prevention methods, such as the female condom or microbicides.

7. Be sure to spend some time discussing each of these issues, perhaps by referring to Antoinette. Issues of violence against women, which may lead to fear of VCT or fear of negotiation around sexual and reproductive decisions, are important to discuss.

8. Depending on the community, the following issues may be relevant to men. If these issues do not come up, but they may still be pertinent, ask the participants if these are issues in the local area.

    - The expectation that men should be risk-takers and have many sexual partners may increase the chance of HIV infection because men feel pressured to have many partners, to have partners outside of marriage, or to have sex without a condom.

    - The expectation that men should always be strong may keep a man from going to the doctor or health clinic, as it may be perceived as a sign of weakness. (This can mean that men are infected with STIs for a long time without knowing it or without getting treated for it, which greatly increases the risk of getting infected with HIV or transmitting it to a partner.)

    - The expectation that men should only be having sex with women may keep men who have sex with men from access to the information and services that they need.

    - The acceptance/belief that men need, or even the desirability, of multiple partners.

- The expectation that men should be the decision makers may keep the family from making decisions that might be more healthy for the family; such as avoiding frequent pregnancy; using family planning methods; using condoms to protect against HIV infection; or VCT to find out if the partners are infected with HIV.

9. After thoroughly discussing the possible sources of vulnerability to HIV infection, ask participants to look at the lists of social/cultural expectations posted on the wall again.

    - Are there any of these expectations that can be used to help fight HIV/AIDS in our communities?

    - Are there any positive aspects of these expectations/roles that can be beneficial in the fight against HIV/AIDS?

    Examples may include—

    - The expectation that men should be the protector of the family can mean that men will do everything they can to protect the family from HIV, including condom use, VCT, and accessing medical services when necessary

    - Initiation rites for girls can be changed a bit to include some kind of symbolic circumcision (instead of cutting), followed by education about HIV/AIDS and so on

Wrap-up

Summarize the session by suggesting that, although it is clear there are many social or cultural expectations and roles which may make us more vulnerable to HIV/AIDS, there are also ways to work within the community to keep social and cultural traditions, while still protecting ourselves against HIV/AIDS.

Beginning some honest dialogues with community members and family members about these issues may go a long way towards protecting the community from HIV/AIDS.

Religious leaders are in a position to guide the community and even to challenge harmful cultural or social norms, such as the lower status of women and spousal violence.

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 1: Cultural, Social, and Economic Issues and HIV/AIDS

Additional Activities and Handouts for Cultural, Social, and Economic Issues and HIV/AIDS

- **A Case Study on Cultural, Social, and Economic Barriers to HIV/AIDS**

Activity A Case Study on Cultural, Social, and Economic Barriers to HIV/AIDS

Objective

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

- Analyze a case study
- Identify cultural and social practices that increase risk
- Recommend solutions that will reduce harmful practices

Time allotted

45 minutes

Preparation

Copy each case study from pages 3-123 to 3-126, and distribute one copy to each group member. Become familiar with each case study and identify the factors that are both helpful and harmful before the session.

(The trainer may want to write his/her own case study/studies with issues specific to the participant group or culture.)

Facilitation steps

1. Divide participants into four groups of six or less, depending on the number of participants.

2. To get a deeper understanding of the complexity of social, economic, spiritual, and cultural issues surrounding HIV/AIDS, explain that each group is going to be given a case study that tells a story about a certain issue or individual. Group members should appoint a note-taker.

   Each group will have 20 minutes to read and discuss the case study. Group members should identify the helpful and harmful factors in the case study and recommend a few solutions (including existing or fictional interventions) for each problem.

3. At the end of 20 minutes, the entire group will reassemble and one member of each group will present the results of his/her group's discussion.

Wrap-up

Present the results of each case study. Ask participants to offer additional solutions to the case studies.

Handout

Case Study Number 1

Emanuel is a pastor in a neighboring community. He is an admired spiritual leader in his village and respected by his congregation. Nearly everyone feels welcome in his church where sermons are delivered with energy and conviction. However, upon learning that one woman in his congregation was recently diagnosed with HIV, Emanuel lets the woman's family know she is no longer allowed to attend church activities. Emanuel tells them "I don't want that sick woman infecting anyone else in my church!"

The next Sunday he dispenses a sermon in which he characterizes people with HIV as "prostitutes and tainted by the Devil." Soon many in the community refuse to talk with the family of the woman with HIV, even the woman's husband leaves her and takes her children away. Few people stop by their courtyard and some avoid working in the fields with them. Soon after that event you see Emanuel at a regional gathering of religious leaders.

Handout

Case Study Number 2

Natasha is a 15-year-old girl from a local farming community. Her parents are farmers and the last crop did not do well. The family has little money for school fees. Lately, the local postmaster has been greeting her and asking her to go for walks with him. He told her if she would be his girlfriend he would help pay for her school fees. Natasha has never taken a boyfriend before because she is afraid of getting pregnant. The man assures her he will pay for the pill. She is thinking of giving-in to him because she feels she can keep the relationship a secret and she needs the money her family can no longer provide to study to become a teacher.

Handout

Case Study Number 3

Ananda is a 35-year old Hausa speaking woman with four children living in Port Harcourt, Nigeria. She is a refugee from the neighboring country of Niger. She sells tomatoes and other vegetables in the market but does not have enough money to send her children to school. Her husband of many years was unable to find work for some time and began to drink too much alcohol. He recently went away to work in the swamps, looking for oil. Ananda lives with her husband's family while her own family lives in Niger. Although her husband is not around much, she is faithful to him, but she wonders if he has other sexual partners.

Ananda is worried because her youngest daughter has had severe diarrhea for a month. She went to the health clinic for treatment of her baby, but could not find a Hausa-speaking counselor. She has been feeling tired and is worried about her baby. Her mother-in-law told her "I do not want you in my house." Ananda thinks she may have AIDS and thinks her mother-in-law might have cursed her with it.

Handout

Case Study Number 4

Mamadou is a 28-year-old math teacher who lives in a small town in Rivers State. He has been teaching at the school for about two years. Mamadou occasionally has sex with female students. The students sleep with him and he gives them extra classes for free and improves their marks.

The headmaster is aware that Mamadou has relationships with the students, but told him "It is ok, as long as you keep it quiet." Recently, Mamadou experienced some rashes in his genital area. He went to a traditional healer but the treatment did not work. He is afraid one of his students gave him a STI.

He confided in his friend, Raphael, the school's science teacher, who recommended he go to the health center to be tested for HIV. Mamadou is scared because he knows he has not been using condoms with his students. He assumed that he was their only sexual partner, and plus, he thinks condoms reduce sensitivity.

He thinks that maybe if he waits the rash will just go away, plus he is afraid that the test results will not be confidential.

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 2: Stigma

Objectives

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

- Recognize stigma and discrimination in their lives
- Explain ways in which PLWHA and their families are stigmatized
- Recommend ways in which religious leaders and churches/congregations can combat stigma

Overview

A *stigma* is a mark that is a token of disgrace, infamy, or reproach. In many communities, HIV/AIDS is a stigma and being **infected or affected** can lead to discrimination. People have been judged and found guilty by means of their disease, which is seen as a sign of promiscuous sexual behavior in some countries. Examples of discrimination include—

- Government testing of specific populations for HIV (i.e. prostitutes)
- Health care workers refusing to care for those infected with HIV
- Refusing to buy vegetables from a market woman who has AIDS
- Firing an employee because they have AIDS
- Children refusing to play with a small boy because his mother died as a result of AIDS

Adapted from Granich 1999

As a result of this stigmatization, people are cast out from their families and left alone to face HIV/AIDS. This can be devastating; it means the loss of social, economic, and emotional support. It can lead to depression, poverty, and hasten the death of an individual with HIV. To combat stigma in our communities, it is important to examine the root causes.

In section 1, participants examined some environmental, social and cultural factors that contribute to the spread of HIV. Stigmatization is a large barrier to prevention efforts and thus requires a more in-depth examination. In this section, participants will experience stigma first-hand through role-playing. As religious leaders and workers, they will also examine how they can work to reduce stigma in their communities.

Chapter 3, Section 2: Stigma

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social, and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social, and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 2: Stigma

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**Examining Stigma and Discrimination**	Discussion, brainstorming	Flipcharts, markers	Associate stigma with a personal experience
60 minutes	**The Role of Religious Institutions in Combating/Reducing The Stigma of those Affected by HIV**	Guest speaker(s) Discussion, Brainstorming	Flipchart, markers, tape	Demonstrate a level of understanding through discussions and by contributing ideas

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 2: Stigma

Activities and Handouts for Stigma

- **Examining Stigma and Discrimination**
- **The Role of Religious Institutions in Combating/ Reducing Stigma of Those Affected by HIV**

Activity Examining Stigma and Discrimination

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

- Recognize stigma and discrimination in their lives

Time allotted 30 minutes

Preparation Prepare flipchart with definitions from Step 1 below. Bring blank flipcharts and markers. Make copies of Important Terms on page 3-54 for participants.

Facilitation steps

1. Define stigma and discrimination for the participants. Display the following on a flipchart.

Discrimination	Discrimination occurs when a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their belonging or being perceived to belong to a particular group. Discrimination is stigma in action.

Stigma	Stigma is a mark that is a token of disgrace, infamy, or reproach. HIV/AIDS-related stigma builds on and reinforces existing prejudices. It also plays into and strengthens existing social inequalities—especially those of gender, sexuality, and race. Ultimately, stigma creates and is reinforced by social inequality.

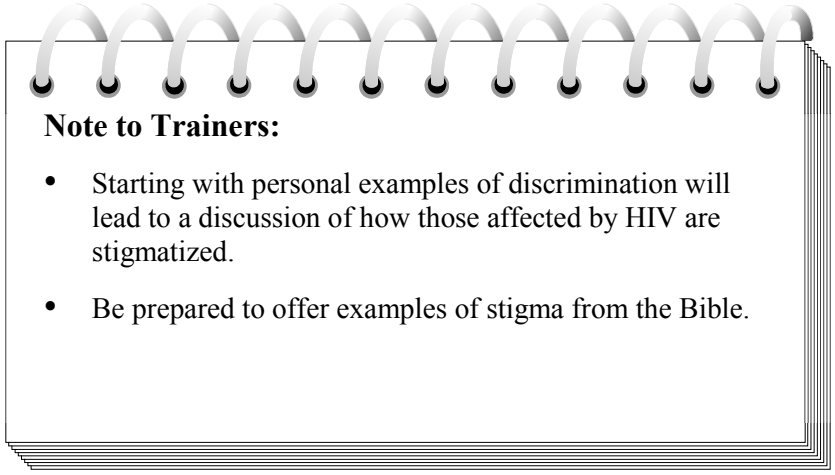
2. Ask participants to raise their hands if they or someone they know have experienced discrimination. Invite participants to share their examples with the audience.

3. Point out that PLWHA are often discriminated against because of their disease. Brainstorm ways that stigma and discrimination can affect PLWHA.

4. Ask participants to cite examples from the Bible where someone was stigmatized or experienced discrimination. Point out that even Jesus was against stigma and discrimination.

Wrap-up

Have participants think of some ways that, as community leaders, they can combat stigma and discrimination against PLWHA using the compassion of Christ. Hand out Important Terms.



Note to Trainers:

- Starting with personal examples of discrimination will lead to a discussion of how those affected by HIV are stigmatized.
- Be prepared to offer examples of stigma from the Bible.

Activity The Role of Religious Institutions in Reducing Stigma For Those Affected by HIV

Objective

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

- Recommend ways in which religious leaders and churches/congregations can combat stigma

Time allotted

60 minutes

(This session may take a longer amount of time, especially for participants to process their feelings after the speakers leave.)

Preparation

Contact local HIV/AIDS advocacy and education groups at least two weeks prior to the training and invite HIV-positive individuals or those affected by HIV/AIDS to give testimonials on their experiences with stigma and discrimination.

Another option is to contact local religious groups that work in HIV/AIDS and invite their leaders to discuss how their churches are dealing with the stigmatization of those living with HIV/AIDS.

(**Note:** Before inviting PLWHA to speak to the group, get to know their philosophy and experiences related to public speaking on personal experiences of living with HIV/AIDS ahead of time. Talk to some of the speakers, explain the training and its purpose, and select the speakers that most closely fit the participants (ensure that at least one male and one female speaker are selected). It is important to select speakers who are honest, prepared, and eager to speak with groups, and who can model what it means to live positively with HIV. Offer a stipend or a meal, along with transportation to and from the venue. Also ask the speaker(s) to provide a list of any questions or topics that they would not feel comfortable discussing, so that the trainer may lead the discussion away from those issues should they arise.)

Facilitation steps

1. Explain to participants that people affected by HIV/AIDS will be visiting with them for the next half-hour.

2. Inform the participants that no matter how much one is educated about HIV/AIDS, perhaps the best source of information and understanding comes from talking and working with people who are living positively with HIV infection every day. (*It will be useful to set ground rules at the beginning regarding what topics/questions that the PLWHA will not discuss, and request that the discussion remains confidential.)*

Participants will have the opportunity to learn about first-hand experiences with discrimination. The volunteers will speak for 20 minutes.

3. After the volunteer explains his/her experience, participants can ask questions and interview the individual to find out how religious leaders were involved in combating stigma, if at all.

Wrap-up

Thank the PLWHA and let them leave.

Bring participants back together as a group. Give participants time to process what they have learned and how they feel after having spoken with the PLWHA.

Participants can then brainstorm how faith communities may work to combat stigma with the individuals.

Chapter 3: Cultural Issues Concerning HIV/AIDS

Section 2: Stigma

Additional Activities and Handouts for Stigma

- **Stigma Against PLWHA**

Activity Stigma Against PLWHA

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

- Identify ways in which PLWHA and their families are stigmatized

Time allotted 45 minutes

Preparation Set up a table and some chairs for the role-players.

Bring a flipchart, markers, and tape.

Facilitation steps

1. Have two peer educators from a local NGO, AIDS advocacy or prevention organization, or the health department demonstrate through a role-play two examples of the type of stigma that people in your area experience when they have HIV/AIDS. Each educator will have 20 minutes to present.

   (Alternatively, two of the facilitators can demonstrate the role-play.)

Examples of scenarios might include—

- A woman's husband has gone to a neighboring country to work in a gold mine.

  The woman has heard about AIDS and children on the radio. Her youngest daughter has experienced prolonged diarrhea. Her husband returns and they take her to the clinic to get tested. As a result, the girl is found positive and the husband turns out both the mother and child onto the street

- A woman's husband has died of AIDS.

  Her extended family members accuse her of infecting her husband by having other sexual partners. They refuse to let her have any of their joint belongings and throw her out of the house.

- At a local school a child taunted by his peers

  His father recently died of AIDS. All the children are afraid of him and refuse to play with him. The child does not have HIV.

2. After each role-play is complete, lead the participants through a discussion of what just happened. Ask the audience to tell you what happened during the role-play; remind them of the presentation's key elements and facts.

3. Identify the root causes of the stigmatization of each person who is affected by AIDS (i.e. lack of education, lack of communication between partners, denial, and fear).

4. Building on what was previously learned in other chapters, discuss what the perpetrators (i.e. those who are stigmatizing) should know to change their minds.

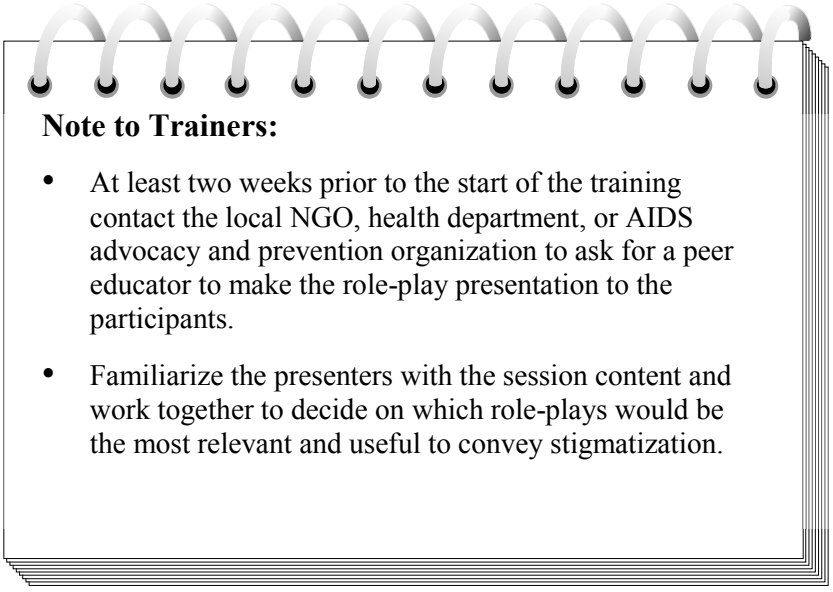
5. Ask participants to modify the outcomes to each situation in the absence of stigma, prejudice, and ignorance.

Wrap-up

Discuss how religious leaders could be involved in combating stigma.

Participants should brainstorm how faith communities may work to combat stigma with the individuals.

List these ideas on a flipchart and post the flipchart on the wall for future reference in other activities.



Note to Trainers:

- At least two weeks prior to the start of the training contact the local NGO, health department, or AIDS advocacy and prevention organization to ask for a peer educator to make the role-play presentation to the participants.
- Familiarize the presenters with the session content and work together to decide on which role-plays would be the most relevant and useful to convey stigmatization.

Chapter 4

Faith Community Responses to HIV/AIDS: Care and Counseling

"The loving care offered by God's people, not the tasks that are performed… is the feature of the church's ministry in the HIV/AIDS crisis that distinguishes it from the services provided by governments and secular agencies"

—AIDS AND THE CHURCH: THE SECOND DECADE, EARL E. SHELP AND RONALD H. SUNDERLAND, 1992

Table of Contents

Faith Community Responses to HIV/AIDS

Chapter 4: Care and Counseling

Chapter 4: Care and Counseling

Key Questions

- What are the steps of behavior change?
- What is needed for a person to change his/her risk behaviors?
- What skills are needed to counsel people affected by HIV/AIDS?
- In what ways can faith communities care for their members?
- What role can faith leaders and community play in counseling those affected by HIV/AIDS?
- What role does faith/spirituality play in prolonging and/or improving the lives of people with HIV/AIDS?

Introduction

Religious leaders are a key element in the fight against HIV/AIDS. They often have great influence in the community and are able to educate others about the dangers of risky behavior. Furthermore, people affected by HIV/AIDS and their families, friends, and partners need caring support from their respective faith communities to help them deal with their grief and fears. Caregivers need special support in their ministry of healing.[24]

The response of faith communities to the HIV/AIDS pandemic has varied worldwide. Faith communities can help protect people with AIDS against discrimination, educate themselves and

[24] From "Acts and Proceedings of the 114th General Assembly," WCC, 1988.

their communities about the disease, and help provide those affected with the same health care and human rights that unaffected people enjoy. Faith communities can make the church a safe place for openness and acceptance, an environment of trust and commitment where members—women, men, young people and children—acknowledge their mutual vulnerability and act toward inclusiveness.

Examples of responses include—

- Providing congregations and the community at large with HIV/AIDS information
- Improving the quality of life for families affected by HIV/AIDS
- Pastoral care and counseling for people living with HIV/AIDS
- Weekend retreats for people with HIV/AIDS, or those affected by HIV/AIDS
- Integrating HIV/AIDS messages into sermons
- Holding memorial services and AIDS days
- Prayer meetings for those affected by HIV/AIDS
- Networking with other faith communities and holding state and national conferences to exchange information and experiences
- Operating a confidential hotline to provide counseling and referral services to individuals with HIV/AIDS and their friends, families, and partners
- Offering HIV counseling, testing, and simple treatments in faith-operated hospitals
- Preparing family members and friends for roles as caregivers
- Preparing people for death (writing wills, securing belongings, identifying guardians for children, encouraging memory books)
- Helping people start income-generating activities (IGAs) to supplement the family income
- Providing basic support (food, clothes, other supplies) and home care for those too ill to care for themselves
- Organize guide groups to protect human rights and women's rights for people living with HIV/AIDS
- Organize a healing/anointing service for physical healing is not the only kind of healing that is needed or experienced

In this chapter, participants will learn about how their communities can show compassion and support for those affected by HIV/AIDS through **pastoral care and counseling**. They will build on lessons learned in previous chapters, learn behavior change concepts and HIV counseling skills, and learn how essential their spiritual guidance and compassion is to supporting those living with HIV/AIDS as well as their families, friends, and partners.

Chapter 4: Care and Counseling

Section 1: Behavior Change

Objectives

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

- Understand the steps of the behavior change process
- Describe the steps of the behavior change process
- Name an environmental support factor that can help an individual change behavior

Overview

Prevention education is based on providing individuals with information about what they can do to prevent themselves from becoming sick or injured (e.g. be immunized against infectious diseases, or always wear a seatbelt). Health promotion is based on what foods to eat, or activities or behaviors that individuals can practice to promote their health and wellbeing (e.g. exercise, good nutrition). Both prevention education and health promotion rest on a person's individual behavior and that person's ability and willingness to act on the information that the health worker provides.[25] Before one can begin to counsel for HIV/AIDS, one must understand behavior change.

There is a wide range of health behaviors that take from little to great effort to maintain. For example, it takes little effort to set up an appointment with a doctor. Other efforts, such as reducing the amount of fat in one's diet or getting regular exercise, require discipline over a long period of time. Some efforts will require consistency, resources, planning, and commitment. Therefore, many people who lack these skills engage in unhealthy behaviors. To change unhealthy behavior, the individual must—

- Identify the behavior as harmful
- Know what alternatives are available to him/her
- Be able to act on that knowledge
- Receive the support necessary to maintain the behavior change

The surest way to avoid contracting HIV is to stop doing the behavior that puts one at risk, but this is not always easy. The person may feel more comfortable taking small steps towards behavior change, for example, suggesting condom use with a partner who has not been tested for HIV, rather than stopping having sex altogether.

Behavior Change Process

Behavior change can be thought of as taking place in stages or steps. The stages of change are not absolute and do not always follow a predictable pattern. A person may go through the stages many times before the desired behavior is achieved. These stages can be seen as a tool for the counselor to use to assess where the client is in the process. These stages/steps have been adapted from the Center for Disease Control and Prevention, *HIV Counseling Guidelines, 1993*, CEDPA's *Social Mobilization for Reproductive Health: A Trainer's Manual* and *Johns Hopkins University Center for Communication Programs*, (Piotrow et al 1997).

[25] "Zimbabwe HIV Prevention Manual," Family Health International, 1999.

1. Knowledge

One must identify the behavior as harmful and know one is at risk before behavior change can occur. Open-ended questions are a good tool to use to make an assessment of the client's knowledge or awareness. (For example, a young man may be having sex. He will need to know the risks involved for pregnancy and STIs including HIV. The counselor can ask him what the consequences of having sex might be.)

2. Approval

The client approves of the *idea* of reducing risky behavior. "Significance to self" is the ability of the client to connect the information that s/he has to his/her own behavior. Many times clients will know how HIV infection occurs, but not be able to see how they are placing themselves at risk for HIV infection. They may recognize that their own behaviors put them at risk, or be unwilling to accept that their behaviors put them at risk, or they may even recognize the risk, but feel helpless to change their behaviors. (For example, the young man now knows about the risks of pregnancy and STIs, but he still continues to have sex. The counselor might ask him to imagine what he would do if he got someone pregnant or contracted a STI.)

3. Intention

The client looks at the pros/cons of both the current behavior and the desired change, and the client makes the decision to change the behavior. S/he knows what alternatives are available to her/him. S/he has the intention to change.

Capacity building is important preparation for behavior change, including gaining practical skills and other supports to manage the risks of behavior change, such as losing a sexual partner because s/he does not want to practice safer sex, and the costs of behavior change, such as paying for a condom. Strategies the counselor can use include providing the client with specific, practical, achievable skills and using role-plays and affirmations. For example, counselors can demonstrate how to use a male or female condom and also use role-play to find out what keeps the client from using condoms. (For example, the young man now realizes that he is at risk and wants to change his behavior, but does not know how to protect himself from STIs or unwanted pregnancy. The counselor may suggest some options, such as abstaining from sex entirely or using condoms consistently and correctly every time he has sex. The young man may be embarrassed to buy condoms, so the counselor could role-play with him pretending to be the shopkeeper until the young man feels confident that he could actually buy condoms.)

4. Practice

The client is able to act on that knowledge and actually carries out the desired behavior. A "provisional try" is when the client leaves the counseling session and tries to implement a step towards behavior change. Counselors should help the client prepare for obstacles the clients may face, to reframe "failure" with clients, and to use the "positive why." "Why" questions need to be used carefully, because often they sound negative and make people feel defensive. "Positive why" questions help clients explore the dynamics of their successes, rather than their failures. For example, "Why do you think you were able to avoid having risky sex in that situation?"

Keep in mind that the behavior change process has endless opportunities for failure. Counselors should support any successes to help the client maintain the behavior change. (For example, the young man goes to the pharmacy and buys condoms, but then fails to use them with his partner. The counselor can praise him for actually carrying through on his intention to buy the condoms and then explore why he has not been able to use them. The counselor might ask, "Why were you able to buy the condoms?" The young man might say, "Perhaps it was because we practiced together that I was able to do it successfully." They could then explore the barriers the young man has about using a condom with his partner.)

5. Advocacy

The client can describe the personal benefits that the changed behavior has brought to his/her life. They can then speak to others and promote positive behavior change. (For example, the young man is able to use condoms consistently and correctly every time he has sex and tells his closest friends how much safer he feels now that he has reduced the risk of causing an unwanted pregnancy or contracting a STI. He recommends that they protect themselves and their partners as well.)

Maintaining behavior change

To maintain changes in sexual behavior over time, interventions must be continuous and repetitive in nature. Some individuals may change their behavior over time, for example, when a person decides to marry and enter into a monogamous relationship with someone who is HIV negative. Other changes may invalidate a previous safe behavior and lead to HIV infection.

Challenges and the role of education

Many counselors find the "significance to self" issue one of the most difficult because the client needs to connect one's HIV knowledge to her/his own behavior. There is a gap between knowing something and making the behavior change, regardless of how much information one has. The brain's knowledge center is the cortex, whereas sexual behavior is centered in the brain stem, which controls emotions, behavior, and motivation. To connect these two areas, the counselor may discuss the mind's pleasure functions and learning functions. The counselor may also connect what people know to what they desire. The counselor must be able to identify what the client's feelings are, not simply what they know. Assessing the clients' feelings and connecting the behavior the client engages in to what they mean to the client are as important as assessing the client's knowledge.

Chapter 4, Section 1: Behavior Change

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling 30 minutes	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Chapter 4: Care and Counseling

Section 1: Behavior Change

Sample Lesson Plan

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
15 minutes	**Crossing the Line**	Game	Colored tape	Understanding level observed in relating exercise to behavior change process
45 minutes	**Behavior Change Process**	Discussion, group work	Prepared flipcharts, blanks flipcharts, markers, tape	Level of understanding demonstrated in discussion and interventions proposed

Chapter 4: Care and Counseling

Section 1: Behavior Change

Activities and Handouts for Behavior Change

- **Crossing the Line**
- **Behavior Change Process**

Activity Crossing the Line[26]

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

- Understand the steps of the behavior change process

Time allotted 15 Minutes

Preparation Place a strip of colored tape along the length of the floor in the middle of the room to create a line that divides the room in half. (The issue used in this game can be changed to reflect a culturally appropriate, but not emotionally charged, health message.)

Facilitation steps

1. Explain that before one can counsel people about HIV/AIDS, one must understand behavior change. Explain that the participants will now experience the behavior change process for themselves by playing the "Crossing the Line" game.

2. Have all the participants stand on one side of the line.

3. Tell the group that those who **know** that exercising every other day for 20 minutes is good for you to cross the line (almost all will cross the line). Those who **do not know** should sit down.

4. Next, those who **approve** of exercise every other day for 20 minutes should cross the line. Those who **do not approve** should sit down.

5. Those who have thought about the pros and cons and **intend** to exercise every other day for 20 minutes should cross the line. Those who **do not intend** to should sit down (for this fewer people will cross the line).

6. Those who **actually exercise** every other day for 20 minutes should cross the line. Those who **do not** should sit down.

7. Those who can **describe the personal benefits** that exercise has brought to their lives and who **promote exercise** every other day for 20 minutes to others should cross the line.

[26] Adapted from Piotrow et al, "Social Mobilization for Reproductive Health: A Trainer's Manual," CEDPA 2000 and Johns Hopkins University Center for Communication Programs, 1997.

Wrap-up Invite all the participants to sit down. Discuss what happened during this game. Point out that the number of persons dwindles as you move through the stages of the behavior change process and that knowledge is only one factor in affecting behavior change.

Activity Behavior Change Process[27]

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

- Describe the steps of the behavior change process
- Name an environmental support factor that can help an individual change behavior

Time allotted 45 minutes

Preparation Prepare a flipchart with the "Steps to Behavior Change Model" on page 4-157. Prepare a flipchart with "Task Instructions" (from Step 7 below). Make copies of the handout on "Example of Steps to Behavior Change" from page 4-156. Have blank flipcharts and markers ready.

Facilitation steps

1. Display the "Steps to Behavior Change" flipchart. Explain that this model can help us to see where people are in the process of behavior change.
2. Distribute the "Example of Steps to Behavior Change" handout. Review each step in the process for individuals concerned about HIV/AIDS.
3. Explain that—
    - Individuals start on different steps
    - They may not always go through each step of the process in the same order or at the same speed
    - They can leap over or move back down several steps at a time
    - Once someone has moved up, he or she can still move down again
    - Once someone has moved down, he or she can still move up
    - It is important to know where the individual is to identify opportunities for intervention
4. Point out that many things help people move up the steps including information, emotional experiences, peer pressure, following opinion-leaders, policy changes, and the social environment. Ask participants to give some HIV/AIDS examples of why and how someone might move up and down the behavior change steps.

[27] Adapted from "Social Mobilization for Reproductive Health: A Trainer's Manual."

Examples include the following.

- A man who has resisted condom use learns a friend has contracted HIV from not using a condom (moves from Knowledge up the steps)
- A pamphlet about the link between STIs and HIV motivates a man experiencing pain on urination to go to the clinic (moves from below Knowledge to Practice)
- A man gets a condom from the clinic, but he does not use it (moves from Practice down)

5. Explain the importance of environmental support for behavior change. After spending the morning talking about behavior change from the individual perspective, it is important to understand that change cannot happen without support.

   Have the group brainstorm what "support" means and give examples (e.g. spouse, in-laws, friends, community, and religious leaders). Factors such as family pressures, community norms, and beliefs surrounding HIV/AIDS can influence the health-related behaviors an individual engages in. Thus, an individual's behavioral choices must be seen within the broader context of his or her environment. Explain that activating and involving various levels of society and the environment accelerates behavior change in individuals. Then give a real life scenario appropriate to the community and culture of a person trying to change his/her behavior. Have participants brainstorm "environmental support mechanisms" to help that person change.

6. Ask participants to break into groups of three or four and look at the "Behavior Change Model" flipchart. Pass out flipchart paper and markers to each group.

7. Ask each group to think of at least one kind of intervention that would assist people to move to the next higher step. Include an intervention that involves a supportive environment. Ask participants to think of at least one intervention that would help people to stay on the step where they currently are. Write out their answers on the flipchart to share with the group. (About 10 minutes)

Wrap-up

Reassemble the original group and share interventions. Summarize by explaining that this behavior change model is useful as a map, but is not written in stone. In counseling people for behavior change or in planning prevention programs, it can help us understand where people are and where we might help them to go, but it should be used flexibly.

Handout

Example of Steps to Behavior Change: HIV/AIDS Prevention[28]

Knowledge

1. Recalls HIV/AIDS prevention messages.
2. Understands what HIV/AIDS means.
3. Can name ways to prevent HIV/AIDS.

Approval

1. Responds favorably to HIV/AIDS prevention messages.
2. Discusses HIV/AIDS prevention with personal networks (family, friends).
3. Thinks family, friends, and community approve of HIV/AIDS prevention.
4. Approves of HIV/AIDS prevention.

Intention

1. Recognizes that HIV/AIDS prevention strategies can meet a personal need.
2. Intends to use an HIV/AIDS prevention strategy (e.g. condoms, abstinence, being faithful) at some time.
3. Intends to get condoms.

Practice

1. Goes to a provider or counselor for information/supplies/services.
2. Chooses a prevention strategy and starts to use it.
3. Continues using prevention strategy.

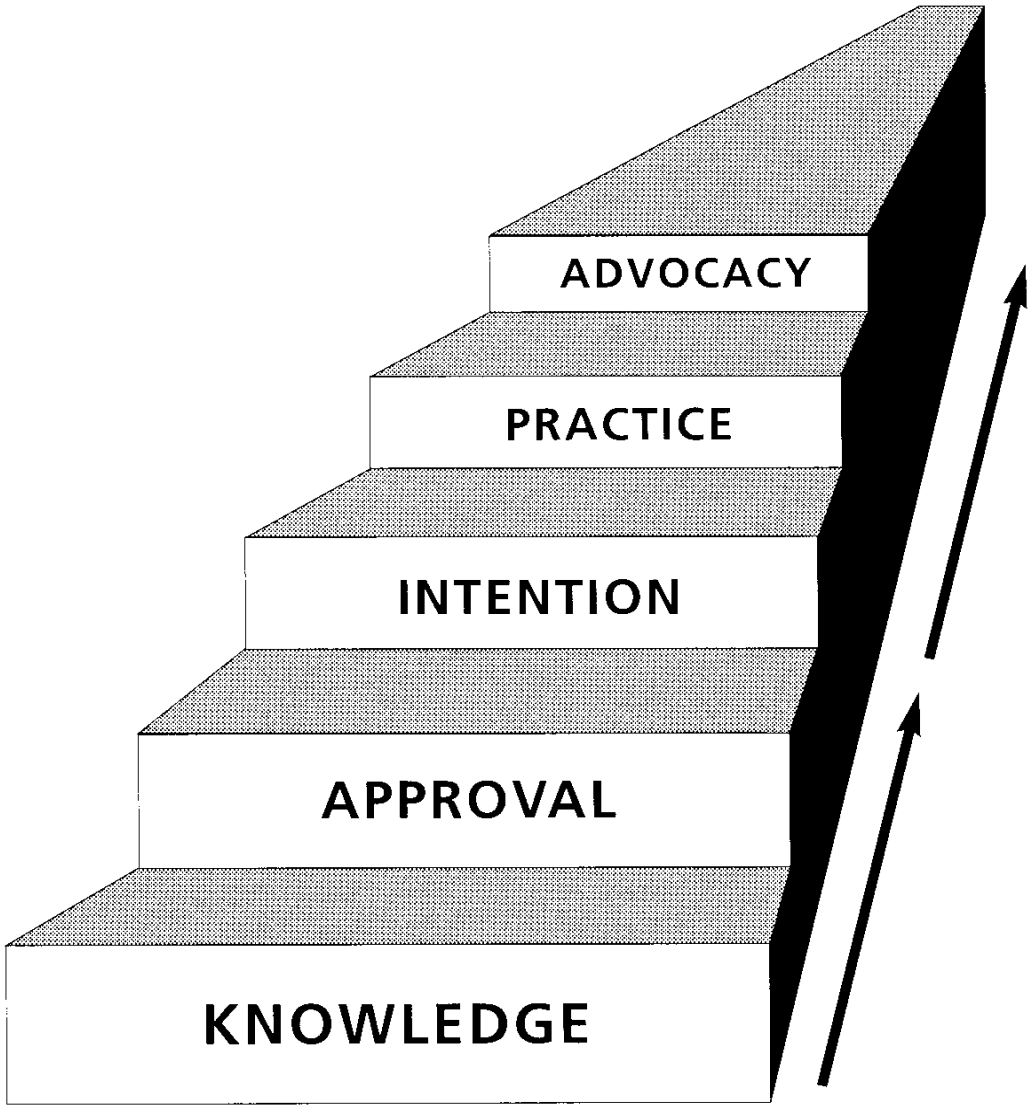
Advocacy

1. Experiences and acknowledges personal benefits of using a prevention strategy.
2. Advocates practice to others.
3. Supports HIV/AIDS prevention programs in the community.

[28] Adapted from "Social Mobilization for Reproductive Health: A Trainer's Manual," p. 87.

Tools for Trainers

Steps to Behavior Change



—Adapted from Piotrow et al

Chapter 4: Care and Counseling

Section 1: Behavior Change

Alternate Activities and Handouts for Behavior Change

- **African Family**[29]

[29] From U.S. Peace Corps, "Life Skills Manual," June 2000.

Activity African Family

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

- Design a behavior change intervention plan for an African family affected by HIV/AIDS

Time allotted 1 hour, 15 minutes

Preparation A thorough discussion of behavior change should precede this session. Hand out the family descriptions on pages 4-160 to 4-163 to each group.

Facilitation steps

1. The facilitator states that a doctor informed an African family that their 18-month-old daughter has died of AIDS.

2. Participants divide into four groups. Each group takes 45 minutes to strategize interventions for one family member. Have one member of each group take on the role of the particular family member (i.e. father, mother, son, daughter) to get a deeper understanding of the person's issues.

3. Each group will have 10 minutes to report their plan to the larger group.

Wrap-up After the presentations, discuss the importance of families knowing about HIV/AIDS transmission and treatment.

Handout

African Family Exercise

Group 1

The 45-year-old **father** of the family is feeling very ill and has been unable to work for two months. He has fever, chills, weight loss, and a cough that is beginning to produce blood. He has taken some herbal remedies, but does not want to go to the hospital. He believes that the doctor's story that his child died of AIDS is just part of the white man's conspiracy to blame Africans and that AIDS does not exist.

Draft an action plan for the father. Select at least one behavioral change that you believe would be important to improve the health of the father. List possible alternative options that would improve his health.

- What attitudes or cultural beliefs might you want to change or strengthen to help him attain the above action?
- What skills will he or other family members need to support him?
- What HIV/AIDS knowledge would you share with him?
- How would you phrase those messages, and whom would you select to share those messages with him? What can the father do to support his family?

Group 2

The 35-year-old **mother** is tired. She is experiencing abdominal pain and chronic vaginal yeast infections. She has just learned that she is pregnant again. She is grief-stricken over her child's death and feels it is her fault that her baby died, maybe because her breast milk was bad. She is very worried about everyone in the family.

Draft a strategy with the mother for an action plan to deal with her situation.

- What actions should she take to improve her health?
- What actions should she take with regard to her pregnancy?
- What specific HIV knowledge does she need?
- What attitudes are creating obstacles or strengthening her health status? For obstacles, what strategies would you develop to deal with them?
- Identify people who could best influence her attitudes and behaviors.
- Among her family, whom does she choose to care for first? What resources exist to help her with these tasks?
- What can the mother do to support her family?
- Who can support her best in her own environment to deal with this situation?

Group 3

The 17-year old **son**, Abubu, is not in school, but he knows that people can get AIDS from sex. Because his father is sick and his mother is busy caring for the rest of the family, he spends a lot of time with his friends on the streets. He is good-looking and has a lot of girlfriends, and he often has sex with commercial sex workers after drinking with friends.

Design an action plan for Abubu that focuses on behaviors you think it is important for him to address. Discuss options with him for addressing those behaviors.

- What attitudes are contributing to his behaviors, and how can you address these attitudes?
- What knowledge or skills does he need to reduce his risks?
- What are the major social, cultural, gender and economic influences on his behavior? How will you help him address these influences?
- What life options does he have to maintain his health?
- What messages will you give, and who will help you give them?
- What can Abubu do to support his family?

Group 4

Kadija is the 11-year-old **daughter** in the family. She is frightened by what is happening at home and does not understand why her baby sister died or why her father is so sick. Because her father is no longer working, she has no money to buy clothes and books for school. A kind man has offered to buy these things for her if she will be sweet to him.

Strategize an intervention plan for Kadija.

- What knowledge does she need?
- How would you phrase messages to make her aware of her vulnerability? Who would be good resources to help her with her confusion?
- What skills does she need to deal with the "kind man?"
- What options does she have to keep herself healthy and safe as well as meet her other needs?
- What can Kadija do to support her family?
- Who can support her in her needs?

Chapter 4: Care and Counseling

Section 2: Basics of Counseling

Objectives

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

- Define counseling
- Identify goals of HIV/AIDS counseling
- Discuss the qualities of an effective counselor
- Discuss the importance of confidentiality in HIV counseling
- Identify concerns and difficulties in HIV counseling
- Discuss the essential concepts of counseling, and identify the basic skills needed to provide effective counseling
- Discuss the HIV counselor's roles and tasks
- Identify the stages of counseling and the appropriate skill needed at each stage
- Practice counseling skills

Overview[30]

Counseling is a form of communication; it is both verbal and nonverbal. Counseling usually occurs between a *"client"* and a trained *provider* (examples may be a health care provider such as doctor, nurse, midwife, a peer educator, a social worker, psychologist or family therapist, community worker, member of AIDS organization, a religious leader, or pastor). Counseling can help to guide a client to explore, express, understand, and accept his/her feelings so that he/she can make decisions and feel more emotionally healthy. Counseling is **not** pushing people to conform to certain "acceptable" standards to live by, but a process where clients identify their own values and decide for themselves how they will modify these values and their behavior. Counseling is different from education, although education can be an important part of counseling, particularly when the client lacks appropriate information. Counseling involves active listening and empathy, where the client feels comfortable to share fears and asks questions, while the counselor remains nonjudgmental.

Counseling someone about HIV/AIDS and someone affected by HIV/AIDS is different than other types of counseling. The **goals of HIV/AIDS counseling** are to—

- Promote behavior change to prevent HIV infection and its transmission to other people
- Give psycho-social support to those whose lives have been affected by HIV

Therefore, the counselor is referred to as an **HIV/AIDS counselor**. An HIV/AIDS counselor must be comfortable discussing sexual practices of men, women and young people, discussing death and dying, be able to recognize and accept people who have different opinions/values than their own, be nonjudgmental, have thorough HIV/AIDS knowledge, be empathetic, be aware of resources to which s/he can refer the client when necessary, and be able to deal with the emotional challenges and stress. The counselor should also be aware of his/her own gender and other stereotypes.

HIV/AIDS counseling is particularly appropriate for—

- People being tested for STI/HIV
- People with STI/HIV/AIDS and their partners and families
- People seeking help/advice because of past or current risk behaviors
- Women or men who have partners with risky behaviors (multiple partners, unsafe sex
- Couples wishing to marry

[30] Much of this chapter was adapted from the Family Health International (FHI), "The Zimbabwe HIV Prevention Counseling Training Manual," October 1999.

- Persons experiencing difficulty in marriage, relationships, employment, housing; and finances due to HIV infection
- Women who are pregnant and/or attending antenatal care

One-on-One Counseling services may be delivered at any location where a confidential HIV/AIDS discussion can take place. Examples are churches, schools, health facilities, prisons, workplace, and at home. HIV counselors are usually on hand at places where HIV-positive people are cared for or where HIV tests are done (i.e. blood donation sites, research sites, and VCT centers).

Before one considers delivering HIV counseling, consider whether one has the following skills—

- Knowledge of HIV/AIDS information
- Good communication and counseling skills, particularly the ability to listen
- Use of developmentally appropriate, nonjudgmental, sensitive, and specific language
- Ability to keep confidentiality
- Cultural and gender sensitivity
- Ability to pay attention to client's emotional reactions
- Can take care of him/herself as a provider

To be an effective counselor, the provider must develop a rapport with the client. A good rapport leads to trust and effective communication. The **essential counseling concepts** are—

- **Feelings first.** Difficult feelings are unavoidable in the counseling process. Counselors must be aware of their own feelings, attitudes, beliefs, and values about HIV/AIDS and be able to not let them interfere with the client's needs. Counselors must acknowledge the client's feelings and realities, understand that it is not his/her job to fix the feelings, but to articulate and respond to the nonverbal, and normalize and validate the client's feelings (i.e. "I know this has been hard to deal with").
- **Use the third person.** Using third person statements helps the client choose whether or not to respond to the statement, reduces the client's defensiveness, and makes the client feel it is normal to feel that way (i.e. "people can feel a lot of confusion and guilt when they hear information about HIV").
- **The Nth degree.** These questions are helpful to get the client started defining his/her priorities, agendas and needs, so that the counselor may know what s/he thinks is most important (i.e. "What is the best way to think about this?" "What's the worst thing that could happen?" "What is the most important issue we can deal with today?").

- **Offer opinions, not directives.** Offering opinions rather than giving directions (such as: "You should not have sex outside marriage!") will give the client control over his/her decisions (i.e. "If you want to avoid HIV infection, then you will want to consider at least one of these options: abstinence, using condoms, or remaining faithful to your HIV-negative partner").
- **"You are not the target."** Clients may express anger towards the counselor. In this case, the counselor may acknowledge the anger and use an "if… then" statement such as "If you want to continue discussion, then you must set aside your frustration or come back later."
- **"Who's in charge."** Counselors must set boundaries, detach their internal assumptions, and keep in mind their clients' own responsibility for behavior change.

The **counseling process** has beginning, middle, and end stages—

- In the **beginning stage**, the counselor and client build a relationship, establish trust, discuss the client's problem and how he/she feels about it, find out how the client would like to manage or solve the problem, and find out what the client expects from counseling.
- The **middle stage** occurs after the client is assured that the counselor can be trusted and will provide information, guidance, and support. The counselor can then help the client implement an action plan. The counselor will continue to support the expression of feelings, refer to available formal and informal resources, monitor progress and modify plans as necessary, promote behavior changes, and help the person move towards acceptance and control.
- The **end stage** occurs after the client has shown willingness to participate in formulating and carrying through plans. The counselor helps the client summarize the problem or the day's session and provides the client with some framework for the next session. Counseling should end only when the client can cope with and adequately plan for day-to-day functioning or has a support system such as family, friends, and support groups to help her/him carry through her/his plan of action.

The **basic counseling skills** are listed below—

- **Open-ended questions** encourage clients to express themselves. For example: "How do you think the virus is passed from one person to another?" "What do you know about HIV infection?" and "Why do you want to be tested?" or "Why are you afraid of being infected?"
- **Attending** refers to behavioral skills that pay close attention to the client by limiting distractions. Examples are: active listening, eye contact, facial expressions, quiet environment, close seating, and affirming a client's response with nod or "yes."
- **Paraphrasing** is restating what the client said in similar but fewer words. Paraphrasing shows attention, clarifies the client's communication, validates the client's statements, and encourages the client to explore his/her concerns.

- **Reflecting feelings** involves the counselor responding in such a way that demonstrates understanding, expresses feelings, recognizes client feelings, and confirms that the client's feelings are normal. For example "I feel like crying all the time because I can't tell anyone about this." The counselor can respond, "You feel sad because you feel you can't tell anyone about this. Tell me more about your feelings."
- **Reframing** involves paraphrasing the client's responses and then following the paraphrase by presenting a *positive view* of the issue. For example, if a client says, "You can't feel anything when you wear condoms," a reframe might be, "You are right, condoms do reduce sensation, but a lot of men find that when they use condoms, they can relax and enjoy their partner more because they do not have to worry about unplanned pregnancies, STIs and HIV."
- **Confrontation** helps identify strong contradictions in the client's behavior between self-perception and behavior, verbal and nonverbal messages, two verbal messages, and expressed feelings. Confrontational phrases include "If… then…," "So… and…" and using the third person. For example: " I'm really concerned that you could get HIV. I hope when you are ready to think and talk more about HIV you know you can come talk to me about it."
- **Silence** on the counselor's part can allow the client time to think and time to express him or herself more fully. Sometimes it is hard for a person to articulate their feelings about sensitive subjects. Give them the time and space to communicate.
- **Self-disclosure** is a technique that a counselor uses only if he/she knows a client well, since it involves revealing the counselor's own feelings, life experience, and emotional concerns, and risks shifting the focus away from the client.
- **Confidentiality** is a critical component of counseling. In any counseling relationship, the most important aspect is trust between the counselor and the client. A crucial way to build and retain that trust is by the counselor keeping everything that is said in a counseling session in strict confidence. This is especially important in HIV counseling, due to the stigma, fear and discrimination surrounding HIV. People are more likely to participate in voluntary counseling and testing programs if they believe that they will not experience negative consequences.

Group counseling may be appropriate for any group, including pregnant women, women practicing high risk behavior, such as hawking, young girls and boys feeling at risk (to address sexual abuse, coercive sex, drug use), or women, men, and children living with AIDS.

Chapter 4, Section 2: Basics of Counseling

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Chapter 4: Care and Counseling

Section 2: Basics of Counseling

Sample Lesson Plan

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**Exploring Value-Loaded Statements**	Game, discussion	four signs, tape	Understanding level observed in discussion
1 hour	**HIV Counselor's Strengths and Concerns**	Lecture, group discussion	Flipchart	Discussion of the experience
1 hour	**Essential Concepts & Basic Skills of Counseling**	Discussion, Brainstorming Demonstration Role-play	Handouts, flipcharts, markers	Understanding level demonstrated in active participation
1 hour 15 minutes (or more)	**Counseling Practicum**	Role-plays	Flipcharts with counseling scenarios	Observed use of essential concepts and basic skills in role-play

Chapter 4: Care and Counseling

Section 2: Basics of Counseling

Activities and Handouts for Basics of Counseling

- **Exploring Value-Loaded Statements**
- **The HIV Counselor's Strengths and Concerns**
- **Essential Concepts and Basic Skills of Counseling**
- **Counseling Practicum**

Activity Exploring Value-Loaded Statements

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

- Understand that clients may have different values than counselors due to culture, socio-economic factors, and gender
- Explore their own values

Time allotted 30 minutes

Preparation Refer to the Trainer's Resource "Value-Loaded Statements" on page 4-174 or the trainer should write statements that are appropriate for the participants. Post four signs in different areas of the room that are labeled Strongly Agree, Agree, Disagree, Strongly Disagree.

Facilitation steps

1. Remind participants of the discussion in chapter 2 about how cultural, gender, economic, and social factors influence people's behavior. Explain that it is important to recognize these differences in background between yourself and the person you counsel.

2. Explain that as counselors and religious leaders, they must have basic respect for the individuals for which they care. They should not be judgmental and should be culture and gender sensitive if they are going to deliver their services effectively.

3. Point out the four areas of the room where the signs, Strongly Agree, Agree, Disagree, and Strongly Disagree, are posted.

4. Explain that the trainer will read a list of statements one at a time. (The statements deal with the issues of the right to die, fidelity/faithfulness, choice, stigmatization, HIV testing, and partner notification, but don't tell the participants this).

5. Each person must listen carefully and decide how they feel about each statement and then move to the appropriate area of the room.

6. Read the statements.

7. Once the group has moved to their chosen places, ask volunteers from each area to share their feelings on why they chose that area. Remind participants that there are no right or wrong answers.

8. Repeat the procedure as time permits.

Wrap-up

Ask what the participants felt during the exercise.

- Was it hard to defend a position when others questioned it?
- Why is it important for counselors to be clear about their own values?
- Why is it important to be aware that other people may have different values?
- How can this be useful in a counseling situation?

Point out that it is important for them to be aware of their own feelings about these issues, so that when a person comes to them with a problem, they will be able to either help that person without judging them or refer them to someone else, if they realize that their personal feelings would get in the way of helping the client.

Tools for Trainers

Value-Loaded Statements

It is my right to die when the pain is unbearable.

There is nothing wrong with extramarital sex as long as the parties involved are adults.

Drugs and alcohol are a good way of relaxing.

It is acceptable for men to have sex with other men.

Beating one's spouse is an acceptable form of discipline.

A woman who tests positive for HIV should not have any more children.

Men who have sex with commercial sex workers are responsible for spreading AIDS.

HIV-positive babies should be left to die since they are going to die anyway.

It is acceptable to have sex for pleasure only.

To eradicate HIV infection, all HIV-positive people must be quarantined.

All HIV-positive people must notify their partners and families.

If a wife wants to use condoms for HIV prevention, but her husband does not want to use condoms, the wife has a right to refuse sex with her husband.

Parents should teach their adolescent children how to use condoms.

Activity The HIV Counselor's Strengths and Concerns

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

- Define counseling
- Discuss the HIV counselor's roles and tasks
- Identify the HIV counseling session's goals
- Discuss the importance of confidentiality in HIV counseling
- Discuss the qualities of an effective counselor
- Identify concerns and difficulties in HIV counseling

Time allotted 1 hour

Preparation Prepare flipchart with the "Goals of HIV Counseling" (on page 4-176) and one with the interview questions (on page 4-177). Make copies of the "Counselor's Personal Resources" handout on page 4-179, and the "HIV/AIDS Confidentiality Guidelines" on page 4-178. Bring flipcharts and markers.

Facilitation steps

1. Discuss the session objectives and note that this session will focus on discussing issues surrounding HIV counseling.

2. Ask participants to define counseling. Write the definitions on a blank page of the flipchart. Ask how counseling is different from education. (An example might be counseling is more than just giving information; it's listening, supporting the client, exploring options, etc.)

3. Ask the participants, "How is HIV counseling different from other types of counseling?" Write their responses on a flipchart page.

4. Responses may include, involves explicit discussion of sexual practices, must address gender-inequity, and requires discussion of death and dying. Counselors may encounter someone whose views and values are different from their own, and counseling someone who is affected by HIV can be stressful and emotionally challenging.

5. Brainstorm the different reasons that people may come for HIV counseling (people with multiple sex partners, persons wishing to marry, persons experiencing difficulty in marriage, relationship, etc. due to HIV infection,

women who are pregnant or seeking antenatal care, people who want to know if they are HIV-positive). List these reasons on a flipchart page.

6. Hand out the HIV/AIDS Confidentiality Guidelines. Spend some time discussing confidentiality. Clergy are probably already engaged in counseling their parishioners and have some standards of confidentiality. But HIV counseling is different for the reasons already discussed and because of stigma and discrimination. It is essential that the clients' privacy be protected. A person's HIV status is the most confidential information and must be protected. HIV counseling must be done in private, where the conversation cannot be overheard. Counseling should always be conducted with the door closed, and there should not be interruptions during the counseling session. Any discussion among counselors should be for purposes of supervision or referral only, and the client's name should never be used in public. Any written records should be kept in locked files. Confidentiality is maintained through providing a secure private environment where clients can feel comfortable and safe.

7. Ask participants to give examples of other people who may deliver counseling. Examples include nurses, doctors or other health care personnel, social workers, psychologists, etc.

8. Display the following on a flipchart.

Goals of HIV/AIDS Counseling

- To promote behavior change to prevent HIV infection and its transmission to others
- To give psychosocial support to those whose lives have been affected by HIV

9. Ask participants to list ways to achieve these goals (including providing information on HIV transmission, helping deal with emotions, discussing what actions to take, encouraging clients to change behaviors to prevent or control infection, couple counseling, referring clients to providers). Write their answers on a flipchart.

10. After you have discussed the topics, explain to the participants that they are going to break into pairs to discuss the **qualities of an effective counselor**. Each member of the pair will have 10 minutes to interview the other. Display the questions below on a flipchart.

Qualities of an Effective Counselor

- Why do you think you will be an effective HIV counselor?
- What concerns to do you have about your ability to be an effective HIV counselor?
- What kinds of clients do you expect will be most difficult for you?

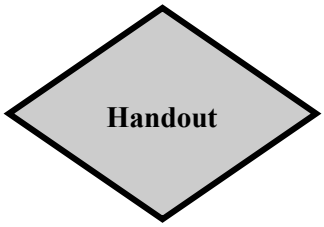
11. The interviewer's job is to elicit opinions about the participant's strengths and weaknesses and examples from the participant. Assure participants that discussions will NOT be shared with the whole group.

Wrap-up

After all participants have been interviewed, bring the group back together to discuss their general experience in this exercise without pressuring them to reveal strengths and weaknesses.

(10 minutes)

Give participants the handout on "A Counselor's Personal Resources" as a resource for private use to further explore these issues.



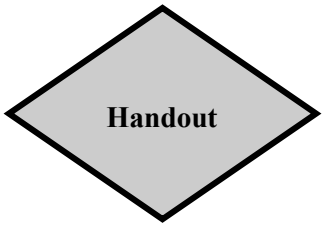
HIV/AIDS Confidentiality Guidelines[31]

AIDS Confidential Information is defined as information that a person has—

- Been diagnosed as having AIDS
- Been or is being treated for AIDS
- Been determined to be HIV infected
- Submitted to an HIV test
- Had a positive or negative result from an HIV antibody test
- Sought and received counseling regarding HIV/AIDS
- Been determined to be a person at risk of being infected with HIV

[31] http://www.ph.dhr.state.ga.us/programs/stdhiv/hivguidelines.shtml

Counselor's Personal Resources



The prospective counselor is invited to reflect on his/her personal resources such as, opinions, feelings, attitudes, strengths and weaknesses before doing counseling.

The following questions should be considered [32]—

- What might be painful for me in my work with HIV-affected/infected people?
- Have I thought about my own death?
- Have I thought about my own risk of HIV infection?
- What is it about people with HIV infection that might be upsetting for me?
- What are my personal limitations in working with people with HIV/AIDS?
- What are my strengths and qualities for working with people with HIV/AIDS?
- What views might I have, for example, on homosexuality, infidelity, prostitution, polygamy, etc.?
- How would I handle objections to this work from my own family, neighbors or congregation, or church hierarchy?
- How would I handle aggression, anger, or hostility?
- What is my interest in committing myself to this work?
- How would I handle someone with very rigid views?
- What other questions should I ask myself?

[32] "A Guide to HIV/AIDS Pastoral Counseling," AIDS Working Group, World Counsel of Churches, 1990

Activity Essential Concepts & Basic Skills of Counseling

Objective

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

- Discuss the essential concepts of counseling
- Name the basic skills needed to provide effective counseling
- Identify the counseling stages and the appropriate skill needed at each stage

Time allotted

1 hour

Preparation

The day before this activity, prepare a role-play using two facilitators or if a trainer is facilitating solo, ask a participant to work with you. Practice a counseling session and demonstrate as many examples of essential concepts and basic skills as possible. Make copies of "Essential Counseling Concepts" on page 4-183, "Basic Counseling Skills" pages 4-184 and 4-185, and the "Stages of the Counseling Process" page 4-186 handouts for the participants.

Facilitation steps

1. Explain the session objectives.

2. Ask what the participants think is the most important aspect of any type of counseling. List their answers on a flipchart. Counseling should be client-centered; it should focus on the individual client's unique situation. If no one mentions it, explain that the most important aspect of any type of counseling is the **trust that is developed between counselor and client**. Note that many of the pastors already have an established trust with the members of their particular faith community. Explain that after this session, the participants will have the chance to practice the basic counseling skills that are covered in this activity.

3. Distribute the "Essential Counseling Concepts." Ask a participant to volunteer to read the first concept and then discuss it. Ask participants to give examples. Make sure that everyone understands the concept. Repeat this process with each concept.

4. Outline the counseling process and define each stage of the process (beginning, middle, and end). Display the following on an overhead or flipchart, but leave the **skills needed** column blank. Distribute the handout.

Stages of Counseling Process

Stage	Function	Skills Needed *(examples)*	Activities
Beginning	Relationship building	*Friendliness, willingness to learn, understanding, caring, good listener, ability to make eye contact, ability to reassure*	Greet Introduce yourselves Ask open-ended questions to find out why client came
Middle	Information gathering Information giving Dialogue	*Ability to organize, be nonjudgmental, knowledgeable about behavior change*	Ask open-ended questions to assess knowledge/risk behaviors Tell basic HIV facts Help to explore feelings Explain options for health/risk reduction
End	Formulate action plan Try new behavior	*Firmness, self-confidence, knowledgeable of referral resources/services in community, ability to plan*	Refer as needed Follow-up to maintain behavior change

5. Have participants brainstorm the skills that are necessary at each stage of the counseling process. Write the skills on the flipchart or overhead, while participants complete the handout.

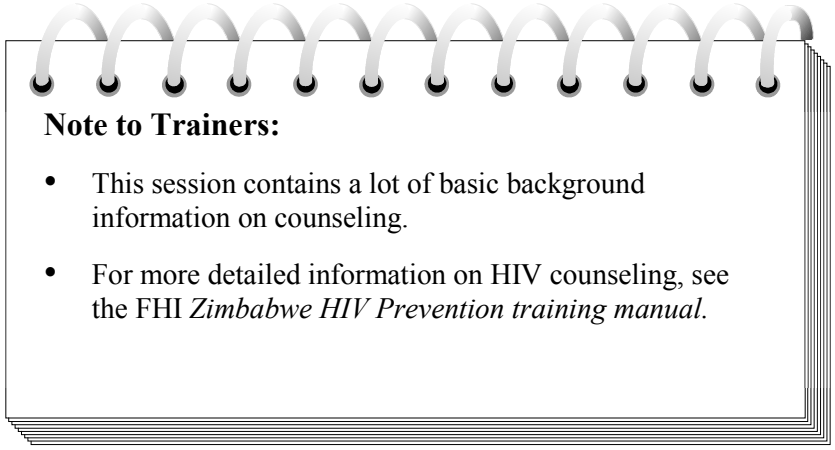
6. Pass out the "Basic Counseling Skills" handout. Go over each basic skill and ask participants to give examples.

7. Explain that the counseling content depends on the situation and is based on client needs and circumstances, physical state, type of problem they are experiencing, and the stage of the problem when the counseling begins.

8. Tell the participants that they will now see a demonstration of these counseling concepts and skills. While the role-play is presented, ask participants to note all the concepts/skills they observe.

9. Perform role-play.

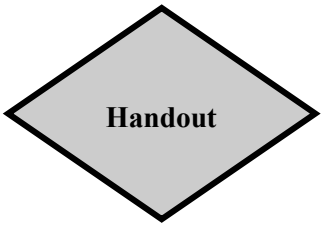
Wrap-up After the role-play, discuss what the participants observed. Ask if any concepts/skills were missing. Ask how they might use these skills in their work.



Note to Trainers:

- This session contains a lot of basic background information on counseling.
- For more detailed information on HIV counseling, see the FHI *Zimbabwe HIV Prevention training manual.*

Essential Counseling Concepts



- **Feelings first.** Difficult feelings are unavoidable in the counseling process. Counselors must be aware of their own feelings, acknowledge the client's feelings and realities, understand that it is not the counselor's job to fix the feelings, articulate and respond to the nonverbal, and normalize and validate the client's feelings (i.e. "I know this has been hard to deal with.").

- **Use of the third person.** Using third person statements helps the client choose whether or not to respond to the statement, reduces the client's defensiveness, makes the client feel it is normal to feel that way. (i.e. "People can feel a lot of confusion and guilt when they hear information about HIV.")

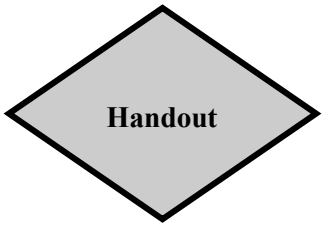
- **The Nth degree.** These questions are helpful to get the client started defining his/her priorities, agendas and needs, so that the counselor may know what she/he thinks is important. (i.e. "What is the best way to think about this?" "What's the worst thing that could happen?" "What is the most important issue we can deal with today?")

- **Offer opinions, not directives.** Offering opinions rather than giving directives or orders (such as "You should not have sex outside marriage!") gives the client control over his/her decisions. (i.e. "If you want to avoid HIV infection, then you will want to consider at least one of these options: abstinence, using condoms, or remaining faithful to your HIV-negative partner.")

- **"You are not the target."** Clients may express anger towards the counselor. In this case, the counselor may acknowledge the anger and use an "If… then" statement such as, "If you want to continue discussion, then you must set aside your frustration or come back later."

- **"Who's in charge."** Counselors must set boundaries, detach their internal assumptions and keep in mind their client's own responsibility for behavior change.

Basic Counseling Skills



- **Open-ended questions** encourage clients to express themselves. For example, "How do you think the virus is passed from one person to another" "What do you know about HIV infection?" "Why do you want to be tested?" and "Why are you afraid of infection?"
- **Attending** refers to behavioral skills that pay close attention to the client by limiting distractions. Examples are active listening, a soft involved eye contact, facial expressions that show interest, affirming client's response with head nodding at times or "yes," quiet environment, close seating maintaining a relaxed alertness, voice relaxed or showing concern, and avoiding emotional leakage-shock-surprise-disgust-approval-disapproval.
- **Paraphrasing** is restating what the client said in similar but fewer words. Paraphrasing shows attention, facilitates communication from client, validates the client's statements, and encourages the client to explore his/her concerns.
- **Reflecting feelings** involves the counselor responding in such a way that demonstrates understanding, expresses feelings, recognizes client's feelings, confirms that the client's feelings are normal. For example the client says, "I feel like crying all the time because I can't tell anyone about this." The counselor can respond, "You feel "sad" because you're afraid to open up."
- **Reframing** involves paraphrasing the client's responses and then following the paraphrase by presenting a *positive view* of the issue. For example, a client says "You can't feel anything when you wear condoms." A reframe might be, "You are right, condoms do reduce sensation, but a lot of men find that when they use condoms, they can relax and enjoy their partner more because they do not have to worry about unplanned pregnancies, STIs and HIV."
- **Confrontation** helps identify strong contradictions in the client's behavior between self-perception and behavior, verbal and nonverbal messages, two verbal messages, and expressed feelings. Confrontational phrases include "If… then…," "So… and…" and using the third person. For example, " I'm really concerned you could get HIV. I hope when you are ready to think and talk more about HIV, you know you can come and talk to me about it."
- **Silence** on the counselor's part can allow the client time to think and time to express him or herself more fully. Sometimes it is hard for a person to articulate their feelings about sensitive subjects. Give them the time and space to communicate.

- **Self-disclosure** is a technique that is only used if a counselor knows a client well, since it involves revealing the counselor's own feelings, life experience, and emotional concerns, and risks shifting the focus away from the client.
- **Confidentiality.** In any counseling relationship, the most important aspect is trust between the counselor and the client. A crucial way to build and retain that trust is by the counselor keeping everything that is said in a counseling session in strict confidence. This is especially important in HIV counseling, due to the stigma, fear and discrimination surrounding HIV. People are more likely to participate in voluntary counseling and testing programs if they believe that they will not experience negative consequences.

Handout

Stages of the Counseling Process

Stage	Function	Skills Needed	Activities
Beginning	Relationship building		Greet Introduce yourselves Ask open ended questions to find out why client came
Middle	Information gathering Information giving Dialogue		Ask open-ended questions to assess knowledge/risk behaviors Tell basic HIV facts Help to explore feelings Explain options for health/risk reduction
End	Formulation of action plan Try new behavior		Refer as needed Follow-up to maintain behavior change

Activity Counseling Practicum

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

- Demonstrate the basic skills of effective counseling
- Demonstrate the essential counseling concepts

Time allotted 1 hour 15 minutes or more (See "Notes for Trainers" on page 4-188.)

Preparation Prepare a flipchart with examples of counseling scenarios (e.g. a man receives a positive HIV test result, a woman thinks her husband is going to commercial sex workers, a teenage boy has been going out drinking with friends and having sex with several girls, etc.).

Facilitation steps

1. Explain that the participants will now have an opportunity to practice the skills and concepts learned in the previous sessions.

2. Have the participants break into groups of three. Each triad should pick a counseling scenario from the list on the flipchart or make up their own situation.

3. Explain that the groups will practice counseling through role-plays, based on their scenario. One member should play the counselor, another the client, and the third the observer. The role-play should include activities and skills from all parts of a counseling session, beginning, middle, and end. (Refer to the handouts from the last session.)

4. Ask observers to watch both for when the counselor uses/doesn't use the skills and other counseling concepts. Suggest that the observers take notes.

5. Role-plays should last about 20 minutes and then the observers should give feedback to the person in the counselor role.

6. After getting feedback, the triad group members should switch roles, so that another person plays the role of counselor. (Groups can change scenarios if they choose.) Continue until everyone has had a chance to play the counselor.

7. This kind of practice is extremely valuable. If time permits, groups can continue switching roles and scenarios until everyone has played the counselor twice.

Wrap-up Bring everyone back to the group and discuss what this practice felt like for the participants.

- Were some scenarios harder to do than others?
- What skills/concepts were most useful?
- How will they use what they learned from this practice in their work?

Note to Trainers:

- Having sufficient time to practice counseling skills is very important. When planning the training, it may be useful to schedule in two or three hours for the practicum.
- For more detailed information on HIV counseling, see the FHI *Zimbabwe HIV Prevention training manual.*
- For additional information and training activities for counselors see the "Voluntary HIV Counseling and Testing Efficacy Study Counselor Training Manual" at:

  http://www.caps.ucsf.edu/projects/c&tcounselor.html

Chapter 4: Care and Counseling

Section 3: Introduction to Care and Counseling

Objectives

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

- Define pastoral care
- Define pastoral counseling
- Describe ways to reach out to individuals and families in the community
- Examine Biblical teachings around issues of compassion, judgment, vulnerability and personal responsibility
- Develop a process towards action for engaging in the struggle between compassion and condemnation

Overview

Pastoral care is compassionate spiritual care given to people who are going through difficult times. Pastoral care helps people to draw on faith resources to see them through. Through pastoral care, faith communities can endeavor to meet the spiritual and emotional needs of people affected by HIV/AIDS, support those living with AIDS at the end of their lives, and convey God's compassion to them. This care may take many different forms. Examples of pastoral care include—

- Pastoral counseling (combines social work and theological training)
- Hospital ministry
- Social work
- Retreats
- Support groups

The type of care offered will depend on the faith community that offers it, but for the purposes of this chapter, the focus is on how the faith leader can help individuals and families deal with HIV/AIDS through **counseling**.

Counseling

Pastoral counseling is a unique form of counseling that uses spiritual resources as well as psychological understanding for healing and growth. In the West, pastoral counseling is provided by **certified pastoral counselors**, who may be religious leaders, lay ministers, family counselors, or support staff who have had in-depth mental health, religious and/or theological training. Pastoral counselors may provide outreach preventive services, wellness programs, religious retreats, and spiritual direction, counseling and community education around various issues (including substance abuse and terminal illnesses, including HIV). The counselor may focus on helping people deal with issues such as—

- Living positively with HIV
- God's role in the life of a person with HIV
- What having HIV/AIDS means for women, men, young people, and their families
- How a person with HIV can live a longer and healthier life
- Identifying resources to help those affected live with the disease
- What dying means

Counselors may **refer** clients to medical, social (i.e. food, shelter, clothing, etc.) or mental health services based on the client's needs. Since formal pastoral counseling certification programs are not widely available in the developing world, this section will focus on building the basic counseling skills of religious leaders and helping them understand where and how to apply these skills. Trained counselors may include deacons, priests, pastors, traditional religious leaders or volunteers from the faith community including health workers, peer educators, and youth leaders. Counseling may be offered to individuals–one-on-one counseling, in groups–group counseling, in a fixed location, or through community outreach. Counselors may meet with clients one-on-one in different locations. The meetings may take place in the church, the health center, or the client's home.

Support groups are made up of people infected or affected by a disease/problem who come together to discuss the challenges that the disease/problem creates in their lives. Talking to someone who has "been there" is beneficial. Support groups may take place in community centers, church meeting-rooms, in school facilities after hours, or in an individual's home. Spiritual retreats led by a pastoral counselor are also a form of group counseling.

Chapter 4, Section 3: Introduction to Care and Counseling

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 4: Care and Counseling

Section 3: Introduction to Care and Counseling

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
20 minutes	**Defining Pastoral Care and Counseling**	Lecture, discussion	Overhead or flipchart of definitions, blank for writing down Care responses	Show of hands
45 minutes	**A Theological Framework for AIDS Response**	Discussion, small group work	Handouts	Understanding level observed in discussion

Important Terms

Pastoral Care

Compassionate, spiritual care given to people with HIV/AIDS, their families, partners, and friends. Through pastoral care, faith communities endeavor to meet the spiritual and emotional needs of people with HIV/AIDS, support them at the end of their lives, and to convey God's compassion to them. This care may take many different forms, including counseling.

Pastoral Counseling

A unique form of counseling that uses spiritual resources as well as psychological understanding for healing and growth. Pastoral counseling providers may not only have had in-depth religious and/or theological training, but also mental health training. Pastoral counselors may provide outreach preventive services, wellness programs, religious retreats, spiritual direction, counseling, and community education. The counselor may focus on helping people deal with issues such as living with HIV; what God's role is in the life of a person with HIV; how God can help a person living with HIV; what having HIV/AIDS means; what dying means; how a person with HIV can live a longer and healthier life; and help identify resources to help those affected live with the disease.

Hospice Care

A program caring for the physical and emotional needs of terminally ill patients in their own home or in an institution.

Support Groups

A support group is made up of people infected or affected by a disease/problem who come together to discuss the challenges that the disease/problem creates in their lives. Talking to someone who has "been there" is beneficial.

Chapter 4: Care and Counseling

Section 3: Introduction to Care and Counseling

Activities and Handouts for Introduction to Care and Counseling

- **Defining Pastoral Care and Counseling**
- **A Theological Framework for AIDS Response**[33]

[33] Adapted from "The AIDS Ministry Handbook," AIDS National Interfaith Network, DC.

Activity Defining Pastoral Care and Counseling

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

- Define pastoral care
- Define pastoral counseling
- Describe ways to reach out to individuals, women, men, young people and families in the community

Time allotted 20 minutes

Preparation Prepare flipcharts or overheads with definitions of pastoral care and pastoral counseling. Make copies of Important Terms on page 4-194. Become familiar with the definitions and the list of ways faith communities can respond to HIV/AIDS.

Facilitation steps

1. Explain that in this chapter the participants will learn about pastoral care and counseling. Acknowledge that participants may already be well versed in counseling as part of their duties within their churches.

2. Refer to Flipchart/overhead with definition of **Pastoral Care.** *Compassionate, spiritual care given to people with AIDS and their partners, families and friends. Through pastoral care, faith communities endeavor to meet the spiritual and emotional needs of people with HIV/AIDS, support them at the end of their lives, and to convey God's compassion to them. This care may take many different forms, including counseling.* Allow participants time to take notes. Hand out Important Terms.

3. Ask the participants to give examples of how faith communities from their locations have shown evidence of "pastoral care." Write their responses on a flipchart. Responses may include visiting sick people at home, counseling people who have HIV/AIDS, etc.

4. Explain that because AIDS is a fatal disease, many people have a hard time dealing with it. They often need someone to talk to, as well as spiritual guidance at the end of life. A trained counselor or "Pastoral Counselor" often gives this guidance.

5. Refer to Flipchart/overhead with definition of **Pastoral Counseling.** *A unique form of counseling that uses spiritual resources as well as psychological understanding for healing and growth. Pastoral counseling providers may not only have had in-depth religious and/or theological training, but also mental health training. Pastoral counselors may provide outreach preventive services, wellness programs, religious retreats, spiritual direction, counseling, and community education. The counselor may focus on helping people deal with issues such as living with HIV, what God's role is in the life of a person with HIV, what having HIV/AIDS means for women men and young people, what dying means, how a person with HIV can live a longer and healthy life, and help identify resources to help those affected live with the disease.*

6. Pastoral counseling can be one-on-one or in groups (support groups). Refer to Handout/flipchart with definition of Important Terms and **support groups.** *A support group is made up of people infected or affected with a disease/problem who come together to discuss the challenges that the disease/problem creates in their lives. Talking to someone who has "been there" is beneficial.*

Wrap-up

With a show of hands, ask the participants to reveal whether they have ever had any counseling training. Also ask whether they have been trained at seminary or elsewhere. Ask whether their churches offer any counseling services.

Note to Trainers:

Resources

- "Comfort and Hope: Six case studies on mobilizing family and community care for and by people with HIV/AIDS", UNAIDS Best Practices collection, 1999, http://www.unaids.org/
- "AIDS Education through Imams: a spiritually motivated community effort in Uganda," UNAIDS Case Study, 1998

Activity A Theological Framework for AIDS Response[34]

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

- Understand Biblical teachings around issues of compassion, judgment, and personal responsibility
- Develop a process towards action for engaging in the struggle between compassion and condemnation

Time allotted 45 minutes

Preparation Make enough copies of each handout from pages 4-200 to 4-202, so that every participant in each of the three groups has a copy of that group's topic. Gather flipchart paper, felt markers and tape (**Note:** May need to revise parts of the lesson plan if references to the Christian bible would not be appropriate for your group).

Facilitation steps

1. Introduce the session and give directions. Tell the participants that, "Today we are going to examine the theological framework for our response as a church to HIV/AIDS and to people living with HIV. To allow us to cover a range of topics in a short time, we're going to work in small groups." For fun, divide into sub-groups (e.g., banana, papaya and mango).

2. Explain that each group will have a topic and a handout. The Group 1 topic is COMPASSION. The Group 2 topics will be JUDGMENT and JUSTICE and the Group 3 topic will be PERSONAL RESPONSIBILITY.

   Each group will discuss its topic in depth, then everyone will have a chance to share their comments on each topic.

3. Hand out worksheets with the group number and topic on top. Each group handout contains one quote with one or two accompanying questions. Explain that someone in each group will read the quote aloud and the group will address the accompanying questions. Each group will need a recorder to take notes on flipchart paper to share later with the whole group. Ask note takers to write legibly. Answer any questions about the instructions.

[34] Adapted from the "AIDS Ministry Handbook," AIDS National Interfaith Network, DC

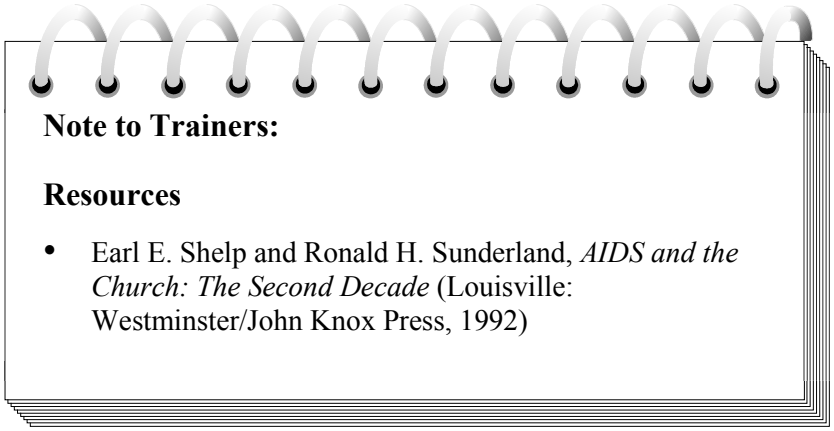
4. **Small group process**. Gather participants into their groups and hand out the materials (paper, felt marker, and handouts). Groups may be separated about the room or in separate rooms. (15 minutes)

5. Ask the groups to have someone read the selection and a recorder write the group responses. After 10 minutes, remind the group they have 5 minutes left. After 3 or 4 minutes into the activity, if the groups have not started to write responses, suggest they do so. It is okay to discuss a long time and write brief responses at the end.

6. **Group reports**. Bring the groups back together. Tape the sheets up and have the smaller groups report back to the larger group. Avoid reading the quote for the group. (15 minutes)

Wrap-up

When all the groups have reported their responses, ask if anyone has thoughts to add. Have the group's recorders add any appropriate comments.



Note to Trainers:

Resources

- Earl E. Shelp and Ronald H. Sunderland, *AIDS and the Church: The Second Decade* (Louisville: Westminster/John Knox Press, 1992)

Handout

Group 1 Topic: Compassion

From *AIDS: Sharing the Pain*

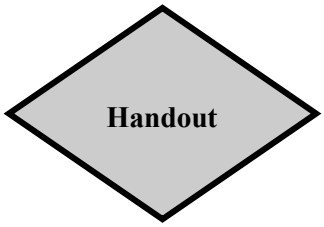
AIDS is a challenge to our compassion, if we are to be faithful to Jesus, who called and appointed us to follow in his example in our attitude towards our brothers and sisters. To do this we have no alternative but to embrace the unique personhood of every woman or man living with HIV/AIDS and those who are affected with them.

This is the work of God-in-Christ and of Christ-in-us-all. This is the work of love's compassionate endeavoring towards all that suffer, whatever the form of suffering, and those who suffer with them. We must be humble enough to allow those living with the virus to minister to us through their suffering. It is their suffering that releases the mutuality of our compassion, one to another.

Questions

- What guidelines does our faith give us in the face of someone infected by/affected by a disease that is considered socially unacceptable by some?
- When we feel like holding back, what can we tell ourselves to keep ourselves involved with this issue?
- What guidance does our faith give us to respond equally to the needs of both men and women affected by HIV/AIDS?

Group 2 Topic: Judgment and Justice



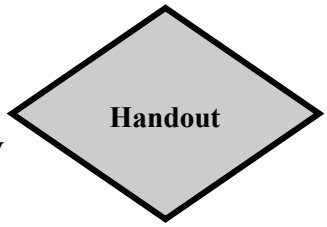
From Susan E. Davies, "Oppression and Resurrection of Faith" in *The Church with AIDS: Renewal in the Midst of Crisis*.

> Oppression is the exercise of authority or power in a burdensome, cruel, or unjust manner… Organizations and social systems are oppressive when they suppress and deny the humanity of individuals simply because they fit certain categories.
>
> People with AIDS in our society are oppressed because they have AIDS and people fear the disease. People with AIDS may be seen as "sinful," "dirty," "prostitutes," "promiscuous," "unfaithful" or "homosexual" because in Africa the disease is spread mainly by sexual activity.
>
> Those who do not have institutional power may establish a norm for themselves and judge others by their ability to meet the defined norm. But unless they have the power to enforce their norm, they are merely bigots, not oppressors… (People living with AIDS) are oppressed because they do not fit the defined norm of person-hood for our society, and because they are victims of institutional and economic power and both institutional and individual violence….
>
> Were the church to live with justice in the context of AIDS, it would mean an end to our condemnation of those whom we have defined as less than human… it would mean confession of the sin of which we are guilty, of distorting the relationship between ourselves and others.

Questions

- What does our faith say about ministering to people who do not fit society's norms or who have subordinate status in some cultures (e.g. women, children)?
- What could you do, in your own personal life, to help end bigotry and oppression, especially against PLWHA?

Group 3 Topic: Personal Responsibility



Adapted from J. Shannon Clarkson, "Resources for Study and Action," *The Church with AIDS: Renewal in the Midst of Crisis.*

> AIDS is not the wrath of God upon [Sinners]…. In the Gospel of John, Jesus' disciples asked him about the man born blind. They asked, "Was he born blind because he sinned, or his parents?" Jesus responded, "It was not that this man sinned, or his parents, but that the work of God might be made manifest in him."
>
> The disciples were astonished. God was and is, giving us an opportunity to heal each other and to love each other.

Questions

- In what ways does our community of faith seek to heal and love people who are in some way outside the mainstream?
- How might we adapt what we are already doing, so that we can respond to the needs of women and men living with AIDS and their loved ones? (**Note:** We can be the answer to the prayer of another by our actions.)
- What other examples of compassion does the Bible offer?

Chapter 4: Care and Counseling

Section 3: Introduction to Care and Counseling

Alternate Activities and Handouts for Introduction to Care and Counseling

- **Commitment to Care and Action**

Activity Commitment to Care and Action

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

- Think about what they can do in their lives to cope with and respond to the issue of AIDS in their communities
- Develop empathy for PLWHA

Time allotted 40 minutes

Preparation Have a blank flipchart and markers handy.

Facilitation steps

1. Ask a participant to summarize what the class has learned in the two previous chapters.

2. Explain that the discussion will be on how the participants, as religious leaders, can cope with the HIV/AIDS issue and respond to it in their respective communities.

3. Write FAMILY at the top of the flipchart page. Ask "What issues does a person living with HIV have to think about with regard to his or her family?"

   Write phrases and sentences on the sheet as participants respond. When it is full, tear it off and tape it to the wall where it is visible.

4. Repeat the above activity with the following headings.

   - **Children**
   - **Partner/Spouse** and **Extended Family**
   - **Friends**
   - **Community** (including health care providers, social-service agencies, financial institutions, and faith communities)
   - **Self**

5. As the facilitator records the answers, ask for clarification when ideas are too brief or clichéd. When views seem rigid or defensive, ask for opposing views or stop for a brief discussion of ideas, keeping in mind that 20 minutes are needed for the remainder of the session.

6. Ask "If you had to live with HIV/AIDS, what do you think might be your biggest challenge?" Ask participants to share/write down responses.

7. Invite participants to look over all this information, think for a moment about how, sitting in this room today, they are affected by HIV/AIDS. Give them time to reflect.

8. Say "I'm going to give you a sentence stem that I'd like you to think about. We'll then go around the room and each of you can finish the sentence however it is true for you. The sentence stem is 'What I'm going to do about HIV/AIDS in my own life is'"

9. Accept any positive response.

Wrap-up Close with a prayer, a moment of silence, or other ritual practice.

Note to Trainers:

Resources

- "The AIDS Ministry Handbook: A Resource Guide for Faith Communities and AIDS Ministries," The AIDS National Interfaith Network, Washington, D.C., 1997
- American Association of Pastoral Counselors http://www.aapc.org/

Chapter 4: Care and Counseling

Section 4: Care, Coping, Social and Spiritual Support, and Counseling

Objectives

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

- Help someone come to terms with death
- List some of the issues, anxieties, or fears that may confront PLWHA while thinking about their deaths and the future of their families
- List strategies for helping PLWHA to prepare to die with dignity
- Describe a "memory book"
- Describe the process for writing and registering a will according to local laws
- List some of the issues, anxieties, or fears that may confront OVC upon the loss of their parent(s)
- List strategies for helping OVC to heal psychologically and emotionally after the loss of their parent(s)
- List strategies for supporting the material and social needs of OVC after the loss of their parent(s)
- Describe an "AIDS Quilt"

Overview

As previously discussed, whether it be the person who is infected with HIV/AIDS, their spouse, partner or family member, people affected by HIV/AIDS feel psychological and emotional distress. This distress may arise from fear of obtaining HIV test-results; fear of disclosing HIV status to a partner; depression and lack of will to live in the face of a serious; fatal illness; sorrow related to loss of loved one; or stress related to stigma and economic hardship as a result of HIV/AIDS. Religious leaders often provide spiritual care and counseling to their faith communities. In the previous three sections, participants learned how to counsel for behavior change, HIV counseling basics, and how faith communities respond through pastoral care and counseling. This section discusses how to address the psychosocial and spiritual needs of the client coping with HIV/AIDS, whether they are a PLWHA or their families, partners and friends.

Psychological Issues

When people learn that they are HIV-positive, there are feelings of uncertainty and a need for adjustment. Uncertainty can relate to the quality and length of life and the response of the spouse/partner and society. People living with HIV/AIDS must make adjustments to respond to these uncertainties. Common reactions to a positive diagnosis include shock, denial, anger, suicidal thoughts, fear, loss, grief, guilt, depression, anxiety, loss of self-esteem, and spiritual concerns (fear of death).

A person with HIV undergoes multiple life stresses that can compromise his/her psychosocial health. Counselors can play a role in assisting their clients in developing a supporting and nurturing environment, experiencing autonomy, and gaining control over their health.

Assessing Psychosocial Support

Psychosocial support is essential to providing comprehensive care to PLWHA and their family members. A positive result leads to extreme stress related to living with HIV; confronting stigma and discrimination; being ill; financial instability; coping with loss and grief; and nurturing affected children.

A variety of interventions can be done to provide the PLWHA with psychosocial support, including—

- Counseling (pre- and posttest counseling, pastoral, individual, group)
- Case management/developing an action plan
- Economic support
- PLWHA support groups and networks

- Home-based care
- Emotional and spiritual support
- Assistance to vulnerable children

Case management involves a social worker assisting the PLWHA with assessing their needs, developing an individual action plan, and recommending follow-up services. A social worker has extensive knowledge of the government and non-governmental support services available for PLWHA. Medical expenses, loss of income, and loss of productivity can all lead to financial burdens. Caregivers also have financial burdens when caring for a PLWHA.

Community-based **economic support programs** are often provided by NGOs to address this issue.

Support groups bring together people who are living with HIV and allow them to express and share their feelings. Peer support can act against negative feelings. Support groups and PLWHA networks provide role models for "living positively" and empower individuals to cope with HIV and practice safe behaviors. Support groups also require little financial investment and are cost-effective. There are different types of support groups. "Drop-in" groups meet regularly and the participants can attend when they want support, or when an emergency arises. Other groups can have set schedules and the same people attend them each meeting whether they have a problem to discuss or not. These groups may last for a long time. Support groups can be more effective when they are made up of people with similar lifestyles, for example, (pregnant) women, youth, married couples, men, etc. Support groups can also be useful for friends and family of people with HIV.

Many people cannot afford to receive care in a hospital, which makes **home-based care** a preferable option. Home-based care or home care involves medical or psychological support provided to symptomatic individuals in their homes or outside of a hospital setting. Home visits and monitoring by medical professionals and social workers may be included. Home care can involve counseling and death/dying/bereavement services.

Spiritual and Emotional Support can supplement counseling services and are sometimes more readily accessible than trained counselors in many communities. The majority of PLWHA seek spiritual support at some point during their illness. Support from religious institutions can help people face their fear of death and dying (For more on home care see Volume 3 of this series, *Home Care for PLWHA: The Power of Our Community*.)

Children (and young people) affected by HIV/AIDS are often referred to as **orphans and vulnerable children (OVC)** and can have complex psychosocial needs. They may feel distress due to caring for parents during a long illness and seeing them die. They may fear HIV/AIDS and fear dying too. They may experience economic hardship, poor nutrition, and poor health. They may be unable to attend school for various reasons. Young orphan girls are more vulnerable to sexual abuse and coercive sex. Training on how to cope with HIV/AIDS and how to provide practical support to parents, as well as bereavement and economic assistance can be helpful to vulnerable children and young people. Placement services may be needed if there is no extended family to support the children.

Living Positively with AIDS[35]

People can live positively with HIV/AIDS. Living positively starts with accepting that one has the disease, avoiding blame, and avoiding negative terms such as "AIDS sufferers or victims." Even though for many people being diagnosed with HIV/AIDS is considered a death sentence, a person can live many years before developing AIDS. Even in the absence of antiviral medications, there are many things people can do to stay healthy. Counselors can encourage clients to—

- Continue working
- Eat a balanced diet
- Get plenty of rest
- Socialize with friends and family
- Protect others from HIV infection
- Seek medical attention early for health problems
- Stay active mentally and physically
- Talk to someone about their diagnosis
- Give both physical and emotional affection
- Avoid isolation
- Become involved in HIV/AIDS prevention and care activities in the community
- Plan for the future with loved ones

Counselors should caution clients about use of alcohol and cigarettes, avoiding exposure to other infections such as TB and STIs (and getting prompt, appropriate treatment if exposed), and to avoid using un-prescribed drugs because these behaviors can weaken the immune system. Counselors should also discuss the importance of having safe sexual relationships, as re-infection with HIV should be avoided. Re-infections contribute to a weaker immune system.

Crisis Counseling

Crisis counseling involves helping people through an emotional crisis. A **crisis** exists when someone feels intensely threatened, surprised, or caught unaware by what is happening; or is emotionally disturbed as a result of loss of control and/or emotionally paralyzed because they can't see a way to solve the problem. A counselor must realize that the client may perceive different events as crises. Many people experience a crisis on learning they are HIV-positive. Counselors can begin helping a client through a crisis.

[35] "HIV/AIDS Care and Support Projects," AIDSCAP.

The following are things a counselor should/should not do.

A Counselor Should	A Counselor Should Not
• Be reassuring and supportive	• Tell clients they are "overreacting"
• Listen	• Be judgmental
• Comment on feelings, fear, or efforts to deal with the problem	• Give advice • Take offense
• Empower client in decision-making	• Feel that you can fix this person by yourself
• Help client maintain control	• Panic
• Remain calm	
• Accept the clients feelings as genuine	
• Gather resources, support from other professionals	

The stages of a crisis include 1) the blow, 2) the recoil, 3) withdrawal, and 4) acceptance. For example, if someone finds out they have HIV, they may first react with fear, realizing there is something wrong. Then the person recoils, struggling to come to terms with the diagnosis, and may seek a new test. Withdrawal may occur if the person isolates him/herself and tries to deal with his/her feelings. People may suffer from depression and anxiety. With psychosocial support, people can recover from a crisis without permanent loss of self-esteem and regain a sense of control. This signifies reaching the acceptance stage. The counselor should use counseling skills to guide the client through the crisis stages.

Bereavement Counseling

People usually experience grief when they learn that they or their partners, family member(s), or friend(s) are HIV-positive. Counselors must understand grief to help their clients through the phases. Grief is experienced in heart, mind and spirit, in a person's feelings, emotions, and thoughts. It can also be expressed physically. All levels of grief need nurturing, compassion, and patience. Grief occurs between diagnosis and death. People grieve when they anticipate their loss and try to prepare for loss of a loved one. After the death of a loved one, the person goes through a time of suffering, doubt, despair, etc. The person is trying to cope with their feelings and understand what happened. Grief can result from death but also from other things such as divorce or loss of health. A person who is grieving will experience many emotions such as shock, emotional release, depression, loneliness, sense of isolation, etc.

As previously discussed, there are many skills counselors can use with clients. For handling grief, the counselor must have excellent listening skills, show compassion and not judgment, avoid clichés (common phrases) such as “Time heals all wounds” or “She’s at peace now.” A counselor must also understand that each person’s grief is unique and that people will respond differently to the death of a loved one. Remember that the grief process is long and that the time to heal will vary for each person.

Spiritual Support

Spiritual support for people affected by HIV/AIDS can take many forms. Any support given by a faith community may be considered “spiritual support.” Counseling, support groups, clinical services, weekend retreats, etc. for PLWHA can be considered spiritual support. Spiritual support can be part of any intervention and focuses on answering questions about how God and religion relate to living with HIV/AIDS. Spiritual support can be given during support groups by helping participants to tap into spiritual resources in order to live happier and healthy lives.

Chapter 4, Section 4: Care, Coping, Social and Spiritual Support, and Counseling

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 4: Faith Community Responses to HIV/AIDS: Care and Counseling

Section 4: Care, Coping, Social and Spiritual Support, and Counseling

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**A Long Journey**	Small group discussions	Flipchart with questions for consideration	Active participation
1 hour	**Supporting PLWHA**	Brainstorming, Discussion	Markers, half sheets colored paper, tape, Inheritance documents, forms, or sample wills, sample memory book	Active participation
1 hour	**Supporting Orphans and Vulnerable Children**	Brainstorming, Discussion	Markers, half sheets colored paper, tape, handout of contact information on OVC groups, pictures of AIDS quilts, samples of children's drawings	Active participation

Chapter 4: Care and Counseling

Section 4: Care, Coping, Social and Spiritual Support, and Counseling

Activities and Handouts for Care, Coping, Social and Spiritual Support, and Counseling

- **A Long Journey**
- **Supporting PLWHA**
- **Supporting Orphans and Vulnerable Children**

Activity A Long Journey[36]

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

- Come to terms with one's own death in a non-threatening way
- Help people prepare for their own death
- Develop empathy for what PLWHA may be going through

Time allotted 30 minutes

Preparation Prepare a flipchart with the questions participants need to consider from Step 2 below.

Facilitation steps

1. Explain to participants that they are going to be divided into pairs. In each pair, one participant will be the talker and the other the listener. Then they will switch roles after 10 minutes and repeat the exercise.

2. Each person should consider the following situation. They should imagine they are going on a long journey in a month's time. (Do not suggest a place that they are traveling to—leave it vague.) They do not know when they will come back to their homes, if ever.

   Ask them to answer the following questions.

   - WHO would you like to speak to before you go?
   - WHAT would you like to say to each of them?
   - WHAT would you like to do before you go?
   - WHO would you trust to look after your land and possessions well, while you are gone?
   - HOW would you ensure that your wishes were fulfilled in your absence?
   - HOW will you ensure that your children are taken care of?

[36] Adapted from "Stepping Stones Manual."

3. The trainer may want to write the questions on a flipchart for easy reference during the activity. Tell the participants that after the first 10 minutes, the trainer will notify them so that they can swap roles.

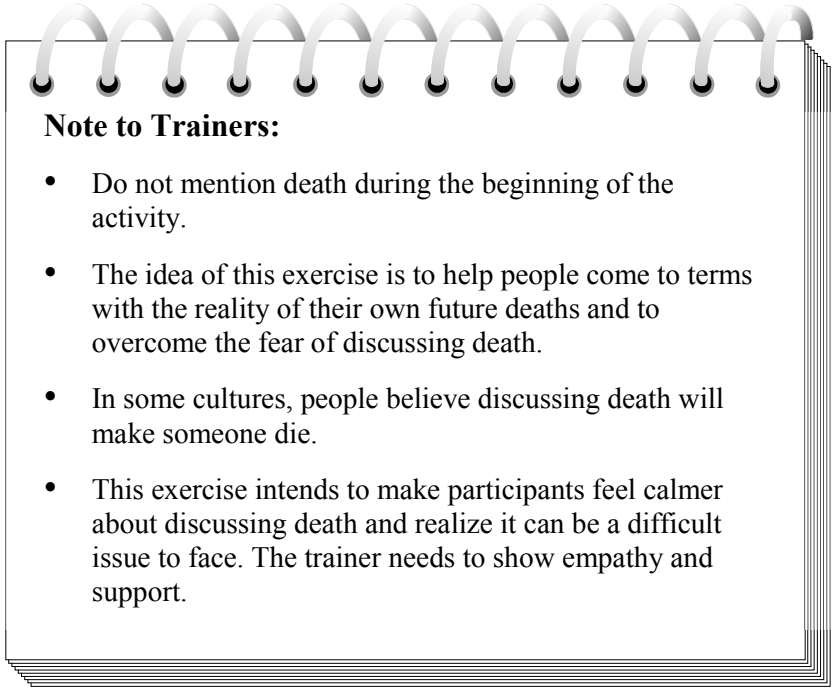
4. Participants should then divide into pairs and begin. After 10 minutes remind them to switch roles.

5. After 20 minutes (after both pairs have talked), call everyone back. Ask participants the following questions.

    - What did you learn from this exercise?
    - In what ways does it relate to real life?
    - Did they find the exercise scary? Helpful? Encouraging? Difficult?
    - How would they have felt if they had to go on the long journey tomorrow, without being given any notice?

Wrap-up

If participants have not yet related this exercise to their own deaths, do so now. Explain that we all have to die some day. This can be very frightening for many of us, but to be able to plan for a journey can often be much less terrifying than having to go with nothing prepared.



Note to Trainers:

- Do not mention death during the beginning of the activity.
- The idea of this exercise is to help people come to terms with the reality of their own future deaths and to overcome the fear of discussing death.
- In some cultures, people believe discussing death will make someone die.
- This exercise intends to make participants feel calmer about discussing death and realize it can be a difficult issue to face. The trainer needs to show empathy and support.

Activity Supporting PLWHA[37]

Objective By the end of this activity, participants will be able to—

- List some of the issues, anxieties, or fears that may confront PLWHA while thinking about their deaths and the future of their families
- List strategies for helping PLWHA to prepare to die with dignity
- Describe a "memory book"
- Describe the process for writing and registering a will according to local laws

Time allotted 1 hour

Preparation A week or more before this session, the trainer should spend some time exploring local laws around inheritance, making wills, and guardianship. Attempt to obtain any documents, forms, or sample wills that may help participants to understand the process for registering a will. In addition, work with local orphan care organizations to acquire a sample copy of a "memory book," or if that is not possible, the trainer can create a sample.

On the day of the session, arrange the chairs in a semi-circle around a blank wall. Give each participant a bright colored marker and several half-sheets of colored paper. The trainer may also wish to tear many pieces of tape and array them along the wall to facilitate the taping during the session. (The trainer may want to make copies of the handouts for "Supporting PLWHA" as a reference for participants at the end of the session.)

[37] Adapted from CEDPA's HIV/AIDS Manual Series, Volume III, "Home Care for PLWHA: The Power of Our Community."

References: "AIDS: Palliative Care," UNAIDS Technical Update, October 2000; Susan Fox. *Investing in Our Future: Psychosocial Support for Children Affected by HIV/AIDS*." UNAIDS Case Study, (Geneva: July 2001); *World Health Organization AIDS Home Care Handbook.* (Geneva: WHO, 1993)

Facilitation steps

1. Refer to the previous exercise. It is often difficult for groups to speak openly about death and dying, but it is perhaps the most important and courageous discussion that a group can have in working with HIV/AIDS. Suggest that sometimes people avoid the topic of death, either because it is a cultural taboo, or because people somehow believe they are inviting death to come if it is discussed. Sometimes one thinks it is better to avoid discussing death because one fears that it will upset or depress PLWHA to talk about it. But in reality, most PLWHA spend a lot of time thinking about and possibly worrying about death, especially in the final stages of AIDS. Having the courage to share these thoughts and fears with PLWHA can relieve the isolation that they may feel in confronting their own deaths.

2. Sometimes it can be difficult to know when to begin to discuss death and dying with PLWHA and OVC. Suggest that it is important to emphasize that they are planning for a time that may be far or near, and not suggesting that death is coming quickly. It may be difficult to decide when to shift from images of life and hope to a discussion of acceptance and dying with dignity.

   Some signs in PLWHA might include—

   - When medical treatment is no longer available or is no longer effective

   - When the PLWHA says he or she is ready to die (It is important to differentiate between someone who is ill and accepting death and someone who has been depressed and is clearly not that sick. The latter should be encouraged not to give up and should be helped to manage their depression)

   - When the body's vital organs begin to fail

3. Suggest that many in this group may have had personal experiences with the deaths of those closest to them. Perhaps they have lived with or cared for someone in the final stages of AIDS or another terminal illness. Perhaps some are HIV-positive and sometimes worry about what will happen to their loved ones when they die. No matter what an individual's relationship to death is, there is a great deal of expertise in this group that may help the group to think through strategies for supporting PLWHA as they strive to die with dignity.

4. Ask participants to take a moment to think about the different issues that may be of importance to PLWHA as they think about their own deaths and as they think about the future of their families after they die.

- What issues may be uppermost in their minds as they prepare to say goodbye?

- What anxieties or fears might they have in the face of death?

5. Have participants write down every issue that they think of on a separate half-sheet of paper. They should continue to write new cards until they have exhausted all ideas.

6. When participants seem to have finished, invite them to come up and tape their cards to the blank wall.

7. When all cards are along the wall, invite participants to take 15 minutes to read all of the ideas presented. If they see any similarities in the cards, they should feel free to move them around on the wall to arrange them in logical groups. They should also feel free to add any ideas using new cards.

   Although each group may have totally different ideas, possibilities might include—

   - Fear of a painful death

   - Possibility that there is no afterlife; that "this is it"

   - Feeling like there is so much "unfinished business"

   - Sadness at missing key moments in the lives of their children or families

   - Worries about money or resources

   - What will happen to the children? Worries about the children becoming orphans or street children

   - Fear that they will not be remembered, that their lives were meaningless

   - Worry that they will not have a chance to say goodbye

   - Fear that they will not go to heaven

   - Worry that there will not be enough money for a proper funeral

8. After 15 or 20 minutes, ask participants to take their seats. Ask the group which ideas stood out for them, which need more clarification and so forth.

9. Lead a large group discussion around the ideas on the wall—reading a few and then discussing them with the group. Throughout the discussion, ask participants to consider any **strategies that they might employ as spiritual counselors to support PLWHA** with these issues. List these strategies on a flipchart.

   Possible strategies include the following.

   - Listening. Allow PLWHA to feel comfortable talking with you about their thoughts about death and dying. Although it may be uncomfortable at first, it will be easier as you go along, and it may be a great comfort to PLWHA.

   - Arrange visits with a spiritual leader of the PLWHA's faith if they are of a different faith. Spirituality, prayer, and meditation may be especially important for PLWHA at this time.

   - Arrange visits with a trained counselor if the PLWHA would feel more comfortable talking with someone outside of their faith.

   - Put the PLWHA into contact with a support group. As the participants in a support group are often confronting the same issues, the PLWHA may feel more comfortable discussing these issues in such a group.

   - Gather information about local inheritance laws and share that knowledge with the PLWHA. Work together to develop a plan for the inheritance of any property. This may involve writing a will together or putting the PLWHA in touch with someone to help him or her write and register a will. (At this point, distribute any copies of inheritance laws, documents, sample wills, and so forth. Briefly discuss these documents and anything you might have found out about the inheritance process.)

   - Encourage the PLWHA to talk with their children about their deaths. People often try to avoid talking with children about death or allowing them to express their feelings about death—usually because it is assumed that children will not understand death, because there is a fear that children will be frightened, or because it makes adults uncomfortable. This is a mistake that may lead to feelings of guilt, depression, confusion, loss of control, anxiety, or fear in the children. Talking about death and dying can be a positive experience for both PLWHA and OVC. It gives both the opportunity to say goodbye, to ask questions, to give advice for the future, and to help the children to begin to let go. It is often said that the best person to prepare a child for a parent's death is that parent.

- Suggest that the PLWHA work with their children in choosing a guardian(s). The PLWHA can use the time while they are still healthy to discuss guardianship with the extended family, to choose the guardian(s), and even to allow the child to spend some days or weeks with the guardian(s). Planning for the future in this way can ease anxiety for the PLWHA, OVC, and the entire extended family and can lead to a smoother transition for the children upon the parent's death.

- Encourage the PLWHA to create a Memory Book for their children. Originating in Uganda, the Memory Book is a journal of facts and memories for children who are facing the loss of a parent. The Memory Book is a way for the parent to impart important memories to the children—about the history of the family, facts about the parent(s), family traditions, favorite memories, and so forth. It can include stories, pictures, photographs, or anything else, under headings such as "My favorite memories of you," "How I met your father," "Family traditions and events," "Special family recipes," and so on. The Memory Book is a comfort to the PLWHA because it is a way for them to live on in their children's memories. It is a comfort to the OVC because it increases the children's sense of belonging and allows children to keep family memories alive even if they must relocate to another area. PLWHA can either, complete the Memory Book on their own and then discuss it with the children, or the PLWHA and OVC can create the books together. It is important that the Memory Book be discussed with the children while the parent is still alive, so that the children can ask questions about the family history, talk about loss or feelings of grief, and seek advice. The Memory Book can also be a way to disclose HIV status to the children or to talk with them about HIV prevention for themselves. (If a sample Memory Book is available, pass it around for the participants to see it during this discussion.)

In the final stages of dying—

- Encourage communication with the family and community. Help the PLWHA to use this time to say goodbye, to heal old wounds, to give advice to children, and so on

- Provide physical contact by touching, hugging, and holding hands

- Arrange for counseling or spiritual guidance

- Help the PLWHA to stay as independent as possible

- Accept the person's own decisions such as refusal to eat or get up
- Respect requests, for example, regarding visitors
- Ask them what they are feeling. Listen and allow the person to talk about how they feel
- Accept the person's feelings of anger, fear, grief, and other emotions
- Work with the PLWHA on funeral arrangements and other last-minute preparations that may ease anxiety about what will happen after he or she dies

Wrap-up

Summarize this segment of the session by asking for any final comments about supporting PLWHA in managing death and dying. Suggest that these issues are perhaps the most difficult and the most crucial of the many responsibilities as spiritual counselors for PLWHA. Successfully managing this difficult period for PLWHA requires the support of the entire community, and faith-based organizations are uniquely situated to motivate their congregations to this mission. Hand out "Supporting PLWHA" from pages 4-223 to 4-226, as a reference.

Inform the participants that the next discussion will be on working with OVC after the loss of their parent(s).

Handout

Supporting PLWHA

It is often difficult for groups to speak openly about death and dying, but it is perhaps the most important and courageous discussion that a group can have in working with HIV/AIDS. Sometimes people avoid the topic of death, either because it is a cultural taboo or because they somehow believe that they are inviting death to come if they discuss it. Sometimes people think it is better to avoid discussing death because they fear it will upset or depress PLWHA to talk about it. But in reality, most PLWHA spend a lot of time thinking about and possibly worrying about death, especially in the final stages of AIDS. Having the courage to share these thoughts and fears with PLWHA can relieve the isolation that they may feel in confronting their own deaths.

Sometimes it can be difficult to know when to begin to discuss death and dying with PLWHA and OVC. It is important to emphasize that they are planning for a time that may be far or near and not suggesting that death is coming quickly. It may be difficult to decide when to shift from images of life and hope to a discussion of acceptance and dying with dignity. Some signs in PLWHA might include—

- When medical treatment is no longer available or is no longer effective
- When the PLWHA says he or she is ready to die (it is important to differentiate between someone who is ill and accepting death and someone who has been depressed and is clearly not very sick. The latter should be encouraged not to give up and should be helped to manage their depression)
- When the body's vital organs begin to fail

Many in this group may have had personal experiences with the deaths of those closest to us. Perhaps you have lived with or cared for someone in the final stages of AIDS or another terminal illness. Perhaps you are HIV-positive and worry about what will happen to our loved ones when we die. No matter what our relationship to death is, there is a great deal of expertise in this group that may help us to think through strategies for supporting PLWHA as they strive to die with dignity.

Take a moment to think about the different issues that may be of importance to PLWHA as they think about their own deaths and as they think about the future of their families after they die. What issues may be uppermost in their minds as they prepare to say goodbye? What anxieties or fears might they have in the face of death?

Some possibilities might include—

- Fear of a painful death
- Possibility that there is no afterlife; that "this is it"
- Feeling like there is so much "unfinished business"

Supporting PLWHA, continued

- Sadness at missing key moments in the lives of their children or families
- Worries about money or resources
- What will happen to the children? Worries about the children becoming orphans, street children, and so forth
- Fear that they will not be remembered that their lives were meaningless
- Worry that they will not have a chance to say goodbye
- Fear that they will not go to heaven
- Worry that there will not be enough money for a proper funeral

Consider any strategies that might be employ as spiritual counselors to support PLWHA with these issues. Possibilities include—

- Listening. Allow PLWHA to feel comfortable talking with you about their thoughts about death and dying. Although it may be uncomfortable at first, it will be easier as you go along, and it may be a great comfort to PLWHA
- Arrange visits with a spiritual leader of the PLWHA's faith if they are of a different faith. Spirituality, prayer, and meditation may be especially important for PLWHA at this time
- Arrange visits with a trained counselor if the PLWHA would feel more comfortable talking with someone outside of their faith
- Put the PLWHA into contact with a support group. As the participants in a support group are often confronting the same issues, the PLWHA may feel more comfortable discussing these issues in such a group
- Gather information about local inheritance laws and share that knowledge with the PLWHA. Work together to develop a plan for the inheritance of any property. This may involve writing a will together or putting the PLWHA in touch with someone to help him or her write and register a will. (At this point, distribute any copies of inheritance laws, documents, sample wills, and so forth. Briefly discuss these documents and anything you might have found out about the inheritance process).

Supporting PLWHA, continued

- Encourage the PLWHA to talk with their children about their deaths. People often try to avoid talking with children about death or allowing them to express their feelings about death, usually because it is assumed that children will not understand death, because there is a fear that children will be frightened, or because it makes adults uncomfortable. This is a mistake that may lead to feelings of guilt, depression, confusion, loss of control, anxiety, or fear in the children. Talking about death and dying can be a positive experience for both PLWHA and OVC. It gives both the opportunity to say goodbye, to ask questions, to give advice for the future, and to help the children to begin to let go. It is often said that the best person to prepare a child for a parent's death is that parent
- Suggest that the PLWHA work with their children in choosing a guardian(s). The PLWHA can use the time while they are still healthy to discuss guardianship with the extended family, to choose the guardian(s), and even to allow the child to spend some days or weeks with the guardian(s). Planning for the future in this way can ease anxiety for the PLWHA, OVC, and the entire extended family and can lead to a smoother transition for the children upon the parent's death
- Encourage the PLWHA to create a Memory Book for their children. Originating in Uganda, the Memory Book is a journal of facts and memories for children who are facing the loss of a parent. The Memory Book is a way for the parent to impart important memories to the children, about the history of the family, facts about the parent(s), family traditions, favorite memories, and so forth. It can include stories, pictures, photographs, or anything else, under headings such as "My favorite memories of you," "How I met your father," "Family traditions and events," "Special family recipes," and so on. The Memory Book is a comfort to the PLWHA because it is a way for them to live on in their children's memories. It is a comfort to the OVC because it increases the children's sense of belonging and allows children to keep family memories alive even if they must relocate to another area. PLWHA can either, complete the Memory Book on his or her own and then discuss it with the children; or PLWHA and OVC can create the books together. It is important that the Memory Book be discussed with the children while the parent is still alive, so that the children can ask questions about the family history, talk about loss or feelings of grief, and seek advice. The Memory Book can also be a way to disclose HIV status to the children or to talk with them about HIV prevention for themselves. (If a sample Memory Book is available, pass it around for the participants to see it during this discussion)

In the final stages of dying—

- Encourage communication with the family and community. Help the PLWHA to use this time to say goodbye, to heal old wounds, to give advice to children, and so on
- Provide physical contact by touching, hugging, and holding hands
- Arrange for counseling or spiritual guidance
- Help the PLWHA to stay as independent as possible
- Accept the person's own decisions such as refusal to eat or get up
- Respect requests, for example, regarding visitors
- Ask them what they are feeling. Listen and allow the person to talk about how they feel
- Accept the person's feelings of anger, fear, grief, and other emotions
- Work with the PLWHA on funeral arrangements and other last-minute preparations that may ease anxiety about what will happen after they die

Activity Supporting Orphans and Vulnerable Children[38]

Objective By the end of this activity, participants will be able to—

- List some issues, anxieties, or fears that may confront OVC upon the loss of their parent(s)
- List strategies for helping OVC to heal psychologically and emotionally after the loss of their parent(s)
- List strategies for supporting OVC material and social needs after the loss of their parent(s)
- Describe an "AIDS Quilt"

Time allotted 1 hour

Preparation About a week before this session, it will be useful to explore all the local and national support systems for OVC. Find out about any support groups, camps, community organizations, and other organizations that work with orphaned children, and prepare a handout of contact information for the group. In addition, attempt to acquire a panel of an AIDS quilt to use as a sample or, if that is not possible, collect photographs of AIDS quilts to use as samples. Finally, samples of children's drawings (from local orphan care organizations) would be useful examples during the session.

The room arrangement and supplies will be the same as with the first half of the session. Chairs should remain arranged in a semi-circle around a blank wall (although half of it should now be covered with the papers from the PLWHA exercise). Ensure that each participant receives a bright colored marker and several half-sheets of colored paper. Use a different color to the one used for the PLWHA exercise. It will be useful to tear off many pieces of tape and array them along the wall to facilitate the taping during the session. (The trainer may want to make copies of the handouts for "Supporting Orphans and Vulnerable Children" on pages 4-232 to 4-234, as a reference for participants at the end of the session.)

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[38] Adapted from CEDPA's HIV/AIDS Manual Series, Volume III, " Home Care for PLWHA: The Power of Our Community."

References: Tamara Aboagye-Kwarteng and Rob Moodie, ed., "Community Action on HIV," Australian Agency for International Development. April 1995; Susan Fox, "*Investing in Our Future: Psychosocial Support for Children Affected by HIV/AIDS*."

Facilitation steps

1. After completing the discussion around support for PLWHA during death and dying, indicate that this session will focus on caring for OVC after the loss of their parent(s). (It may be useful to explain the acronym OVC-Orphans and Vulnerable Children.)

   Suggest that as spiritual counselors, their roles continue after the death of PLWHA, as they strive to help the families overcome their grief, manage financial and other arrangements, and transition the children into new homes and situations.

2. Ask participants to take a moment to think about the different issues that may be of importance to OVC after the loss of their parent(s).

   - What issues may be uppermost in their minds after their parent dies?
   - What anxieties or fears might they have?
   - What material or social needs might they have?

3. Suggest that participants write down every issue that they can think of on a separate half-sheet of paper. They should continue to write new cards until they have exhausted all ideas.

4. When participants seem to have finished, invite them to come up and tape their cards to another section of the blank wall.

5. As in the last exercise, when all cards are along the wall, invite participants to take 15 minutes to read all of the ideas presented. If they see any similarities in the cards, they should feel free to move them around on the wall to arrange them in logical groups. They should also feel free to add any ideas using new cards.

   Although each group may have totally different ideas, possibilities might include—

   - Sadness, grief, or anger at the loss of the parent(s)
   - Fear or anxiety about their care. Who will feed them? Where will they live? Who will take care of their school fees? Will their new guardian(s) be kind or cruel?
   - Worry that relatives will snatch their property or anything left to them by their parents
   - Fear about the future

- Stigma or discrimination from the community because their parent(s) died of AIDS. Anxiety that the community will think they are also infected with HIV

- Fear about being infected with HIV or worry that they, too, will die of AIDS

- Nightmares or bad memories of parent's illness and death

6. After 15 or 20 minutes, ask participants to take their seats. Ask the group which ideas stood out for them, which need more clarification, and so forth.

7. Lead a large group discussion around the ideas on the wall—reading a few and then discussing them with the group. Throughout the discussion, ask participants to consider any **strategies that they might employ as spiritual counselors to support OVC** with these issues. List these strategies on a flipchart.

   Some possibilities include the following.

   - Offer to help the extended family make any arrangements for the funeral or for the transitioning of the children. Invite the children's new guardian(s) to accept your help and continued counseling. Since you were involved in the counseling of the parent(s) during the time of illness and death, you may be an important link to the parents' memory for the children during this transitional period and thereafter.

   - Visit the children's new home as often as you can or as often as is appropriate. Offer to help with practical matters or just spend time listening to the needs of the children or of the extended family.

   - Where possible, mobilize the community to assist in offsetting the cost of food, clothing, or school fees for the children. As much as possible, work with the community to provide resources so that children are able to remain with their extended families. Investing money and resources into the extended family can keep OVC from becoming street children, from involvement with crime or violence, or from having to exchange sex for food. But remember that **assisting only AIDS orphans and vulnerable children can create further stigmatization of OVC**. Attempt to involve *all children* in any special community support schemes.

- Provide connections to counselors, other spiritual advisors, or other support systems for the children to help them to manage their feelings of grief and sadness. Investigate any support groups for OVC and try to connect children to these groups. A parent's death can often leave children feeling a profound sense of loss, abandonment, and guilt. Children may require special emotional and psychological support to help them to manage these feelings.

- If life-skills camps, girls' clubs, boys' clubs, vocational training, or other opportunities exist in the community, help the children to become involved in them. Also, try to provide opportunities for the children to play or to "get away from it all."

- Talk to teachers or other school leaders to help them to better understand the situation. Helping teachers to understand the trauma suffered by the children can better prepare them to deal with any problems that may arise.

- Training programs or HIV/AIDS information sessions in schools, churches, with traditional healers, or in other venues may be helpful in changing community norms about HIV/AIDS. This may help reduce stigma and discrimination for OVC.

- Help OVC to understand how HIV is transmitted and assure them of their own HIV status. Answer any questions they may have about HIV/AIDS and offer to facilitate testing if necessary to relieve children's fear of being infected.

- Listen to the children's needs. Talk to them about their situation, their fear and anxieties, their hopes. Sometimes, especially with younger children, drawings can be helpful in evoking some of the grief and sadness they may wish to discuss. This can be as simple as inviting the child to draw a picture of their home life, or of their parent(s), and so forth. Ask the children to describe the picture to you, or ask specific questions about the picture to help the children to begin to open up. (At this point, show any samples you may have of children's drawings and guide the group through a discussion of the pictures.)

- Involve the children in decision-making about their futures. Ask them what they want to do about school, vocational training, play, and so forth, so that they can feel more in control of their own lives. Involving older children in the care of younger children can help them to feel more responsible and keep them from engaging in risky behavior.

- Give children many opportunities to talk about and to honor their lost parent(s). You may do this by looking through the Memory Book together, or you may work with the children to create an AIDS quilt. The children and/or remaining family members to memorialize the lost parent(s) create an AIDS quilt. It can be made out of anything—fabric or clothing that was special to the parent, photographs, favorite items, religious symbols, and so on—anything that evokes the lost parent and allows the children to honor them. You can use the time taken to work on the quilt to help children to talk about their parent(s), to discuss their feelings of grief and loss, and to help them to remember them. (At this point, show participants the AIDS quilt or pictures of AIDS quilts as an example.)

- Touch the children as often as you are comfortable with doing so and according to cultural and pastoral norms, for example, hugging, patting head or shoulder, letting them sit on your lap. Hugging and other forms of casual touch of PLWHA and OVC in public help to reduce stigma.

Wrap-up

Summarize the session by inviting any final comments or discussion regarding supporting OVC upon the loss of their parent(s). Suggest that these issues are perhaps the most difficult and the most crucial of our many responsibilities as OVC spiritual counselors. Successfully managing this difficult period for OVC requires the support of the entire community, and faith-based organizations are uniquely situated to motivate their congregations to this mission. Distribute handouts as reference.

Handout

Supporting Orphans and Vulnerable Children

The roles of spiritual counselors continue after the death of PLWHA, as we strive to help the families overcome their grief, manage financial and other arrangements, and transition the children into new homes and situations. Counselors can help orphans and vulnerable children to understand how HIV is transmitted and assure them of their own HIV status. Spiritual counselors must answer any questions they may have about HIV/AIDS and offer to facilitate testing if necessary to relieve children's fear of being infected.

Take a moment to think about the different issues that may be of importance to OVC after the loss of their parent(s). What issues may be uppermost in their minds after their parent dies? What anxieties or fears might they have? What material or social needs might they have?

Some possibilities include—

- Sadness, grief, or anger at the loss of the parent(s)
- Fear or anxiety about their care. Who will feed them? Where will they live? Who will take care of their school fees? Will their new guardian(s) be kind or cruel?
- Worry that relatives will snatch their property or anything left to them by their parents
- Fear about the future
- Stigma or discrimination from the community because their parent(s) died of AIDS. Anxiety that the community will think they are also infected with HIV
- Fear about being infected with HIV or worry that they, too, will die of AIDS
- Nightmares or bad memories of parent's illness and death

Consider any strategies that spiritual counselors could use to support OVC with these issues. Some possibilities may include—

- Offering to help the extended family make any arrangements for the funeral or for the transitioning of the children. Invite the children's new guardian(s) to accept your help and continued counseling. Since you were involved in the counseling of the parent(s) during the time of illness and death, you may be an important link to the parents' memory for the children during this transitional period and thereafter
- Visiting the children's new home as often as you can or as often as is appropriate. Offer to help with practical matters or just spend time listening to the needs of the children or of the extended family

- Where possible, mobilize the community to assist in offsetting the cost of food, clothing, or school fees for the children. As much as possible, work with the community to provide resources so that the children are able to remain with their extended families. Investing money and resources into the extended family can keep OVC from becoming street children, from involvement with crime or violence, or from having to exchange sex for food. But remember that **assisting only AIDS orphans can create further stigmatization of OVC**. Attempt to involve *all children* in any special community support schemes
- Providing connections to counselors, other spiritual advisors, or other support systems for the children to help them to manage their feelings of grief and sadness. Investigate any support groups for OVC and try to connect children to these groups. A parent's death can often leave children feeling a profound sense of loss, abandonment, and guilt. Children may require special emotional and psychological support to help them to manage these feelings
- If life-skills camps, girls' clubs, boys' clubs, vocational training, or other opportunities exist in the community, help the children to become involved in them. Also, try to provide opportunities for the children to play or to "get away from it all"
- Talking to teachers or other school leaders to help them to better understand the situation. Helping teachers to understand the trauma suffered by the children can better prepare them to deal with any problems that may arise
- Training programs or HIV/AIDS information sessions in schools, churches, with traditional healers, or in other venues may be helpful in changing community norms about HIV/AIDS. This may help reduce stigma and discrimination for OVC
- Helping the OVC to understand how HIV is transmitted and assure them of their own HIV status. Answer any questions they may have about HIV/AIDS and offer to facilitate testing if necessary to relieve children's fear of being infected
- Listening to the children's needs. Talk to them, about their situation, their fear and anxieties, their hopes. Sometimes, especially with younger children, drawings can be helpful in evoking some of the grief and sadness they may wish to discuss. This can be as simple as inviting the child to draw a picture of their home life, or of their parent(s), and so forth. Ask the children to describe the picture to you, or ask specific questions about the picture to help the children to begin to open up. (At this point, show any samples you may have of children's drawings and guide the group through a discussion of the pictures.)
- Involving the children in decision-making about their futures. Ask them what they want to do about school, vocational training, play, and so forth, so that they can feel more in control of their own lives. Involving older children in the care of younger children can help them to feel more responsible and keep them from engaging in risky behavior.

Supporting Orphans and Vulnerable Children, continued

- Giving children many opportunities to talk about and to honor their lost parent(s). You may do this by looking through the Memory Book together, or you may work with the children to create an AIDS quilt. The children and/or remaining family members create an AIDS quilt to memorialize the lost parent(s). It can be made out of anything—fabric or clothing that was special to the parent, photographs, favorite items, religious symbols, and so on—anything that evokes the lost parent and allows the children to honor them. You can use the time taken to work on the quilt to help children to talk about their parent(s), to discuss their feelings of grief and loss, and to help them to remember them. (At this point, show participants the AIDS quilt or pictures of AIDS quilts as an example.)
- Touching the children as often as you are comfortable with doing so and according to cultural and pastoral norms, for example, hugging, patting head or shoulder, letting them sit on your lap. Hugging and other forms of casual touch of PLWHA and OVC in public help to reduce stigma.

These issues are perhaps the most difficult and the most crucial of responsibilities as spiritual counselors for PLWHA and OVC. Successfully managing this difficult period for PLWHA and OVC require the support of the entire community, and faith-based organizations are uniquely situated to motivate their congregations to this mission.

Chapter 4: Care and Counseling

Section 4: Care, Coping, Social and Spiritual Support, and Counseling

Alternate Activities and Handouts for Care, Coping, Social and Spiritual Support, and Counseling

- **Formation of Home-Based Care Teams**
- **PLWHA and OVC Support Groups**
- **Disclosure of HIV Status to Children**
- **Disclosure of HIV Status to a Partner**

Activity Formation of Home-Based Care Teams

Objective

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

- Identify role of home-based care teams
- Identify skills needed on a home-based care team
- Identify qualities needed to participate in a home-based care team

Time allotted

30 minutes

Preparation

Flipcharts, markers

Facilitation steps

1. Introduce the session objectives. Ask participants to think about what kinds of assistance a PLWHA might need.

2. Ask if anyone has had experience in home-based care either for a PLWHA or another illness. What kinds of things did the person need (such as medical care, nutritional advice, someone to talk to, etc.)? Ask for examples of PLWHA needs and list them on a flipchart.

3. Ask participants to think about what the role of a home-based care team should be. What kinds of things should they do (e.g. provide physical care, counseling, etc.)? List the suggestions on a flipchart.

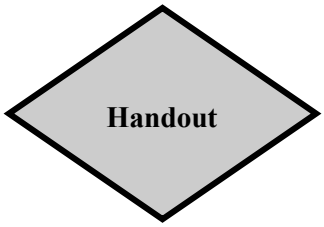
4. Ask participants to think about what kinds of skills or skilled persons would need to be included on a home-based care team (e.g. health care provider, knowledge of nutrition, minister/priest, knowledge of HIV transmission). List the answers on a flipchart.

5. Suggest that not everyone has the qualities to provide home-based care to PLWHA. What kinds of qualities would someone need to participate in a home-based care team (e.g. volunteerism, confidentiality, compassion, etc.)? List answers on a flipchart.

Wrap-up

Summarize the discussion and point out that relatives of PLWHA give most of the care and support, but can be assisted by home care volunteers. It is very important that someone *acceptable to the PLWHA* give the home-based care. To avoid stigmatization, any home-based care should be available to *anyone who is ill in the community*, not just PLWHA. Home-based care teams should come from within the community as much as possible. Faith-based groups are well placed within the community to facilitate the development of home-based care teams.

PLWHA and OVC Support Groups[39]

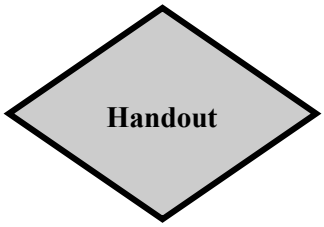


Support groups can help PLWHA and OVC overcome feelings of isolation and can provide an outlet for their fears and anxieties. Support groups can also provide valuable strategies for dealing with problems arising from being HIV-positive. In areas where there are active PLWHA groups, there also appears to be less of a stigma in the community around HIV/AIDS and VCT. Because parents can often be preoccupied with their own grief or with illness, it can often be difficult to provide enough support to their children. An OVC peer group can provide a forum for the children to discuss their fears openly with other children who are also affected by HIV/AIDS.

In situations in which you are the support person for PLWHA or OVC, try to remember these items.

- Actively listen without feeling that you always have to provide advice.
- Try to understand what the person is feeling, but don't assume you can understand fully.
- Ask questions.
- Respect people and their feelings but don't feel that you have to change them.
- Don't try to distance yourself from their pain by denying their emotions or providing advice; these messages imply that there is something wrong with the way the person is feeling and that you are uncomfortable dealing with their issues.
- Respect confidentiality.
- Provide correct information, admit when you do not know information, and offer to find out.
- Encourage PLWHA and OVC to use spiritual outlets for their pain and grief. Prayer, meditation, attending religious services, or speaking with a spiritual advisor can all help in finding answers to the difficult questions around life and death and can bolster one's feelings of power and hope during the battle with HIV/AIDS.
- Try not to become impatient or angry. If you feel yourself losing patience, acknowledge that as a PLWHA or OVC counselor, you will also need support and a respite from these issues.
- Offer to help. This may include helping with physical ailments, picking up supplies or food, helping with the children or with household chores, or helping PLWHA to plan for the future.

[39] Adapted from CEDPA's HIV/AIDS Manual Series, Volume III, "Home Care for PLWHA: The Power of Our Community."



Disclosure of Parent's HIV Status to Children[40]

Parents must overcome many barriers and taboos to disclose HIV status to children. These may include the stigma associated with HIV/AIDS itself or traditional rules that discourage adults from discussing death with those younger than themselves. Parents may wish to avoid the embarrassment that comes with discussing HIV/AIDS and potential questions about how they became infected. As there may also be fear in some societies around bewitchment, parents may also wish to protect their children by keeping their status a secret. Parents may debate whether disclosing their status will help or hurt their children. Working with traditional healers and perhaps training them to serve as counselors for HIV/AIDS can reduce stigma around bewitchment.

- Parents must come to accept their HIV status before they can feel comfortable guiding their children through the news.
- Parents should be aware that children might suspect their illness and maybe even their HIV-positive status. Children are keen observers, but often do not know how to interpret what they see. Consequently, children may fear that the illness is much worse than it is or that they themselves have caused their parent's illness. Children may fear that their parent may die immediately. It is important to make some decision about disclosure to children early on. This should be made before the parent's illness begins to cause anxiety in the child that may manifest itself in the child's performance at school, behavioral problems, or the child's overall wellness.
- The child's age may figure in to whether or not the parents choose to disclose their status to them. Children who are seven years old are usually mature enough to understand death and they may have heard about HIV/AIDS by that time. Often, children at this age do not yet understand the stigma and discrimination around HIV/AIDS.
- Discussing HIV infection and transmission with all family members, including children, can help them to protect themselves from potential infection that may come from caring for their sick relative.
- It is important to remember that it is the PLWHA's decision to disclose their status to their children. As a counselor, you may provide the PLWHA with as many facts and as much support as you can, but ultimately, it is an intimate and personal decision. It is the parent's right to choose how and when to disclose their status to their children, and you can help them to understand the affect that disclosure or non-disclosure may have upon the children.

[40] Adapted from CEDPA's HIV/AIDS Manual Series, Volume III, "Home Care for PLWHA: The Power of Our Community."

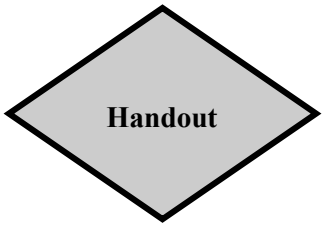
Disclosure of Parent's HIV Status to Children, continued

Once parents decide to disclose their status to their children, it is important that they emphasize that—

- Their HIV infection is not their child's fault, nor is any other illness that comes from that infection
- They clarify what their HIV status means including issues around death, what will happen to the children if they die, and so on. Children should be educated about the disease's progression, so that they will understand that their parent(s) can live healthily with the virus. As much as possible, parents should emphasize a hopeful outlook so that they will fight to live positively with HIV/AIDS
- They remember that the entry of HIV/AIDS into a household can often substantially change the child's role in the family. Children may become caregivers for the sick, may have to take on additional housework or income generation responsibilities, and may suffer withdrawal from school or other youthful pursuits
- They reassure the child that being HIV-positive does not mean that the child is infected or will become infected. Encourage VCT if available to ease fears

The best person to prepare a child for the death of a parent is that parent. Many adults believe that not talking to children about death is a way of protecting the child, but in fact, it is often a way of protecting the adults from a painful discussion. It is important to remember that even if an adult is not talking to a child about death and illness, they are still communicating about it—but in a negative way. It is important to keep the lines of communication open with children about HIV/AIDS so that they can continue to feel included and sure of the situation as the disease progresses and as the circumstances of their lives change.

Disclosure of HIV Status to a Partner[41]



It is important to disclose status to one's partner(s) so that the couple can prevent infection or re-infection, plan for the future of the family, and attempt to avert mother-to-child HIV transmission. Sometimes the very decision to test can suggest problems with trust in the relationship or can be construed as an admission of risky sexual behavior. As such, clients may fear that disclosure of HIV results will call the relationship into question.

- Women may feel that they need permission from their sexual partners to take the HIV test. Taking the test without their partner's consent and then disclosing positive results can lead to fear of violence or rejection for the female partner. In addition, those tested are far more likely to disclose their test results if their partner knows beforehand that they are going to take the test. Therefore, outreach efforts aimed at education around HIV/AIDS might begin to target strategies for communicating with one's partner about the HIV test.
- Violence can often be a very real part of life for female clients and, as such, the possibility of it should be addressed during the VCT session and beyond. Women may often need a great deal of support to deal with the issue of violence around disclosure of HIV status. Religious institutions can work to change cultural norms and sanction partner violence in the community.
- Greater community awareness of HIV and the presence of support groups often make it easier for a person to disclose their HIV status to a partner. As such, community programs to target stigma and discrimination around HIV/AIDS can help reduce the anxiety around disclosure.
- Although many women fear being blamed for the result or may worry about physical abuse or abandonment, studies seem to indicate that reactions are usually not so negative. Despite this research, some woman may still be in a risky situation around disclosure of results, so the counselor should work with all women to create safe disclosure strategies. Counselors should also keep in mind that they should encourage, but not force disclosure, as only the woman involved truly understands the reactions that may accompany such disclosure.
- Because of the risk of violence in the lives of (especially) women, counselors should be trained to ask questions about partner violence, to honor client confidentiality, and to strategize about safe disclosure plans.
- Pastors and other religious leaders may be asked to assist someone in disclosing his/her HIV status to a partner.

Working on community interventions to change norms around violence, as well as legal recourse for the victims of violence, may be the most powerful tools in supporting those who wish to disclose their HIV status to their partners. Faith-based organizations are uniquely positioned to have an impact in these areas.

[41] Adapted from CEDPA's HIV/AIDS Manual Series, Volume III, "Home Care for PLWHA: The Power of Our Community."

Chapter 5

HIV/AIDS Education and Outreach

"The purpose of all ministry, including AIDS ministry, is to represent God's love for all humanity, without condition, and to embody and express that love in all human relationships… The prospect for relationship is significantly lessened when the first priority is seen to be that of convincing people that they are evil or that their behaviors are wrong."

—*Earl E. Shelp and Ronald H. Sunderland*

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Faith Community Responses to HIV/AIDS

Chapter 5: HIV/AIDS Education and Outreach

Chapter 5: HIV/AIDS Education and Outreach

Key Questions

- What types of media are used to disseminate messages about HIV/AIDS?
- What are appropriate messages that faith communities can send to their members?
- How can faith communities integrate HIV/AIDS messages into sermons, speeches, and prayers?
- How does one create a good message to teach people about HIV?

Introduction[42]

Chapter 4 discussed how people might provide support to others living with HIV/AIDS through counseling. In addition to educating people on HIV/AIDS transmission, prevention and care, and treatment, counseling specifically addresses emotional challenges that come with HIV/AIDS.

Apart from or in addition to counseling, faith communities may also want to help educate their congregations and even the broader community about HIV/AIDS. Some examples of AIDS education are [43]—

- Offering AIDS-awareness forums for adults
- Including AIDS awareness in the church curriculum
- Offering Bible study classes on AIDS-related issues

[42] Rueben Granich, M. D., M.P.H. and Jonathan Mermin, M. D., M.P.H., *HIV, Health and Your Community: A Guide for Action* (Stanford*:* Stanford University Press, 1999).
[43] AIDS National Interfaith Network, "The AIDS Ministry Handbook: A Resource Guide for Faith Communities and AIDS Ministries," Washington, DC, June 1994.

- Using AIDS-awareness items in the congregation's bulletin/newsletter
- Offering the use of church facilities for gatherings on HIV/AIDS
- Offering HIV/health education in conjunction with clinical facilities
- Including AIDS issues in training lay people
- Holding special activities such as "AIDS Sabbath"
- Providing AIDS training for staff members
- Providing AIDS literature in the church's library/resource room
- Supporting an AIDS workshop for other local churches
- Supporting an AIDS conference for the broader community

Information, education and communication (IEC) campaigns and outreach are education techniques that are used to disseminate educational messages to a greater number of people in the community. This chapter focuses on how to develop IEC messages and to integrate HIV/AIDS themes into sermons, prayers, statements, and other religious media.

Also, individual churches can influence the governing bodies of their national churches or churches from all denominations in their city or geographic area to advocate for all of the above. Efforts of a single pastor in a local church can be strengthened and multiplied by influencing other councils or governing bodies of churches to take a specific action.

Chapter 5: HIV/AIDS Education and Outreach

Section 1: IEC—Developing Messages

Objectives

By the end of this class, participants will be able to—

- Describe the components of IEC campaigns
- Identify the pros and cons of mass media campaigns
- Select media that can be used to educate on HIV/AIDS
- Develop a media message, including identifying target audience, message objective/action, tone, presentation and benefits
- Define outreach

Overview

IEC Programs and Message Development

Professional IEC programs usually use a variety of media to disseminate messages to the community. When developing an IEC campaign, specialists try to get a sense of what the community's current level of HIV/AIDS knowledge is. This can be done from looking at data from the Ministry of Health, Demographic and Health Surveys (DHS), non-governmental governmental or community-based organizations, universities, religious denominational offices, groups/associations, health facilities or research groups. They may also conduct a survey of community members to assess their knowledge of HIV/AIDS and related services.

Faith-based groups can use or adapt many of these strategies and community resources to educate and inform congregations, such as involving members in taking a survey of HIV knowledge and attitudes among parishioners. IEC can be a powerful tool in spreading messages of "compassion, love, healing and hope that can break through the judgment, shame and fear so often associated with HIV/AIDS."[44]

There are several steps to follow in creating an IEC campaign—

- Decide if you want to educate the congregation about HIV/AIDS (based on need)
- Determine the audience (whom you want to reach)
- Determine what the message will be (what you want to say)
- Determine the medium (the way the information will be presented)

Examples of **audiences** within the congregation could include youth groups, men's leadership groups, bible study groups, women's groups, etc. Wider audiences could include interfaith groups, that is, members of different churches in the area. **Messages** that a pastor might want to communicate to church members may range from dispelling myths about modes of HIV transmission to informing the congregation that the church supports those with HIV/AIDS. **Medium** could be anything from a printed material such as a church bulletin or newsletter, to sermons from the pulpit or speeches in formal gatherings, to songs or dramatic presentations.

[44] African Religious Leaders Assembly on Children and HIV/AIDS, "Plan of Action," Nairobi, Kenya, 9-12 June 2002.

Audience, medium and message need to be kept in mind when developing an IEC campaign. For example, if the audience is a woman's group that includes pregnant women, it might be useful to reach them in cooperation with a health center with messages about mother-to-child transmission. The medium could be a group discussion, poster, role-play, or a flyer. For young audiences, messages from music performers, movie stars, and sport stars are more persuasive. Religious institutions and leaders have a great deal of credibility with their members; messages coming from them can be powerful and influential. The best target audience for IEC efforts may be groups within the congregation that you have worked with in the past.[45]

Messages should contain the following parts—

- **Content:** What is being said.
- **Objective/Action:** What you want the target audience to do as a result of this message.
- **Presentation:** How it is being said.
- **Tone:** The message's mood (happy, serious, inspiring, hopeful, solemn, intimate).
- **Benefits:** What the person will gain from learning the information.

When developing messages, one must consider the target audience's reaction to the message. One should determine if the message works with the audience through pretesting or formative research, before the message is circulated widely. A **focus group** is a group of people from the congregation, which is invited to help develop a message. A focus group may be used prior to message development. For example, church youth group members may be asked what is the best way to get messages to people in that particular age/sex group. Focus groups also may be used after a message has been developed to help determine if the words, pictures, and message tone are being interpreted as intended. Repeated focus groups may be used to fine-tune messages. Also it may be useful to ask health professionals to provide input and to review materials for technical accuracy.[46] Although testing messages may initially be costly, producing high-quality materials in large volume will be more cost-effective over time.

Alternatively, faith-based groups may want to use materials that have already been developed by health professionals or NGOs working in HIV/AIDS. It may be cost effective to work with these groups to adapt their materials for use with specific groups in your congregation.

An important thing for faith-based groups to remember is to maintain **confidentiality of PLWHA** in developing and delivering messages about HIV/AIDS, because of the stigma and discrimination surrounding HIV/AIDS. Be sure to use fictitious characters and situations in dramas and role-plays. Never identify someone as living with HIV in sermons or discussion groups, unless they themselves wish to testify to others.

[45] AIDSCAP, n.d.
[46] Piotrow 1997

Message Dissemination

In addition to developing a message, a decision must be made as to how to get it out to people and whether the audience is just those in the congregation or the wider community. This may happen at the same time as with message development. Knowing what media will be used will influence the message and vice-versa. Examples of **message media** used by professional IEC campaigns include—

- Hotlines
- Television
- Radio
- Pamphlets
- Posters
- Billboards
- Community theatre AIDS days and fairs
- Newspaper articles
- Videos and films
- Bumper stickers
- Puppet shows
- Letters
- T-shirts
- Using famous people

Print media (newspapers and magazines) and broadcast media (television and radio) are common choices for message dissemination. They are known as "**mass media**" because they can reach large numbers of people. Newspaper stories and television shows on HIV/AIDS teach people and make the stories personal, often changing peoples' attitudes about others living with HIV/AIDS.

Within your religious organization, newsletters or bulletins may be the print media available or you may want to write articles for the local newspaper. If your institution has access to radio or television, that media may be an excellent way to reach members and the wider community, with specific faith-based messages of compassion and acceptance of PLWHA. Television and radio have the advantage of reaching more people because they do not require the audience to be literate. There are several pros and cons that go with using mass media (See handout on page 5-257). Mass media messages work better if they are specifically targeted, have an acceptable presentation format, clear message, suggest to people that they take action, and connect people with other programs that are available in the community.

Media can be combined to be more effective; for example, a song or sermon may be combined with a discussion group, pamphlets, and posters.

Outreach

Outreach involves person-to-person contact in the community. Many faith-based organizations have well-developed networks of outreach workers in their congregations. Outreach workers (also may be known as community workers) talk with people and often use other forms of communication media such as pamphlets, drama, and posters. Talking to people about HIV/AIDS reinforces other messages they hear through print, radio, TV, song, etc. Outreach workers act as role models and can inspire people in the community to teach each other about preventing HIV and to treat people affected by HIV/AIDS with compassion and caring.

An advantage of using outreach workers is that they meet and talk with people in homes, places of work, community centers, parks, bars, schools, churches, etc. Some people will be more comfortable with this than going to a church function, health center or hospital to get information. By reaching people in familiar comfortable settings, talking with them personally, and offering information on HIV/AIDS, including where to get tested, and how to change behaviors, outreach workers can make a difference and help to break down stigma and fear associated with HIV.

Many churches already have "ministries of outreach" within their congregations, groups that visit the sick or help families in need that may be recruited and trained to disseminate HIV/AIDS messages within their congregation and to the wider community. They may be compensated for their work or may be volunteers. Usually, volunteers will be retained if they are given incentives (such as t-shirts, bicycles, certificates, food, etc.). Some volunteers may need no material compensation; they stay on due to supportive supervision, commitment to the church, and to obtaining results.

Chapter 5, Section 1: IEC – Developing Messages

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC— Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC— Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 5: HIV/AIDS Education and Outreach

Section 1: IEC – Developing Messages

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
45 minutes	**Introduction to IEC and Message Development**	Lecture, group work	Flipcharts, handouts, posters, video clips, etc.	All message components correct
45 minutes	**Developing Media Messages**	Group work	Flipcharts, handouts	All message components correct

Important Terms

Audience	Who the message targets and benefits
Benefits	What the person will gain from learning the information
Content	What is being said
Focus Group	A group of people from the community who are invited to help develop a message; a focus group may be used prior to, during and after message development
Mass Media	Media that can reach large numbers of people, such as print and broadcast media, i.e. newspapers, pamphlets, television, radio, video
Medium	What you are using to get across your message
Message	What you are trying to communicate
Objective/Action	What you want the target audience to do as a result of this message
Outreach	Involves person-to-person contact in the community
Presentation	How the message is being said (i.e. poster, radio spot, video)
Target Audience	The specific group you want to reach with a message, (For example, in a youth group, young girls between 10 and 15 years of age)
Tone	The mood of the message (happy, serious, inspiring, hopeful, solemn, intimate)

Chapter 5: HIV/AIDS Education and Outreach

Section 1: IEC—Developing Messages

Activities and Handouts for IEC—Developing Messages

- **Introduction to IEC and Message Development**
- **Developing Media Messages**

Activity Introduction to IEC and Message Development

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

- Describe the components of IEC campaigns
- List the components of a message
- Identify the pros and cons of mass media campaigns
- Select media that can be used to educate on HIV/AIDS
- Define outreach

Time allotted 45 minutes

Preparation Collect examples of materials from IEC campaigns (about HIV/AIDS and by religious groups, if possible), such as posters, radio messages, videos, and pamphlets to use as examples. Prepare flipcharts beforehand. Prepare handouts of the "Mass Media Pros and Cons" on page 5-257, "Introduction to IEC & Message Development" on page 5-258 and prepare handouts of Important Terms on page 5-54.

Facilitation steps

1. Begin the session by asking participants if they know of any IEC activities in which the church may have been involved. Discuss briefly.

2. Suggest that to address the HIV/AIDS pandemic, your church may want to educate and inform the congregation and others about how to prevent HIV/AIDS or to be compassionate, forgiving, nonjudgmental and supportive of PLWHA.

3. Display the information below on a flipchart and review the parts of an IEC campaign.

Creating an Information, Education and Communication (IEC) Campaign

- Decide if you want to educate the congregation about HIV/AIDS (based on need)
- Determine the audience (whom you want to reach)
- Determine what the message will be (what you want to say)
- Determine the medium (the way the information will be presented)
- Determine the campaign's reach and impact (get feedback, monitor & evaluate)

4. Discuss the types of media, messages, and audiences. Use an example such as a poster showing a young couple with a young child and a message that "Being faithful is a way to protect your family from HIV" or use a message with religious theme. Ask the participants to determine to whom the message is aimed.

5. Display the following on a flipchart.

The Parts of a Message

- *Content*. What is being said
- *Presentation.* How it is being said
- *Tone*. The mood of the message (happy, serious, inspiring, hopeful, solemn, intimate)
- *Benefits*. What the person will gain from learning the information

6. Have participants identify the message content, the presentation, the tone and benefits from the poster displayed.

7. Explain that messages work best when targeted at a specific audience and the purpose of focus groups. For example, focus groups can be used to pretest a message with a small group of the specific type of people at whom the message is aimed. (See "Overview," on pages 5-246 to 5-249. Ask participants to play the role of a focus group by listing aspects of the message that could be improved on, while reinforcing that this is what focus groups do.

8. Hand out the "Pros and Cons of Mass Media;" discuss it with participants and have them add other examples into the blank spaces of the handout.

9. Link this demonstration to the delivery of IEC messages by faith communities. Ask participants to come up with some examples of

messages that they would consider appropriate for their audience (congregations, believers, etc.). Point out that messages based on fear are not helpful in getting people to change behavior. Such messages increase stigma and discrimination against PLWHA.

10. Ask participants if they think an IEC campaign alone will change people's behavior. Explain that a combination of IEC and outreach are more effective, as long as the messages are **consistent**. Ask participants to define "outreach."

11. Display the following on a flipchart.

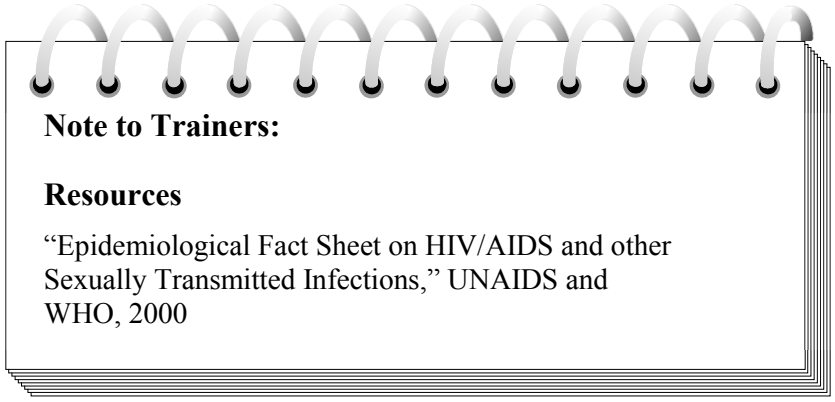
> *Outreach* involves person-to-person contact in the community. Outreach workers (also known as community workers) talk with people and often use other forms of communication tools or media such as pamphlets, dramas, and posters

12. Ask for examples of outreach, who does it, and how it can be supported through use of IEC materials. List the answers on a flipchart.

Wrap-up

Summarize the ideas covered in creating messages. Point out that important messages for Christian groups to spread are those of prevention of HIV and compassion and acceptance of PLWHA.

Remember to stress that when developing and delivering messages about HIV/AIDS, it is important to protect PLWHA confidentiality. Never use people's names or exact situations that identify someone as living with HIV/AIDS in dramas, role-plays, sermons, etc. Remind then that it has also been found that HIV messages based on fear are not useful. They do not help people change their behavior and they increase stigma and discrimination. Then hand out the Important Terms and the Introduction to IEC & Message Development.



Note to Trainers:

Resources

"Epidemiological Fact Sheet on HIV/AIDS and other Sexually Transmitted Infections," UNAIDS and WHO, 2000

Mass Media Pros and Cons[47]

Handout

Mass media includes print media, posters, radio, and television

Pros	Cons
Attractive: People like visual images.	**Cost:** It can cost a lot of money, especially film and video.
Influential: Messages are seen by many people and can influence public opinion.	**Difficulty:** Experience is needed to make a good video, film, or radio drama.
Educational and entertaining: They can combine a message with a story.	**Limited audience:** You will not reach people who do not have access to radio, film, TV or who cannot read.
Emotional: They can touch people's emotions and change their viewpoints.	**One-way information flow:** The media do not always allow feedback to get back to the creator.
Inspirational: They can show role models teaching about HIV.	**One-way information flow:** Can't always determine the reaction of the audience
Cost-effective: Print media can reach a lot of people at once; they can be copied and used many times.	**Message can be lost:** To reach large audiences, messages are often general and don't address the needs of specific audiences.
Portable: Radios easily can be moved from place to place.	

[47] Adapted from Rueben Granich, M. D., M.P.H. and Jonathan Mermin, M. D., M.P.H., *HIV, Health and Your Community: A Guide for Action (*Stanford: Stanford University Press, 1999).

Handout

Introduction to IEC and Message Development

Creating an IEC Campaign

1. Decide what you want to educate the congregation about concerning HIV/AIDS (based on need)
2. Determine the audience (whom you want to reach)*
3. Determine what the message will be (what you want to say)
4. Determine the medium (the way the information will be presented)
5. Determined the campaign's reach and impact (monitor and evaluate)

Message Components

1. *Content:* What is being said
2. *Objective/action:* What you want the target audience to do as a result of this message
3. *Presentation:* How it is being said (packaging)
4. *Tone:* The mood of the message (happy, serious, inspiring, hopeful, solemn, intimate)
5. *Benefits:* What the person will gain from learning the information

Outreach

Outreach involves person-to-person contact in the community. Outreach workers (also known as community workers) talk with people and often use other forms of communication tools such as pamphlets, dramas and posters.

* **Note:** When developing a message, be sure to consider the target audience, that is, to whom you are directing the message. You may need to be very specific in segmenting the audience. For example, you may want to target "youth," but you may need to develop different messages for boys and girls or different age groups.

Activity Developing Media Messages

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

- Develop a media message including identifying target audience, objective/action, tone, presentation, and benefits of the message

Time allotted 45 minutes

Preparation Prepare a flipchart with the message below. Leave the "What" and "Why" sections blank as on the handout on page 5-261. Make copies of the handout for the participants.

Message: "We can choose to know our status so we can plan for the future and ensure the health of ourselves, our partners and our children." The song has a male and female youth singing about their relationship, HIV testing and where to get tested, because they want to plan a bright future together.

What? (example)	Why? (example)
Audience: Youth	Youth ages 15-24 represent the majority of new HIV infections
Objective/action: To encourage youth to get tested	To be marriageable, to be able to play football, to finish school
Tone: Cheerful, empowered and knowledgeable	Conveys optimism for the future
Presentation: song	Youth listen to the radio often
Benefits: Ensure the health of ourselves, partners and children	Not knowing one's status can lead to denial, spread of HIV, lack of treatment and care

Facilitation steps

1. Display the Message flipchart. Review the definitions of audience, tone, presentation, and benefits from the previous exercise using the example above. Ask participants to suggest answers for the "What" and "Why" sections. Distribute the handouts so the participants can take notes.

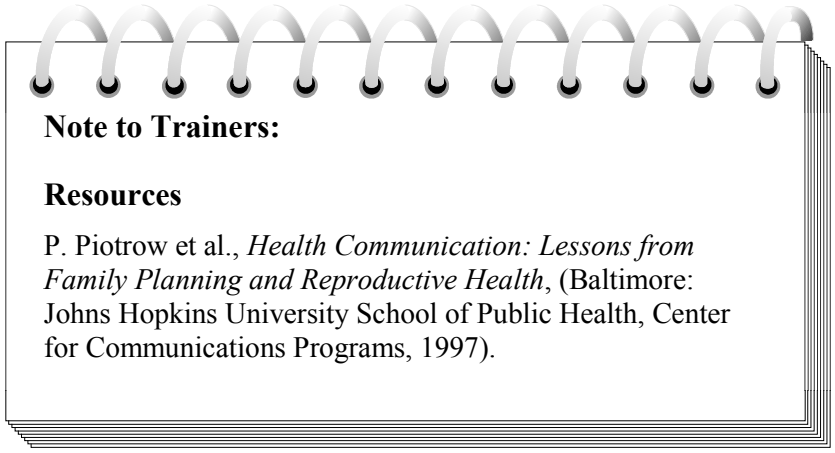
2. Explain to the participants that for the next 20 minutes they are going to work with a partner to develop a message on HIV/AIDS that would be appropriate for their congregation. Encourage them to be creative! They can use songs, drawings, role-play, or any medium to get the message across. While developing the message, they need to identify the message's audience, tone, presentation and benefits. They should be prepared to explain why they chose each one, based on what was learned in the previous section.

3. Have participants count off 1, 2, 1 and 2.

4. Participants work in pairs for 20 minutes to develop their message.

Wrap-up

Have several volunteers read/show their message to the group and explain the audience, tone, presentation, and benefits.

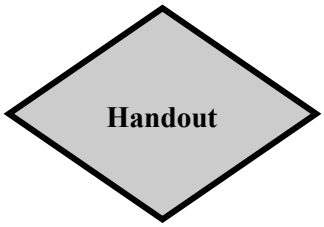


Note to Trainers:

Resources

P. Piotrow et al., *Health Communication: Lessons from Family Planning and Reproductive Health*, (Baltimore: Johns Hopkins University School of Public Health, Center for Communications Programs, 1997).

Developing a Message



Message: "We can choose to know our status so we can plan for the future and ensure the health of ourselves, our partners and our children."

The song has a male and female youth singing about their relationship, HIV testing and where to get tested because they want to plan a bright future together.

What?	Why?
Audience:	
Objective/action:	
Tone:	
Presentation:	
Benefits:	

Chapter 5: HIV/AIDS Education and Outreach

Section 1: IEC—Developing Messages

Alternate Activities and Handouts for IEC—Developing Messages

- **Outreach Guest Speaker**

Activity Outreach Guest Speaker

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

- Discuss the experiences of an HIV/AIDS outreach worker

Time allotted 1 hour

Preparation Two weeks prior to the workshop arrange to have a local HIV/AIDS outreach worker talk to participants. The worker should highlight the following topics—

- What project he/she works on
- The project goal, objectives, and target audiences
- How they use IEC materials to enhance their work
- Incentives and motivation to work on the project
- Challenges they face in addressing HIV/AIDS in the local environment
- Stigma as it affects their work

Facilitation steps

1. Introduce the guest speaker.
2. Allow the guest speaker to talk and then take questions from the audience.

Wrap-up Have participants summarize the greatest challenges and benefits of being an outreach worker and list them on a flipchart. Ask the participants to think about how outreach work could be integrated into their current church programs and list the responses on a flipchart.

Chapter 5: HIV/AIDS Education and Outreach

Section 2: Integrating Messages into Sermons

Objectives

By the end of this class, participants will be able to—

- List at least three activities that churches can do to integrate HIV/AIDS into worship
- Discuss why many people believe AIDS is punishment from God
- Refute this belief with examples from scripture
- Draft an explanation/statement/prayer based on scripture that shows that AIDS is not punishment from God
- Draft a sermon that integrates messages on HIV/AIDS (for homework)

Overview

Faith leaders can communicate messages about HIV/AIDS to their community members through worship services, congregational prayers, ceremonies, home visits, pastoral counseling, and group talks. The roles of pastor, priest, Imam, or traditional religious leaders are highly respected and trusted in many communities. Religious leaders have credibility and high standing in the community. Many messages delivered by religious leaders, such as compassion, God's love, acceptance, self-discipline, tolerance, mercy, forgiveness, patience, care, and support in times of crisis, lend themselves well to discussions about HIV/AIDS. Faith communities can combine health messages with religious teachings.[48]

In chapter 4, participants learned about various counseling techniques, which are suited to one-on-one contact with clients (parishioners/community members/etc.). This section examines how religious leaders can integrate HIV/AIDS messages into worship services and spiritual teaching and deliver them to larger groups (i.e. their congregations). A firm knowledge of scripture is needed. Faith leaders must be able to identify examples of scripture from the Bible and apply the messages learned there to the current HIV/AIDS pandemic.

Examples of worship activities include the following[49]—

- Remembering those with HIV/AIDS and their loved ones in prayers
- Using AIDS examples in services/homilies (but being mindful of confidentiality)
- Offering a special AIDS service/vigil/healing service
- Encouraging memorials in the name of those who have died from AIDS
- Setting aside a day of prayer for people with AIDS and their loved ones
- Observing an annual "AIDS Ministries Sunday" with an offering in support of ministries
- Having special AIDS-related music in worship services
- Including someone with HIV/AIDS as a liturgist/preacher
- Religious leaders being open about their status

[48] "AIDS Education through Imams,"1999.
[49] "AIDS Ministry Handbook," 1997.

- Organizing activities for children and adolescents who are affected by HIV/AIDS
- Compiling a worship-resource library available to churches in the pastor's area
- Instituting an "affirmation of remembrance" as a visible way of keeping the names of loved ones who have died of AIDS before the congregation
- Organizing a ministry to deliver food to a family with member(s) who are HIV-positive

Chapter 5, Section 2: Integrating Messages into Sermons

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 5: HIV/AIDS Education and Outreach

Section 2: Integrating Messages into Sermons

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
15 minutes	**Worship-related AIDS activities**	Brainstorming	Flipchart	Active participation
75 minutes	**Is AIDS Punishment from God?**	Discussion	Bible	Ability to find passages that refute the statement
30 minutes Homework	**Integrating Messages into Sermons**	Discussion, individual work	Sample sermons, Guidelines for Communicating about HIV	Positive HIV messages in homework assignment

Chapter 5: HIV/AIDS Education and Outreach

Section 2: Integrating Messages into Sermons

Activities and Handouts for Integrating Messages into Sermons

- **Worship-Related AIDS Activities**
- **Is AIDS Punishment from God?**
- **Integrating Messages into Sermons**

Activity Worship-Related AIDS Activities

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

- List at least three activities that churches can do to integrate HIV/AIDS into worship

Time allotted 15 minutes

Preparation Flipchart, marker

Facilitation steps

1. Explain to participants that this section will discuss how to integrate HIV/AIDS into sermons and other worship activities.

2. Ask participants to think about and write down at least three ways to integrate HIV/AIDS messages into worship activities for the next five minutes.

3. After five minutes, ask for volunteers to read their suggestions and write examples on the flipchart.

4. Explain that this section will focus on integrating messages into sermons, prayers, and the like, but that a church can become involved in a variety of activities.

Wrap-up Have participants show hands if they have done any of the activities listed. If they have, ask them to share challenges and successes they experienced.

Activity Is AIDS Punishment from God?

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

- Discuss why many people believe AIDS is punishment from God
- Refute this belief with examples from scripture
- Draft an explanation/statement/prayer based on scripture that show's that AIDS is not punishment from God

Time allotted 75 minutes

Preparation Post "Agree," "Disagree," and "Don't Know" signs in three different areas of the room. Bring flipcharts, bibles, paper and pen.

Facilitation steps

1. Start the session with a values-clarification activity. Tell participants that they will hear a statement and then they must decide if they agree, disagree, or don't know about it. They should move and stand by that sign and be ready to discuss why they agree, disagree, or don't know.

2. Read the first statement from the tools for trainers on page 5-273. Ask participants in the disagree area to explain why they disagree, then ask someone in the agree area to state why they agree. Let debate develop. Continue to read the statements and let the participants discuss the issues.

3. When all the statements have been discussed, have participants sit down. Point out that the ways in which HIV is transmitted are very clear (refer to earlier sessions). If participants have learned and accepted that HIV is transmitted through germs, then it will be easier to refute the idea that AIDS is punishment from God. When AIDS is referred to as a punishment from God, it lets people avoid taking responsibility to protect themselves and others from infection and reinfection and to take care of others that are infected and affected by HIV/AIDS. Suggest that "God helps those who help themselves."

4. Build on what was discussed in the first activity. Explain to participants that their work is important to spread messages on HIV/AIDS prevention and PLWHA acceptance and that each time they worship they have the opportunity to integrate positive messages into prayers, sermons, etc.

5. The next activity will address how to take a common issue related to HIV/AIDS and discuss it during a worship service.

6. Explain that they will be taking an example of a commonly-held belief that "AIDS is punishment from God" and determine what basis, if any, it has in the scripture; what messages are found in scripture that refute this belief; and draft a statement/prayer/sermon that would help educate others that this is not the case.

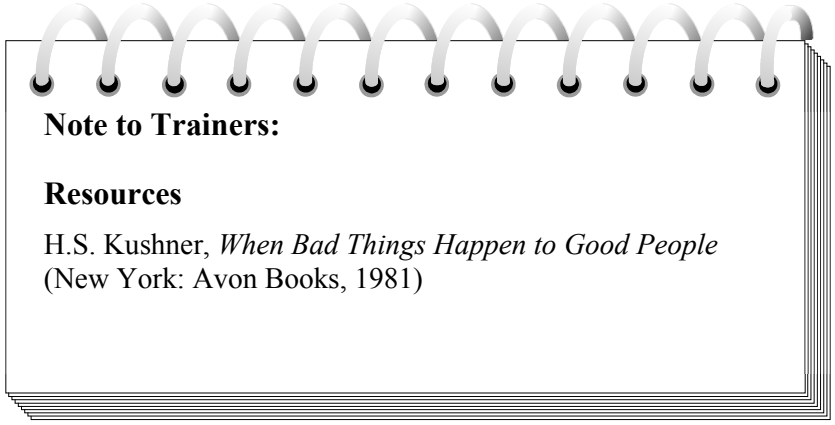
7. Explain that this belief is a point of confusion for many lay people, as well as clergy in the Christian and other faith traditions as well.

8. Divide participants into groups of three. Each group should work together for the next 25 minutes to find examples from scripture that refute the statement.

9. Have each group member write a statement, sermon, or prayer that incorporates the messages from the scripture. The statement should be less than one page written.

Wrap-up

Ask participants to share the passages from scripture that refute the punishment from God statement. Ask a few volunteers to read their statements, sermons, or prayers aloud. Point out the common messages found by each group. Ask participants to explain why it is important to integrate messages on HIV/AIDS into sermons, messages, etc.



Note to Trainers:

Resources

H.S. Kushner, *When Bad Things Happen to Good People* (New York: Avon Books, 1981)

Values Clarification Statements

These statements are meant to reinforce the "germ theory of disease," upon which all of the previous sessions on HIV/AIDS transmission and prevention are built. If participants understand and accept that HIV is transmitted through germs, then the idea that it is punishment from God can more easily be refuted—

- A cold is caused by a virus so small that you can't see it, but you can catch it from another person
- Children get diarrhea because they put dirty hands in their mouths
- People get AIDS from blood transfusions
- Women get pregnant from having sexual relations with men
- Babies can be infected with HIV when they are born
- People catch AIDS as a punishment from God

Activity Integrating Messages into Sermons

Objective

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

- Draft a sermon that integrates messages on HIV/AIDS (for homework)
- Follow guidelines for using accurate, consistent and positive messages about HIV

Time allotted

30 minutes

Preparation

Obtain examples of sermons, prayers, and the like that were given by various faith leaders (See the Alternate Activities and Handouts, on pages 5-277 to 5-297) and make copies for participants. Also, make copies of handout "Guidelines for Communicating about HIV/AIDS" on page 5-276. Participants should each have a Bible. (This is a **homework** assignment. Be sure to build time into the next day's schedule to have volunteers read their sermons/prayers and get feedback from the group.)

Facilitation steps

1. Begin the session by reviewing the components of message development. Explain that when delivering messages through worship services (sermons, prayers, etc.) one must also consider the message's audience, objective/action, tone, presentation, and benefits.

2. Reflect back on the example just presented about refuting the belief that "AIDS is punishment from God." Ask participants to list other topics, beliefs or information that would integrate well into worship services. Examples may include—

    - Relating God's teachings to behavior change
    - Relating God's love, acceptance, etc. to combat stigma in the community
    - Relating messages about taking care of the body, and others
    - Relating messages from the Bible that encourage support and caring for PLWHA

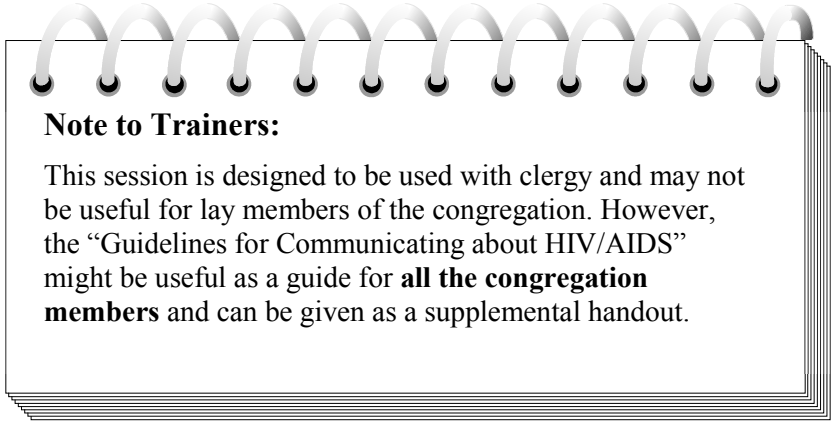
3. Ask participants if they are already integrating HIV/AIDS into their worship services and to give examples.

4. Hand out the "Guidelines for Communicating about HIV/AIDS." Read and discuss each item. Suggest that they should follow these guidelines when writing sermons/prayers.

5. Handout sample sermons. Suggest that participant may read these to get ideas for integrating HIV messages.

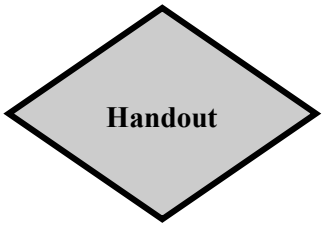
Wrap-up

Explain that for homework they will practice integrating messages into worship services, either by writing a sermon or a prayer. Each participant should write a short (no more that 10 minutes) prayer or sermon (or even part of a sermon) using the guidelines and the information they have learned in the workshop about HIV/AIDS. Volunteers will be asked to read them during the next day's session.



Note to Trainers:

This session is designed to be used with clergy and may not be useful for lay members of the congregation. However, the "Guidelines for Communicating about HIV/AIDS" might be useful as a guide for **all the congregation members** and can be given as a supplemental handout.



Guidelines for Communicating about HIV/AIDS[50]

These guidelines are intended to help ensure accurate, consistent and positive HIV/AIDS content in sermons and other types of messages. Words have power, and positive words can reframe the way our congregations and we think about HIV/AIDS. Positive, nonjudgmental messages, and both verbal and nonverbal gestures, can combat stigma and discrimination.

1. Refer to "people living with HIV/AIDS" rather than "AIDS patients" or "AIDS sufferers." "Patient" or "sufferer" implies that people living with HIV or AIDS are sick all of the time, which is not typically the case, and it takes away hope. One may use an acronym when writing (PLWHA), but be sure to spell it out the first time it is used. Never use the acronym in speech.

2. Don't use "AIDS victims" rather use "people with AIDS." "Victims" robs people with AIDS of dignity and hope and inaccurately implies that they are passive about their health.

3. Instead of saying one is "dying from AIDS," say that they are "living with AIDS." At any given time, everyone is "dying" as that is the inevitable outcome of life. People with AIDS can live longer and richer lives when living positively and getting support for living positively. Referring to someone as "dying from AIDS" takes away hope.

4. When referring to children living with HIV/AIDS, use nonjudgmental specific wording, such as "the child was born infected." rather than "the child was innocent, having been born infected."

5. Instead of referring to "high-risk groups" use "high-risk behavior." No group is predisposed to HIV infection and should not be stereotyped as such. What individuals do causes infection, not who they are.

6. When using examples of PLWHA or situations around HIV as illustrations, do not use actual names of anyone in your community. Because of the stigma and discrimination surrounding HIV/AIDS, it is important to protect PLWHA and their families. Confidentiality should be paramount. Only the PLWHA has the right to decide to disclose his or her status to others.

7. When using examples to preach about HIV issues, be sure to change the situation enough that the community *cannot* identify the persons involved. Often, community members are aware of each other's life situations and, unless the situation is disguised, individuals, families, the community, and the church may be hurt.

8. When there are PLWHA open about their status, be the first to share a meal, put your arm around the person, and show your acceptance and support through casual touch.

9. At every opportunity, reinforce the fact that AIDS is caused by a virus like measles, colds, and many other diseases. Many illnesses are related to how we live and should not be a reason for judgment or discrimination (there are no "good" or "bad" diseases).

[50] Adapted from "The AIDS Ministry Handbook," 1997.

Chapter 5: HIV/AIDS Education and Outreach

Section 2: Integrating Messages into Sermons

Alternate Activities and Handouts for Integrating Messages into Sermons

- **Sample Sermons, Prayers, etc.**
- **Key Biblical Passages**

Handout

Sample Sermon 1

AIDS in Africa—A Worship Service

A Call to Worship

Jesus said, "You shall be my witnesses… to the end of the earth." Witnessing is not speaking only. It is doing something, an action. Christian witnessing is in the actions of every Christian who lives out the "good news of Jesus Christ." Witnessing is made manifest in the contagious joy that comes from a life of absolute trust in the Divine Goodness and Power over the world and sinfulness. Witnessing is made manifest in the compassionate actions of caring persons, individuals, and communities who carry God and God's compassion into the world. Yet the lure and clamor of the world are so consuming, tumultuous, strident and demanding. We scarcely can hear the still small whispered voice of calm. We are gathered out of a concern for immense suffering among the people and the nations of Africa…. We do not know well the realities of this epidemic. We do not see clearly yet how to be responsive in a meaningful way. We come simply as a people of faith, convinced that God wills healing, justice and peace; that God gives wisdom and shows us the way; that God gives us grace and livens our hearts.

Hymn: *There is a Balm in Gilead (Verses 1 and 2)*

Period of Silence

LEADER: Let us pray together *a prayer of Martin Luther* (in unison)

> Behold Lord; we are empty vessels that need to be filled. Lord do You fill us. We are weak in faith. Do You strengthen us. We are cold in love, do You warm us and make us fervent. At times we doubt and become overwhelmed with helplessness. We become unable to trust in your Ultimate Power over the world. We are poor, but You are rich, and You came to bring mercy to the poor. With us, there is an abundance of selfishness, but in You, there is fullness of Spirit and Love. Therefore we turn to you, O Lord God of all. We come as individuals and as your church, repentant and in need.

A Responsive Reading on AIDS in Africa

(The quotations are from various news sources and the UNAIDS /PROJECT)

LEADER: The HIV/AIDS epidemic has so devastated southern African countries that there are now more than a million orphans, with their numbers expected to double by the year 2010.

Response: Dear God in Heaven, help us.

LEADER: Many orphans have no place to live and, due to the deaths of so many adults, no one to care for them.

Response: Dear God in Heaven, help them.

Sample Sermon 1, continued

LEADER: About 20 percent of the population (one in every five persons) - is infected with HIV.

Response: Dear God in Heaven, help us to see how to help them.

LEADER: The AIDS situation is worsened by poor economic conditions and high unemployment—a situation based on economic realities imposed by such groups as the International Monetary Fund and the World Bank.

Response: Let us be partners with people of good will.

LEADER: To form a united front and alter the course of the epidemic, an International Partnership Against AIDS in Africa, composed of African governments, donor countries, UN bodies, civil society and the private sector, is being established.

Response: Let us be partners with people of good will.

LEADER: The hope is that churches in Africa, augmented by help from others, can help resettle children orphaned by AIDS back into their extended families or with foster mothers in the same community. The Christian Council of Churches in Zambia for example has started a home-based program focusing on both prevention and care of HIV/AIDS sufferers and also is providing education and counseling.

Response: Dear God in Heaven, help us to see how to stand with them.

LEADER: Yet we are far from powerless against AIDS in Africa. With strong political leadership, openness about the issues, and broad crosscutting responses, and with the help of outside human and financial resources, clear success is being demonstrated.

Response: Dear God, forgive us our apathy, our self-pre-occupations, our abundant waste of resources, our often hardened and indifferent past.

LEADER: Let us be comforted in the sure faith that God indeed forgives those who repent. Let us hear the reassuring words of Jesus, "Go and sin no more." Let us hear some ancient words of wisdom echoing through the centuries.

What does love look like? It has the hands to help others. It has the feet to hasten to the poor and needy. It has the eyes to see misery and want. It has the ears to hear sighs and sorrows. That is what love looks like.
--St. Augustine

LEADER : Let us listen with freshly awakened hearts to the Word of God.

John: 4: 7-15

Mark: 9: 14-29

Providing Living Waters to a Dying World

Reverend Tyrone Pitts[51]

There is a story that is told of a man who was walking through a graveyard late one night and fell into a hole. Before reaching the bottom of the hole, he grabbed a tree limb and began crying for his dear life. Little did he know that his feet were just several inches from the bottom of the hole? "Is anybody there?" he cried over and over again. Finally, he called out, "Oh God, please help me!"

A voice from the top of the hole responded, "Yes, do you need help?" "Oh yes, please help me!" he replied. Then this voice with great authority, said, "Okay my son. Let go of the tree limb." After a few minutes of silence, the man raised his voice and said, "Is there anybody else up there?"

Like the man in the hole, our world suffers from a crisis of faith. We know both intellectually and personally that our nation and our world are facing one of the greatest crises in human history.

The AIDS epidemic has claimed the lives of millions and millions of people across the globe. We have witnessed the destruction of our environment and seen the increase in poverty, racism, and the unparalleled destruction of communities and nations due to famine and war.

In the name of progress, we have developed the capacity to feed the entire world. We have also developed medicines that are helpful in stopping the spread of AIDS and other diseases. Yet with all this technology, we witness a dying world in which starving women and children are pitted against national and international interests. And medicines and health care are only available to those who can afford it.

In this century alone, we have developed the communicative technology to advance the cause of brotherhood and sisterhood. Yet with all of this technology, we witness a dying world in which race and culture fragment us and cause us to mistrust each other because of the color of our skin, the language we speak, or our cultural backgrounds.

We now have the capacity to stop the making and distribution of guns and weapons of destruction and to transform our cities into living viable non-violent communities. But because of the politics of greed, we witness a dying world in which the killing of our children is tolerated, and our cities have been abandoned. We have the capacity for world peace. Yet we live in a dying world in which economics and selfishness create tensions that foster wars and destabilize communities.

[51] From an Executive Board Meeting, National Council of the Churches of Christ in the USA, Washington, DC, May 2000.

Sample Sermon 1, continued

We have the capacity to be better stewards of our world and protect the natural resources, provide universal health care, which is a natural resource, but instead we face a dying world in which consumption and consumerism are destroying without replenishing and taking from the earth without giving back.

For the Christian church, this paradox of progress has created within us a schizophrenia of the soul that causes us to pause and take notice of the moral and spiritual abnormalities in our lives. While at the same time we find ourselves indulging and enjoying the privilege of being pallbearers at the funeral of a dying world.

Like the disciples in our text this afternoon, we often struggle with pettiness rather than performance. We are too concerned about preserving our structures and institutions and about "who gets the credit" or "who's doing what." In a real sense we have been waiting for someone else to give the cup of cold water in Jesus' name to hungry and thirsty and dying world. We know who we are, but we are not quite sure always of "whose" we are. We know what we are supposed to do, but somehow we do not seem to have the capacity to do it.

The Christ we follow must be our living water. Living water that never runs dry. Living water that leads us and guides us. Why is it that Jesus compared himself to living water when he met the woman at the well?

Jesus could have compared himself to any of the four elements of nature: Earth, Wind, Fire, or Water. But he chose to compare himself to water. He did it because living water is dynamic. It reaches its own level. It is transforming and is constantly in motion, changing, improving and nurturing. Jesus compared himself to living water to transform a dying world.

One of our greatest challenges of the ecumenical movement today is to transform a dying world. Yet as we confront this dying world, we are often overwhelmed and lose our perspective and our belief that we as part of the body of Christ can make a difference.

Like the disciples in our text, as the organism that represents one of the largest pieces of the puzzle of the ecumenical movement, we often appear to be powerless to perform the duties that it was called to do. For a moment, reflect with me on this chapter.

Here the disciples were confused and disoriented when they were unable to cast out the demon from the boy. The feelings of these disciples are not uncommon to us as followers of Christ. We are often confused when we do all we can to cast out the demons in our lives and in society and end up focusing on internal organizational problems rather than Christian witness. The challenge for us in the ecumenical movement is the same challenge that these disciples faced. Their failure was not due to their insincerity or their commitment to follow Jesus. It was due to their lack of focus and faith.

Sample Sermon 1, continued

In other words, Jesus was saying to the disciples, you are a part of the water, which springs eternal, but you have lost the dynamic quality of living water. You have become stagnant because you have not nurtured the spiritual gifts of prayer and fasting within you that revitalize your water supply. Yes, you are water, but you are focusing your energy in the wrong direction. You want to be a part of my body, you want to be recognized and accepted by society, you want people to respect you as my followers and praise you for your power and authority. But you fail to listen to the cries of the poor. You are so focused on your own selves that you are not dynamic and living. You are not flowing. You are dammed up.

The challenge for us, as an ecumenical witness to the power of the body of Christ in the United States of America today, is to become living water in a dying world. Our challenge is to listen to those hidden voices of the faith that call us to witness and to action. Our challenge is to listen to those voices that speak plainly from their misery, sickness, and oppression and respond to them. Our challenge today is to listen more faithfully to the voices of the women of the faith. For it was they who first proclaimed the "Good News" of the resurrection of our Lord and Savior Jesus Christ. Our challenge today is to heed the voices of those who stand on the underside of history, the indigenous, the poor, the needy and those who suffer with AIDS and other diseases who cannot help themselves. To let God's power reside in whomever God wills. Our challenge today is not to confuse unity with uniformity, nor see diversity as disunity. Our challenge today is to celebrate our oneness in Christ by lifting up our unity and diversity as a symbol of our being a living, viable ecumenical organism.

Our challenge today is to constantly remind ourselves of the distinction between culture and Christ. Our challenge is to be an organic ecumenical witness for Christ, not a vehicle or an institution that is self-serving or glory seeking but to strive to become living water like Jesus who remained faithful even unto death, providing living water to a dying world.

There were those who thought that they could stop him or harness him and separate him from his wellspring eternal. But he endured.

One of his closest advisors, his chief accountant, the keeper of his bank account, betrayed him with a kiss. But he refused to let this act separate him from his wellspring eternal.

His closest friends and aides denied him when he needed them most. But he refused to let these acts separate him from his wellspring eternal.

His enemies persecuted him on trumped up charges, they mocked him, placed a crown of thorns on his head and beat him. But he refused to let this act of cruelty separate him from his wellspring eternal.

They compelled him to carry his own cross through the dreary streets of Jerusalem, until he could bear it no longer. But he refused to let this act separate him for his wellspring eternal.

Sample Sermon 1, continued

They took him to old Golgotha's hill where they nailed him to an old rugged cross between two thieves; thirsty and dying they gave him vinegar instead of water to drink. They gambled for his clothes; they pierced him in his side. But through it all, he refused to let these acts of cruelty separate him from his wellspring eternal.

Even at his death, he provided living water to a dying world. From the cross, he saved a sinner. From the cross, he made provisions for his mother. From the cross, he forgave those who persecuted him.

Like living water that reaches its own level, he remained the champion of justice, he remained the embodiment of love, and he remained the Prince of Peace.

Then they took him from that old rugged cross, placed him in a borrowed grave, where he lay until the first day of the week.

He lay there. He lay there until the calm waters of faith began to stir. He lay there.

He lay there. He lay there until the kettle of hope began to boil. He lay there.

He lay there. He lay there until the rain of love began to fall. He lay there.

He lay there until the rivers of mercy began to overflow. He lay there.

He lay there until the waves of Justice began to crest. He lay there.

And like water that reaches its own level, and then overflows when it fills up its space, the grave could not contain him any longer. So he got up. Yes, he got up. He got up, as living water to a dying world. He got up and proclaimed that all power is in his hands. Because he lives, we can face tomorrow. Because he lives, all fear is gone. Because he lives, we are now able as an ecumenical body to provide living water to a dying world.

Closing Prayer

LEADER: Oh God, bless those who suffer and die of AIDS in Africa. Bless their loved ones and those who mourn them. And bless us gathered here to know Your Will and to respond as You would have us to respond in love and compassion. In Jesus' name we pray. *Amen.*

Closing Hymn: *There is a Balm in Gilead (Verses 1 and 3)*

Handout

Sample Sermon 2

When We Get Out of The Boat!

Matthew 14:22-33

Prepared by Rev. Eugene Bartell

Simon Peter was one of the most amazing and interesting of all of the disciples of Jesus. Simon Peter was a man who was impulsive; sometimes his actions were not predictable. He was enthusiastic and excitable and had a flair for the dramatic. He was truly alive. He was not the quiet retiring type. Have you been around people who seem to generate excitement and interest? You can always tell when they are around because there is energy in the room. Peter was a man of action and courage. He was bold and daring. The story that we have just heard in the gospel of Matthew gives us a very good picture of this man and encourages us to follow his example. In the church, we can learn much from this story. Let us take a closer look at this passage and see what God is telling us about our life in the church today.

Jesus has just sent Peter and the disciples away in a boat so that he could go off by himself to pray. He needed time to be in solitude and prayer to renew his spirit. So the disciples got into the boat as he commanded. When the boat was quite a distance from the shore a storm came up very suddenly. The strong winds were whipping up the water in great waves so that the disciples began to fear for their safety and even for their lives! This reminds us how quickly life can change. Maybe you have been in a boat when this very thing has happened. Or suddenly you can be in a road accident and life can change very quickly; you can be seriously injured before you have a chance to protect yourself. The circumstances of life can and often do change very quickly, and we become as frightened as those disciples did in the boat in the storm.

While their boat is being violently tossed about on the troubled waters they see a figure coming to them on the water. Their immediate reaction is one of great fear. They cry out in terror “It is a ghost!” They are in a state of panic. Now they don’t know which is worse, the storm or the ghost! Scripture says that immediately Jesus spoke to them, “Take heart, it is I, have no fear.” The disciples were immediately relieved and their fears vanished. What a great and sudden sense of calm they felt. Perhaps they wiped their brows in relief and settled back in the boat as they waited for Jesus to come to them.

The disciples all relaxed into a serene mood. All of them except our friend Peter. We said that Peter was not always predictable, sometimes excitable. That he had a flair for the dramatic. So while all of the other disciples began to relax, our friend Peter instantly calls out to Jesus “Lord if it is you, bid me come to you on the water.” Put yourself in the place of the other disciples in the boat. I can just hear them saying, “What is the matter with this Peter? Here we are, we are now safe, let’s sit back and wait quietly and calmly and patiently for Jesus to come to us.” But Peter, perhaps he is even now standing up in the boat and calling out to Jesus. Maybe he is even causing the boat to rock back and forth. Our friend Peter just cannot leave good enough alone. He is really getting on the nerves of the other disciples.

Sample Sermon 2, continued

While the disciples are annoyed with Peter, Jesus is not. Jesus calls back to Peter in the boat and answers with one firm word, "Come." Maybe the other disciples couldn't believe their own ears. Jesus calling for Peter to "come." What are we to make of this? Jesus seems to be encouraging Peter in this mad act. Since we know that Jesus loves Peter, wouldn't we expect him to tell Peter to sit back down, to remain calm, and assure him that he would be with him soon?

This is really not the way most of us would react in this situation, is it? Would not most of us tell Peter to just sit quietly and wait? Those of us who are parents or care for children always encourage our children to avoid danger, to be safe, and not take unnecessary chances. We have been taught since we were very young to play it safe and not put ourselves in dangerous or unsafe situations. Even in the church we are usually very cautious. We do things as we have always done them. If someone in the church suggests that we reach out to minister in new ways and to reach out to heal the hurts and woes of the world in new and innovative ways, we are likely to act just like the disciples in the boat, to sit still and wait for Jesus to come to us. It is hard for the church to reach out in bold and even daring ministries. Yet Jesus seems pleased with Peter and bids him come.

Do you begin to see where this scripture is leading us? Our gospel lesson today tells us that in answer to Jesus' invitation to "Come," Peter gets out of the boat and begins to go to Jesus. Peter's conduct and behavior look mad! He is walking on the water and with his eyes on Jesus he goes across the water. All is well. All is well for only a brief time until Peter sees the wind and the waves, and he becomes alarmed. There he is out there on the water with the wind and water in a frenzy. He takes his eyes off Jesus and begins to sink. In his fear he cries out, "Lord, save me." Scripture says that "Jesus immediately reached out his hand and caught him, saying, 'O man of little faith, why did you doubt?'" All was going well for Peter until he took his eyes off Jesus and became instead distracted by the storm, the wind, and the waves. He began to concentrate on the obstacles instead of the opportunities. He lost his focus. There is a wonderful gospel hymn that states:

> Turn your eyes upon Jesus
>
> Look full in his wonderful face
>
> And the things of earth
>
> Will grow strangely dim
>
> In the light of his beauty and grace

Peter's difficulties began when he took his eyes off Jesus, and he began to sink. As we have all experienced in difficult times in our own lives, Jesus did what Jesus always does, he immediately reached out his hand and caught him, saved him, saying, "Why did you doubt?"

Sample Sermon 2, continued

The lessons from this scripture for the church this day are many. I believe that God is telling us that the church ought to pattern itself after Jesus. God is calling the church to get out of the boat's safety and security and go to Jesus out there on the water, just as he bid Peter to come to him. Jesus knew that the waters were rough and wild, yet he bid Peter, "Come."

My dear friends, the waters of the world in our village, in our city, in our country, and in many other countries are very troubled. The furious storm of the HIV/AIDS pandemic has caused many who are living with this disease untold trial and tribulation. Who can possibly fathom the hardship and the heartache that this calamity has brought about? Can you comprehend what it must be like to one of the six million children in sub-Saharan Africa under 15 who have lost either their mother or both parents from this catastrophic situation? Can we imagine the plight of the millions of women who have contracted this disease from their husbands and the isolation and abandonment many perhaps most of them experience? For most of us it is enough to deal with disease and illness itself, but when one has also to experience the rejection of friends, spouse, and families, the hardship is even further multiplied.

Can we be content to stay in the boat when so many are struggling and feeling so abandoned and isolated and suffering alone? Can we remain in the boat when we could be offering comfort, help, and healing? Can we remain in the boat when Jesus bids us "Come?"

My friends, Jesus is standing out there in the midst of this raging storm today, calling to those of us who are his disciples in the boat to "Come" to meet him on these troubled, storm-tossed waters. He calls us to get out of the boat and be present with him, and those he is with, in the storms of life.

God calls us to be as bold and daring as a Peter, when he got out of the boat in answer to Jesus' one word, "Come." Church, do you believe the promise of God that if we keep our eyes on Jesus, he will help is walk on the water, just as Peter did until he took his eyes off Jesus?

It is so tempting to play it safe in the church. It is easy to just seek our own ease and comfort. The church is at its best when it is where Jesus is, ministering to the needs of a troubled world. Where do you think Jesus would be today if this story from Matthew's gospel were to be written today? Would he be telling the church to remain quietly and calmly in the boat until this storm of AIDS has passed, or do you think he would be calming the waters, bringing comfort and hope, and welcoming those living with AIDS into the church's loving family fellowship?

When we get out of the boat we will be where Jesus is—in the world, bringing a measure of his help and hope during these difficult times on these troubled waters.

Handout

Sample Sermon 3

We Never Saw Anything like This!

Mark 2:1-12

Prepared by Rev. Eugene Bartell

I very much enjoy this passage of scripture. It is such a good example of what can be accomplished when we are truly motivated to making a positive difference.

Let's look at the story a little closer. First there is the man who had been paralyzed. We don't know exactly what his disability was or how he became paralyzed, but we do know that he had four friends who carried him on his pallet to see Jesus to get some relief for his predicament. When they got to the house where Jesus was they found that their errand of mercy had come to an abrupt halt. The crowds who had gathered blocked the doorway to the house where Jesus was staying. Since they could not gain entry by the door they proceeded to the roof. They sat the pallet down on which they had been carrying their friend. Then they began to chop a hole in the roof! Well, scripture doesn't exactly say they chopped a hole in the roof, but it does say that "they removed the roof" from the room where Jesus was teaching. Having accomplished that job, they then let down the pallet on which their friend lay. What a surprise this must have been to not only Jesus, but to the crowd of people who were gathered in that house.

Do you have a picture of this scene in your mind? First, do you think that the four friends on the roof very carefully and meticulously disassembled the roof? I think that they chopped away at it! The house was probably not unlike many houses that we know. The roof was probably made of a wet mud-clay like mortar mixture that was laid over rough pieces of timber or small branches of trees and dried. To make a hole in the roof you have to break up the mud-clay surface and then pull up the timbers. You can imagine the mess they made! Jesus is in the room just below these busy workers, teaching away and pretty soon there are chunks of clay and dried mud coming down on those who are crowded in the room! A very bold and dramatic action on the part of the four friends with their paralyzed mate! Can you imaging the reaction of the house's owner! Do you think that he was really very happy about needing to replace his roof? Do you suppose that the four workers asked permission before they began their work? "Oh, do you mind if we tear the roof off your house because…?" I don't think so!

Let us consider some important gospel lessons from this amazing story. First, the friends did not accept the barriers before them. They could have said, "We'll have to wait for the right moment." No, they made the present moment the right moment. Perhaps they felt like saying, "Oh, Jesus has a full schedule today, we can see that he is very busy, Let's go back and come another day. Or, the crowds are just too big today, we can't even see him or hear him." They had a big problem in getting their friend to Jesus but that did not stop them. They were determined to find a way. Big problems can be addressed. And a way was found. Up to the roof!

Sample Sermon 3, continued

We also have big problems. One of the most important big problems that we have in Africa is managing and responding to all of the hardships created by the AIDS pandemic. And it calls for the same qualities of heart, mind, and spirit that the four friends demonstrated for us in the story. I suppose we could be tempted to not do anything. But I believe the reason that this story was included in the New Testament was because it shows how desperately the four friends wanted relief for their friend who was paralyzed. And that their example is one that we should follow. When they decided they wanted to help, they found a way. So the first step is deciding that we want to do something to help. The second step is to get busy and get creative and find a way to help. Can we be as persistent and creative in addressing HIV/AIDS in our community as the four friends were in getting the man, who was paralyzed, to Jesus? Are the children who are orphaned by AIDS to be left alone? Are the pregnant women with HIV/AIDS to be abandoned and not given any solace and support, let alone medical care and help for their babies when they are born? Are there four friends in this congregation who will commit themselves to reaching out to these? Are there four friends in four other churches in four other villages/cities who feel the pull of God's Spirit speaking to their heart to see that this is one of the most important ministries of the church? Do people with AIDS have to live and die outside of the church's reach? Do we not have the four friends' compassion in the gospel lesson to care enough about the one who had fallen to find a way to see that health and healing are possible?

At the end of the story the man with the paralysis received health and healing. Those in the crowded room cry out, "We never saw anything like this!" This is a time of great testing for the church about whether we have the courage of our convictions. May it never be said of us that in this time in history, when there is such great need for so many people that the church was too busy about many lesser things to pay attention to this pandemic. Pray that those who follow us will say of our efforts, "We never saw anything like this!" Do we have the capacity to want to help, and if that is so, do we have the boldness of spirit to raise the roof, to take our own bold and innovative steps? I like to believe that the crowd spoke these words as much to the four friends who tore through the roof of that house, as they did about the healing the man with the paralysis received at the hand of Jesus. The four friends stand out today for us as mighty examples of what can be accomplished if we but have the dedication to act on our impulses to do a new thing. The right moment to act is the present moment.

Handout

Sample Sermon 4

Helping Hope Happen

TEXT: Proverbs 30:24-28
Mark 4:26-34

Prepared by Rev. Eugene Bartell

We are usually encouraged to "Think big." We are impressed with big things. We are impressed with the tallest building, the longest river, with big houses. We even think of the problems facing us in terms of the problem's scope and largeness. Often the scope, complexity, and gigantic proportion of these problems make us feel that we can't do anything about them. We become overwhelmed by the problem's size, throw up our hands, and avoid doing anything at all. The situation seems hopeless, so big and beyond our grasp that we lose heart and walk away. We think the problem is so big that what we could do, would not make any difference, so we don't do anything.

Today I want to encourage you to go with me and "Think small." By thinking small I don't mean being small-minded or narrow-minded or mean spirited or being a "small person."

Let us think in terms of a new Beatitude: Blessed are those who think small, for they shall become a people of HOPE. Hope happens when you get your hands on something you can do something about.

In the Proverbs scripture the writer celebrates and draws our attention to the smallness of things. "Four things on earth are small, yet they are exceedingly wise: The ants are a people without strength. The locusts have no king, yet all of them march in rank. The lizard can be grasped in the hand, yet it is found in kings' palaces."

In the Gospel lesson, Jesus shows his listeners the mustard seed, one of the smallest of seeds, yet when it is sown it grows up and becomes the greatest of shrubs, so that even the birds of the air come and make their nests in its branches. All this from a seed, that is no bigger than a tiny speck of a thing. It is so small that you can barely see it when held in the palm of your hand.

These scripture lessons point us to the importance of small things and in God's eyes, how they teach us important lessons of life. Much in Jesus' ministry had to do with little things, things that are within the reach of everyone. Little acts of charity that when taken together make up attitudes and attributes of spirit and heart that usher in the Kingdom of God. In the 25th chapter of Matthew's Gospel, Jesus says that when the Son of man comes in glory and all the angels with him he will give his greatest praise to those who gave:

Food to the hungry

Drink to the thirsty

Clothing to the naked

Sample Sermon 4, continued

Visited those who were in prison

Visited those who were sick

These are attitudes and actions that are within the range of all of us to act upon and do. You don't need to have advanced degrees from a college or university to figure out how to do these things. They are not complicated. However, they do require a heart that is willing to reach out to those who are in need. Remember also that Jesus offered his highest praise for those whose life is an example of reaching out to those who are hungry, thirsty, naked, sick; those who have no or little hope and who stand in great need. "Truly I say to you, as you did it to one of these humble ones, you did it to me."

A good deal of great Christianity is paying attention to a lot of little things, little things that go to the heart of what it means to be an authentic Christian Church or disciple of Jesus.

God is still depending on the church to minister to the world in this same spirit.

And so it is with the church today. God looks to the church today to help usher in God's Kingdom in hundreds of very small ways, week in and week out. Some might say than any effort or small program of love and mercy that we might develop may be hopelessly small and insignificant if you hold them up to all of those who are living with AIDS. After all, we live on a continent that has 28 million people living with AIDS. A staggering 14 million men, women and children in Africa have already died of this disease since the early 1980s. However, we can take a great big problem like HIV/AIDS and break it down into smaller pieces and figure out how our efforts can make a difference. For example, in our church and in our society we often say that our children are our future. Do we not owe it to our children, the children and youth of this church and in our community, to make them aware of the dangers of this disease that has caused so much heartache and pain already? Sometimes I fear that we are sending our children out into a world unprepared for the choices they will be expected to make. Our children and youth need to be educated on how the disease is spread and to learn how to make healthy lifestyle choices. Do you see how even small efforts on our part could spare our youth from needlessly placing themselves in life-threatening situations?

From the time our children are very young, we teach them many things; that fire is hot and it can hurt you, be careful on busy streets where cars and trucks can hurt you if you don't pay attention. And the many, other lessons that we teach them from their earliest years. What difference could our small efforts make against such a huge problem? But our efforts are not insignificant when seen in the context of the family or village or town. So while there may be millions in the world that we can't reach, and hundreds and thousands in the country that are beyond our reach, there are many (hundreds) that we can.

Our ministries could "help hope happen" for many. Let us not focus on what we can't do, but on what we can do.

Sample Sermon 4, continued

Is it totally unrealistic for us to consider how our church could be used for a support group of people living with HIV/AIDS to come and draw strength from one another?

Is it totally unrealistic that we could enter into conversations with the health workers to plan together how education and testing services could be more widely available in our church and community? Is it totally unrealistic that we see to it that children and youth in this church and community learn how this disease is spread? These are all rather small efforts in the whole scheme of things, but they can have a powerfully positive impact on our community's future.

There is a story about a conversation between Jesus and St. Peter after Jesus died and appeared before St. Peter in the heavens. St. Peter asks Jesus, "What is your plan for furthering the Kingdom now that your earthly work is over?" Jesus answers, "Oh, I have entrusted my ministry to Peter, James, John and the other disciples." St. Peter responds, "But what if Peter, James and John and the others fail? What if they don't follow through with the work? What is your back-up plan? Do you have a contingency plan?" To which Jesus responds, "I have no other plan. I am depending on Peter, James, John and the others. I am counting on them."

If we don't do the job, the job will not get done. There is no second string team that can be called in if we fail. Our God is depending on us.

> God now has no other hands than ours to do his work
>
> No other feet
>
> No other arms than ours to make his will and way known in the world.

And so our God and our Lord turns to us once again as has been true over the centuries and says still, "I'm depending on you, not them, but you."

Handout

Sample Sermon 5 (abridged)

God Gives Life

Prepared by Reverend Attah Edu-Bekoe
Presbyterian Church of Ghana

TEXT: John 5:11-13

Eternal Life through Christ – 1 John 5:11-13

God, promised life and salvation to the fallen person in Genesis 3:15 and He fulfilled this promise through the Christ – Event: Birth, Ministry, Death, Resurrection and Ascension of Christ – His only Begotten Son.

Through Christ, God gives Eternal Life. The word of God says: "And this is the testimony: God has given us Eternal Life, and this life is in His Son. He who has the son has life; he who does not have the Son of God does not have life, l write these things to you who believe in the name of the Son of God so that you may know that you have Eternal Life."

God Gives Life in Christ – V V. 11-12

Whoever believes in God's Son has eternal life. No matter one's status, whether PLWHA or not, Christ gives Eternal Life. He is all we need. One doesn't need to wait for eternal life because it begins with the moment one believes. One does not need to work for it, because it is already one's gift from God.

One does not need to worry about it, whatever is one's status because God Himself has given Eternal Life to you and it is guaranteed. This is our Hope

Assurance of Eternal Life

Some people hope that they will receive Eternal Life. John says we can know we have it – No matter what our status is. Our certainty is based on God's promise through His Son. And what God has promised, He fulfils. This is a fact. This assurance of Eternal Life is true whether you feel close to God or far away from Him. In other words, whether we are PLWHA or not, God gives us assurance of Eternal Life. Now what is HIV/AIDS?

Existential Import

Life Application

God gives life. God values life. We must therefore value life. We must have—

1. Quantity of Life
2. Quality of Life
3. Qualification of Life

Basic HIV/AIDS Facts

1. What is HIV/AIDS?

HIV means: H-Human, I-Imunodeficiency, and V-Virus. HIV is a virus that attacks and destroys the God-created natural defense mechanism of the body – the white blood cells.

AIDS means: A-Acquired, because the person contracts it; I–Immune, which refers to the natural immune system; D-Deficiency because it completely destroys the natural immune system; and S-Syndrome refers to a host of symptoms and opportunistic diseases that attack the person and kills him /her.

2. Basic Statistics

HIV/AIDS is now a global pandemic. In sub-Saharan Africa, about 28 million people had been infected by HIV/AIDS by the year 2001. In West Africa, in terms of sheer numbers, Nigeria is second to South Africa on the continent. Her prevalence rate is over 5 percent. Our nation, Ghana, is fourth after Nigeria and Cote d'Ivoire. Her prevalence rate is 3.6 percent. It is also estimated that according to government statistics, every day about 230 persons are infected. Every age group is affected, but its prevalence is highest among the youth. It mainly affects people between the ages of 15 and 49, out of which about 50 percent falls within 15 to 24 years. This has socioeconomic implications for our nation as well as religious-cultural implications.

Causes and Prevention

Causes

The main causes of HIV/AIDS are—

1. Unprotected sex with an infected person (80 - 85%) - Heterosexual, Homosexual
2. Blood transfusion
3. Use of contaminated sharp instruments
4. Parent to child transmission

This means that—

1. Those who are sexually promiscuous are at a high risk
2. Those who engage in irresponsible use of sex are at high risk
3. And those who have multiple sexual partners are at a very high risk

Prevention

A – Abstinence. 100 percent safe, but the least used
B - Behavioral change. Being faithful with tested, HIV-negative, faithful partner 50 percent safe
C – Condom. Not 100 percent safe, but the most promoted method. Condoms must be used responsibly.
S - Don't use contaminated sharp instruments

Theological Messages

Beloved in Christ, God gives life. Accepting this fact as Christians, there are messages to the three categories of members today.

I. To the Youth

To the youth, we have message of, "As youth we face the three C's of life" —

1. Challenges
2. Choices
3. Consequences

Valuing Life

God values life. Therefore we must value life. God gives us life. We, thus put a very high premium value on life to have—

1. Quantity of life
2. Quality of life
3. Qualification in life

And the greatest qualification is to have Eternal life in Christ. Give your life to Christ. And this goes for adults too.

Behavioral Change

The sex drive is the most powerful drive in persons, especially during this developmental stage of your life. Those of us who engaged in irresponsible use of sex—premarital sex and post-marital sex outside marriage—need to change our behavior. This is difficult. Unless we give our lives to Christ or the power of the Holy Spirit to change us, we cannot do it. The message, therefore, is that of Repentance—

Turn away from sin and turn to God
Turn to God and rejoice in Hope

Your family needs you
Your church needs you
Your nation needs you

II. To PLWHA

Should anyone of us here have tested positive for HIV/AIDS, our messages are—

Christ Gives Abundance of Life

Christ says: "The thief comes only to steal, kill and destroy; I have come that they may have life, and have it abundantly." It is only Christ who gives life and gives it abundantly. Say Amen! Why don't you give your life to Christ?

Christ Gives Eternal Life

There is life hereafter. And it is only Christ who gives Eternal Life.

NOTE: Eternal life is not based on feelings, but on facts. We can know that we have Eternal Life if we believe God's truth. If you want to be sure that you are a Christian and have Eternal Life ask yourself. "Have I honestly committed my life to Him as my personal savior and Lord?" If so, then know by faith that you are indeed the child of God and, thus, have Eternal Life.

Christ Gives Hope

In the midst of hopelessness because the world has not found the cure to this HIV/AIDS pandemic, Christ is our Hope. And with God nothing is impossible. We serve a "possibility God" not an "impossibility God."

There is hope in Christ. Therefore, Never Give Up

Never give up
Never give up on life.

Have a positive view of your God-given life. Eat well. Take your medication. Avoid unprotected sex with your spouses. God gives life. And He is our hope for it.

III. To All Membership

To all of us gathered here, we are given a message of—

Do Not Be Judgmental… Our sins may be greater than theirs

Love and Compassion

God gives life through Christ His Son. Christ reached out to the sick, the widows and orphans, the poor. We must do likewise.

Care and Support

We shall be judged: " I was hungry… I was sick…" therefore we must care for and support people infected and affected with HIV/AIDS.

Keeping the Mission Alive (Luke 4:18)

Deliverance for the oppressed
Healing for the sick
Care for the poor and needy
Care for widows and orphans

Conclusion

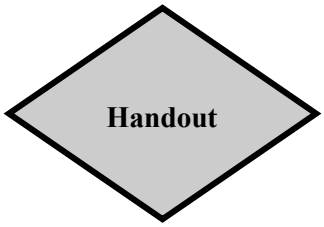
Our Loving God, Our Compassionate God gives real Life in Christ Jesus. As Christians we must—

1. Value Life
2. Have Behavioral Change
3. Have Faith in Christ who gives
   a. Abundant Life
   b. Eternal Life
   c. Hope to the Hopeless
4. Keep the Mission Alive by
   a. Not being judgmental
   b. Having Love and Compassion for PLWHA'S
   c. Caring and supporting the infected and affected

Presbyterian Youth: We love life!

Presbyterians: We care!

AMEN! AMEN! AMEN!



Key Biblical Passages

These passages teach acceptance, reaching out to the abandoned and doing mercy and justice.

Matthew 5:1-17 The Beatitudes. Jesus' teaching on the blessedness of bringing mercy, comfort, peace, etc. Teaching on being the salt of the earth and a light to a dark world.

Matthew 8:1-4 Jesus healed a leper, ones who were untouchable and isolated and abandoned by society.

John 4:27-30 Woman at the Well. A conversation between Jesus and a woman of Samaria; disciples are amazed that Jesus speaks with a woman and places himself against culture and custom.

John 8:1-11 Jesus forgives woman taken in adultery and proclaims: "He who is without sin, cast the first stone."

Luke 4:18 At the beginning of his ministry, Jesus announces his solidarity with the poor, the captives and the oppressed.

Luke 16:19-31 Rich man and Lazarus. The time to do the right thing for those in deep distress is now.

Micah 6:8 What does God require? To do justice, love, and kindness.

Notes:

Chapter 6

HIV/AIDS Advocacy

"The spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the brokenhearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised."

—LUKE 4:18

Table of Contents

Faith Community Responses to HIV/AIDS

Chapter 6: HIV/AIDS Advocacy

Chapter 6: HIV/AIDS Advocacy

Key Questions

- What is advocacy?
- What topics related to HIV/AIDS can we advocate on?
- What steps do we follow in creating an advocacy plan?

Introduction[52]

Advocacy is the act or process of supporting a cause or issue. Advocacy is much more than dissemination of information and education. In addition, advocacy is central to Christian life and witness. Information and education educates individuals and the community about a topic or service. Advocacy goes beyond this by seeking support for a cause or issue, influencing others to support it and/or, influencing or changing policy or legislation that affects it. An advocacy campaign is a set of targeted actions in support of a cause or issue.

Advocacy on HIV/AIDS must be based on factual information. Groups who intend to advocate should collect current studies such as baseline studies and situational analyses. HIV/AIDS advocacy work should focus on—

- Creating awareness of the magnitude and seriousness of the problem
- Diminishing discriminatory practices
- Removing policy and other barriers to prevention and care activities

[52] International Planned Parenthood Federation, *Advocacy Guide for Sexual and Reproductive Health Rights (New edition)* (London: Terracotta Press, July 2001); Mark Cole and F. Codding, Evangelical Lutheran Church in America, *That we may speak…Our ministry of action,* (Chicago: Ausberg Fortress Publishers, 2000); The Centre for Development and Population Activities, "Gender, Reproductive Health, and Advocacy: A Trainer's Manual," CEDPA, Washington, DC, 2000.

- Campaigning for effective and sustainable action

Advocacy work aims to influence the highest authorities in the church and/or the country to provide leadership, political support, and commitment. Advocacy work is important because groups can form partnerships to achieve what one organization could not achieve alone.

In this chapter, participants will get a brief overview of advocacy. For information on the actual process of developing an advocacy campaign, see appendix II.

Chapter 6: HIV/AIDS Advocacy

Section 1: Advocacy Basics

Objectives

By the end of this class, participants will be able to—

- Define advocacy and discuss why it is important
- Identify and order the steps in the advocacy process

Overview

Advocacy Basics

Advocacy is the process of supporting a cause or an issue. Advocacy involves a set of targeted actions in support of a cause or issue. Advocacy seeks support for a cause or issue, influencing others to support it and/or influencing or changing policy and/or legislation that affects it. Advocacy work aims to influence the highest authorities in the church and country to provide leadership, political support and commitment. **Advocacy work is important because groups can form partnerships to achieve what one organization could not achieve alone.**

Faith communities can advocate on HIV/AIDS by [53]—

- Publishing a newsletter on HIV/AIDS
- Encouraging donations to AIDS programs
- Encouraging members to write/speak on AIDS issues
- Networking with colleagues involved in AIDS response
- Organizing a fundraiser for PLWHA
- Adopting a "covenant to care" to put a parish/mosque on record as open to and supportive of people living with AIDS and their loved ones
- Collecting special AIDS offerings
- Writing letters to government leaders, church leaders, newspaper editors, and other officials about the AIDS issue
- Speaking at press conferences
- Encouraging the mobilization of resources for STI/HIV/AIDS prevention programs
- Supporting campaigns for increased availability of antiviral medications
- Promoting good policies and practices
- Promoting respect and justice for women
- Promoting knowledge of HIV and how it is spread
- Reducing stigmatization of HIV/AIDS affected people

[53] "The AIDS Ministry Handbook: A Resource Guide for Faith Communities and AIDS Ministries," AIDS National Interfaith Network, Washington, DC, June 1994; Jeremy Hamand, *Advocacy Guide for HIV/AIDS,* (London: International Planned Parenthood Federation, June 2001).

- Upholding the rights of HIV-positive people
- Strengthening solidarity between NGOs and people living with HIV/AIDS
- Involving people with HIV/AIDS in prevention, education, and advocacy efforts

Steps in the Advocacy Process

Advocacy is rarely a linear ordered process, but looking at advocacy in a systematic way will help participants to plan effective advocacy activities. The steps followed are generally—

- Issue
- Goal and objectives
- Message development
- Channels of communication
- Building support
- Fundraising
- Implementation

Data collection and monitoring and evaluation should take place throughout the process. (See appendix II, "How to Create an Advocacy Campaign.")

Chapter 6, Section 1: Advocacy Basics

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Chapter 6: HIV/AIDS Advocacy

Section 1: Advocacy Basics

Sample Lesson Plan

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
1 hour	**What is Advocacy?**	Discussion	Handouts, flipchart	Level of understanding demonstrated in discussion
1 hour	**Steps in the Advocacy Process**	Discussion, group work	Handouts, overhead, note cards	Level of understanding demonstrated in discussion and group work

Important Terms

Activities	Descriptions of quantifiable actions that are undertaken to meet objectives
Advocacy	The process of supporting a cause or an issue
Building support	Building alliances with other groups, organizations, or individuals who are committed to supporting your issue
Channels of Communication	The means by which a message is delivered to the various target audiences, e.g. radio, television, flyers, press conferences, and meetings
Data collection	Gathering, analyzing, and using appropriate quantitative and qualitative information to support each step of the campaign
Evaluation	A process of gathering and analyzing information to determine if the advocacy objectives have been achieved
Fundraising	Identifying and attracting resources (money, equipment, volunteers, supplies, space) to implement an advocacy campaign
Goal	A statement of the general result to be achieved
Implementation	Carrying out a set of planned activities to achieve advocacy objectives (action plan)
Issue	The problem that requires a policy action
Message Development	Tailoring statements to different audiences that define the issue, state solutions, and describe the actions that need to be taken
Mission Statement	Identifies the advocacy campaign goal and explains its purpose. The mission statement guides activities and states what it is the goal is (the ULTIMATE GOAL)
Monitoring	A process of gathering information to measure progress toward advocacy objectives
Objectives	Incremental steps toward achieving the goal, which are specific, measurable, achievable, realistic, and time-bound
Target Audience	The policymakers that the campaign is trying to influence to support the campaign issue, e.g., parliamentarians, local officials, ministry officials, denominational leaders, and peers in the ministry

Chapter 6: HIV/AIDS Advocacy

Section 1: Advocacy Basics

Activities and Handouts for Advocacy Basics

- **What is Advocacy?**
- **Steps in the Advocacy Process**

Activity What is Advocacy?

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

- Define advocacy and discuss why it is important

Time allotted 1 hour

Preparation Prepare learning objectives on flipcharts. Write "Sample Advocacy Definitions" from pages 6-312 and 6-313 on a flipchart, one sheet per definition. Post definitions around the room, covering the writing with another sheet or fold up bottom of sheet to cover writing. Print enough copies of the handout to distribute to each participant.

Facilitation steps

1. Tell participants that they will learn to use advocacy as a tool for influencing decision-makers to bring about changes in HIV/AIDS issues. Review the learning objectives for this session on the flipchart.

2. First, the group will agree on a working definition of *advocacy*. Many participants will come to the workshop with a solid understanding of advocacy. As a starting point, lead the participants in brainstorming words they associate with advocacy. Record these words on a flipchart, being careful to include all contributions. Repetition is not a problem; simply add a check mark (√) next to the words or phrases that are repeated. The box below shows the responses generated through this brainstorm at a workshop in Mozambique.

Words Associated with Advocacy

Defending	Influence
Sensitizing	Intervening
Change	Decision-making
Persuasion	Selling an idea
Exposure	Lobbying
Communication	Attracting attention
Providing a solution	

3. After the group has generated a list of words associated with advocacy, share with them some definitions that were developed by different organizations and networks. Walk around the room and uncover the definitions.

Advocacy is the act or process of supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a cause or issue. We advocate a cause or issue because we want to—

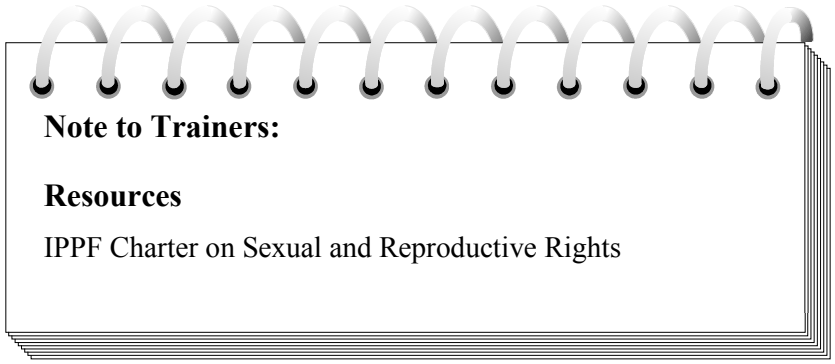
- Build support for that cause or issue
- Influence others to support it, and/or
- Try to influence the policy and legislation that affects it

4. After all the definitions are presented, ask participants to walk around and look at the posed definitions and stand by the one they think is the best advocacy definition.

5. After everyone has read the definitions and picked the one they liked, ask a volunteer from each group to explain why they think that definition is the best. Point out any terms that appeared on the initial brainstorm list.

Wrap-up

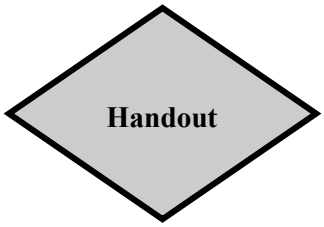
The group should agree on a working definition of advocacy. Current definitions can be modified until the group's preferences are represented. Distribute the handout as a reference for defining advocacy. Use a bright marker to circle the concepts that were unique to the brainstorm.



Note to Trainers:

Resources

IPPF Charter on Sexual and Reproductive Rights



Sample Advocacy Definitions

The definitions below reflect how several organizations understand advocacy and put it into action—

> Advocacy is the act or process of supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a cause or issue. We advocate a cause or issue because we want to—
>
> - Build support for that cause or issue
> - Influence others to support it
> - Try to influence or change legislation that affects it
>
> *INTERNATIONAL PLANNED PARENTHOOD FEDERATION*
> *"IPPF ADVOCACY GUIDE"*

> Advocacy is a process that involves a series of political actions conducted by organized citizens in order to transform power relationships. The purpose of advocacy is to achieve specific policy changes that benefit the population involved in this process. These changes can take place in the public or private sector. Effective advocacy is conducted according to a strategic plan and within a reasonable time frame.
>
> *THE ARIAS FOUNDATION*

> Advocacy is speaking up, drawing a community's attention to an important issue, and directing decision-makers toward a solution. Advocacy is working with other people and organizations to make a difference."
>
> *CEDPA*
> *"CAIRO, BEIJING AND BEYOND: A HANDBOOK ON ADVOCACY FOR WOMEN LEADERS"*

> Advocacy is defined as the promotion of a cause or the influencing of policy, funding streams or other politically determined activity.
>
> *ADVOCATES FOR YOUTH,*
> *ADVOCACY 101*

Sample Advocacy Definitions, continued

Colleagues in India describe advocacy as an organized, systematic, intentional process of influencing matters of public interest and changing power relations to improve the lives of the disenfranchised. Other colleagues in Latin America define it as a process of social transformation aimed at shaping the direction of public participation, policies, and programs to benefit the marginalized, uphold human rights, and safeguard the environment. African colleagues describe their advocacy as being pro-poor, reflecting core values such as equity, justice, and mutual respect, and focusing on empowering the poor and being accountable to them.

INSTITUTE FOR DEVELOPMENT RESEARCH
ADVOCACY SOURCEBOOK

Advocacy consists of different strategies aimed at influencing decision-making at the local, provincial, national, and international levels, specifically.

- Who decides—elections, appointments and selection of policy-makers, judges, minister, boards of advisors, managing directors, administrators, etc?
- What is decided—policies, laws, national priorities, services, programmes, institutions, budgets.
- How it is decided—accessibility of citizens to information and the process, extent of consultation, accountability and responsiveness of decision-makers to citizens and other stakeholders.

Policies and decisions are solutions to concrete problems. Effective advocacy requires sharp understanding and analysis of a concrete problem, and a coherent proposal for a solution."

INTERACTION
"WOMEN'S ADVOCACY WORKSHOP" MATERIALS

Activity Steps in the Advocacy Process

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

- Identify and order the steps in the advocacy process

Time allotted 1 hour

Preparation Use the advocacy card template on pages 6-317 to 6-322, to prepare three (or more) sets of advocacy process cards, depending on the size of the training group. Produce overhead or copies of the "Steps in the Advocacy Process" handout on page 6-317. Prepare flipcharts as indicated.

Facilitation steps

1. Tell the participants that now that the group has reached a consensus on the definition of advocacy and identified some major topics for advocacy that relate to HIV/AIDS that they will look at the various steps that make up the advocacy process. Experience shows that advocacy is rarely an ordered linear process. Some of the most successful advocacy networks operate in a chaotic environment, seizing opportunities as they arise. The ability to seize opportunities, however, does not reduce the importance of a sound process and careful planning. The following exercise will demonstrate that looking at advocacy in a systematic way will help the participants to plan effective advocacy activities.

2. To begin, organize the participants into three teams (by counting off by three). Set each team around a worktable.

3. Distribute one set of advocacy cards to each group. Point out that each card has one step in the advocacy process written on one side and a definition of that step or term on the other side. Present the task on a flipchart.

> Imagine that your team is planning an advocacy campaign. Organize the cards to reflect the order in which you would undertake each step of the process.
>
> Time: 20 minutes

Each group can order its cards on a tabletop, on the floor, or posted on a wall.

4. After 20 minutes, circulate to see if each group has completed the task. Make sure that each team has organized its cards in a location that can be viewed by the whole group. After the groups have finished, ask the first group to present its work. Proceed to the next group after discussing and answering questions.

5. After all the groups have made their presentations, lead a discussion about the similarities and differences in the way the groups arranged their steps. Focus on asking about the starting and ending points of the process and if any of the steps fit in the same level (ordered together as a "package," i.e. audience + message + channels or implementation + evaluation).

Wrap-up

Distribute (or show on overhead) the handout of the steps in the advocacy process. This handout shows the way that CEDPA generally orders the advocacy process.

- The advocates generally begin with the *issue* around which they want to promote policy change. The issue is focused, clear, and widely felt by the advocacy group's constituents.
- The advocates articulate a *mission statement* that is supported by *advocacy goals* (medium- or long-term visions for change) and *objectives* (short-term, specific or measurable) based on the advocacy issue.
- The advocates develop a compelling advocacy *message* and tailor it to the interests of the audience.
- The appropriate *communication channels* are selected to deliver the advocacy message to the audience. This may include a press conference, an executive briefing packet, a public debate, a conference for policy-makers, and other channels.
- The advocacy group seeks to broaden its *support* base among civil society members and other allies.
- The advocacy group *raises funds* and mobilizes other resources to support the advocacy campaign.
- Finally, the advocates *implement* their advocacy strategy according to an action plan.
- *Data collection* runs up one side of the model because it supports many of the other steps. To select an important advocacy issue, the organizers need to gather information. They often need to research the position of their audience regarding the advocacy issue. Data collection is an ongoing process.

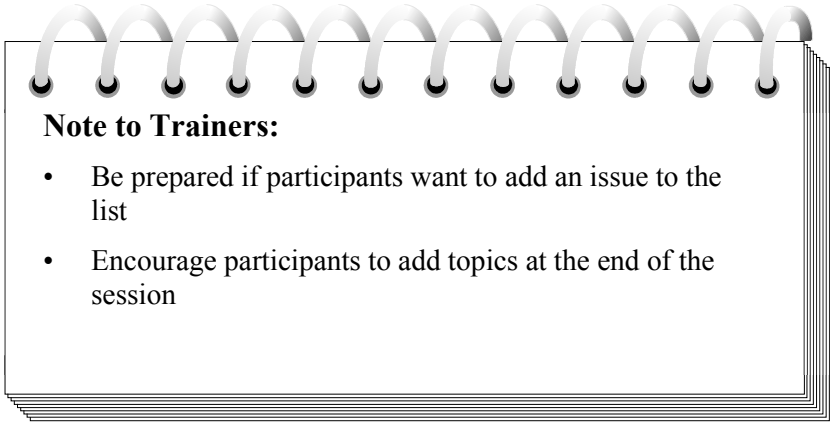
- Likewise, *monitoring and evaluation* take place throughout the advocacy process. Before undertaking the advocacy campaign, it is important for the advocates to determine how they will monitor their implementation plan. In addition, the group members should decide how they would evaluate or measure results.

  - Can they realistically expect to bring about change in policy, programs or funding as a result of their efforts?

  - In specific terms, what will be different after the advocacy campaign is completed?

  - How will the group know that the situation has changed?

- Remind participants that advocacy activities are often conducted in a very turbulent environment. There is not always the opportunity to follow each step according to the model on paper. Nevertheless, a systematic undertaking of the advocacy process will help the advocates to plan well, use resources efficiently, and stay focused on the ultimate advocacy goal.



Note to Trainers:

- Be prepared if participants want to add an issue to the list
- Encourage participants to add topics at the end of the session

Handout

Steps in the Advocacy Process

Data Collection

- **Issue**
- **Goal and objectives**
- **Target audience**
- **Message development**
- **Channels of communication**
- **Building support**
- **Fundraising**
- **Implementation**

Monitoring and Evaluation

Tools for Trainers

Template for Preparing Advocacy Cards

Issue	The problem that requires a policy action
Goal Objective	**Goal:** A statement of the general result you want to achieve **Objective:** Incremental steps toward achieving your goal that are • Specific • Measurable • Realistic • Time-bound

Template for Preparing Advocacy Cards, continued

Target Audience	The policy-makers you are trying to influence to support your issue, e.g., Parliamentarians, local officials, Ministry officials
Message Development	Statements tailored to different audiences that define the issue, state solutions, and describe the actions that need to be taken

Channels of Communication	The means by which a message is delivered to the various target audiences, e.g., radio, television, flyers, press conferences, meetings
Building Support	Building alliances with other groups, organizations, or individuals who are committed to supporting your issue

Fundraising	Identifying and attracting resources (money, equipment, volunteers, supplies, space) to implement your advocacy campaign
Implementation	Identifying and attracting resources (money, equipment, volunteers, supplies, space) to implement your advocacy campaign

Data Collection	Gathering, analyzing, and using appropriate quantitative and qualitative information to support each step of your campaign
Monitoring And Evaluation	**Monitoring:** A process of gathering information to measure progress toward your advocacy objectives **Evaluation:** A process of gathering and analyzing information to determine if the advocacy objectives have been achieved

Chapter 6: HIV/AIDS Advocacy

Section 1: Advocacy Basics

Alternate Activities and Handouts for Advocacy Basics

- **Guest Speaker**
- **Advocacy and Related Approaches**

Activity Guest Speaker

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

- Apply what was learned in this section to a real-life setting

Time allotted 1 hour

Preparation Invite an advocate or HIV/AIDS specialist to address the group.

Facilitation steps

1. Possible topics include—
    - Ability of a non-governmental organization (NGO) or church/faith-based group to represent populations traditionally left out of the decision-making process
    - Personal account or local success story illustrating how advocacy has led to policy change

Wrap-up Questions from the audience.

Activity Advocacy and Related Approaches

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

- Differentiate between advocacy, IEC and public relations

Time allotted 45 minutes

Preparation Prepare a flipchart of advocacy-related concepts as shown in the facilitation step 2. Make copies of handouts "Advocacy and Related Approaches" on page 6-331, and "Issues for HIV/AIDS Advocacy" on pages 6-328 to 6-331.

Facilitation steps

1. The participants have reviewed various advocacy definitions and familiarized themselves with the steps in the advocacy process. Faith based groups have been using advocacy skills and techniques for years. Nevertheless, advocacy is often confused with other approaches that share common elements. These approaches include information, education, and communication (IEC), social marketing, and public relations. To achieve a clearer understanding of what advocacy is, it is helpful to clarify what advocacy is not.

   The following is an exercise to compare and contrast advocacy with related concepts.

2. Present the following information on a flipchart to the group.

Advocacy and Related Concepts

Approach	Target audience	Objective	How do you measure success?
IEC			
Public Relations			
Advocacy			

3. While leading participants through the completion of this chart, there will be many opportunities to draw on their experience with IEC and other approaches to social change. Ask if anyone in the group has experience managing an IEC campaign and use those participants to help complete the IEC row of the chart.

Here are three questions to ask and some possible responses.

- *Who is the target audience of an IEC campaign?*

  Responses include women, men, youth, and members of a Congregation. The answers will vary from one IEC strategy to another, but most often the target is a particular population as defined by sex, age, or geography. Write the participants' responses in the appropriate box on the chart.

- *What is an IEC campaign's objective?*

  Possible responses include raising awareness, changing behavior. Write behavior change in the appropriate box.

- *How do you measure an IEC campaign's success?* In other words, what objective indicators of change will tell the IEC campaign organizers that their campaign has been successful?

  Responses will vary according to the campaign's objective, but write several examples that the participants provide, such as percentage of youth using condoms or delaying the onset of sexual activity, or percentage of adults who know how to access VCT services.

4. Most people are familiar with the public relations (PR) or advertising campaigns that large private companies use to sell their products. Ask participants to identify a local company that is widely known by the general public. Apply the questions from step 2, above, to the case of a PR campaign.

   As background for the trainer, the following is an example of how the row was completed at a workshop in Mexico. The company was Aeroméxico, a large Mexican airline.

   Target audience: The Mexican consumer

   Objective: Promote the company image and boost sales

   Measure of success: Increased ticket sales; percentage increase of new passengers

   Using the local example that the class provides, complete the PR row in the chart.

5. Finally, help the group consider an advocacy campaign. Repeat the questions from step 2, above, and fill in the answers on the chart.

   Here are some common answers.

   Target audience: Policy-makers (those decision-makers with the authority to affect the advocacy objective)

   Objective: Change policies, programs, or the allocation of resources

   Measure of success: Adoption of a new or more favorable policy/program; percentage shift in resource allocation; new line item in a public sector budget or church.

Wrap-up

To summarize the exercise, ask the participants to consider what elements these approaches have in common.

Here are some possible responses—

- They are all strategies for promoting change
- They are all most effective when planned systematically
- They all involve identifying an audience and tailoring messages accordingly

Reinforce how advocacy stands apart from the other approaches because advocacy always seeks to change a policy or program. Like IEC, advocacy requires the intermediate step of raising the awareness of key audiences. However, advocacy does not stop at raising awareness. The advocacy process is complete when a decision-maker takes a prescribed policy action. Participants often point out that the general public can be the target of an advocacy campaign. In most cases, however, public awareness is raised to pressure a particular policy-maker.

Remind participants that they will be able to distinguish an advocacy strategy from an IEC or PR strategy by focusing on the strategic objective. Pass out "Advocacy and Related Approaches" handouts.

As discussed in chapter 2, above, HIV/AIDS is a complex and sensitive issue to tackle in most countries. HIV/AIDS is linked with human rights, gender, stigmatization, access to testing, care and treatment services, and human sexuality. The following highlights some of the major focus areas for HIV/AIDS advocacy. Pass out "Issues for HIV/AIDS Advocacy" handouts.

Issues for HIV/AIDS Advocacy

Human Rights

Many citizens are often denied their human rights after they contract HIV/AIDS such as—

- The right to information
- The right to treatment and services
- The right to work
- The right to attend school
- The right to inherit money and property
- The right to marry

Gender

Gender affects the way that HIV spreads in many countries in the following ways—

- Sexual subordination of women
- Biological susceptibility of young women to HIV infection
- Social and cultural expectations around sex for both genders (i.e. early marriage, men proving "manhood")
- Gender-based violence and discrimination against women and girls
- Lack of empowerment and negotiation skills among women and girls

Involving People with HIV/AIDS

People with HIV/AIDS should be included in the design, planning, and implementation of AIDS-related work. This is beneficial because it—

- Increases the relevance of the work
- Reduces discrimination
- Recognizes PLWHA needs
- Presents the human face of AIDS
- Helps in education and prevention
- Gives PLWHA active work and empowerment

HIV Testing

- Discourage mandatory testing
- Encourage voluntary counseling and testing
- Encourage high quality services and availability of services
- Insist on confidentiality of services

Mother-to-Child Transmission (MTCT)

Mother to child transmission of HIV/AIDS affects many children under the age of 10. MTCT can be prevented by up to 50 percent, if advocates can encourage governments to integrate MTCT prevention into existing MCH services.

Promoting Condoms

Male and female condoms are excellent ways to prevent against STI/HIV/AIDS, as well as pregnancy. Condom advocacy campaigns have had excellent results in countries such as Thailand (100% condom use among commercial sex workers). Advocacy may address an issue that limits condom use, such as resistance of condom use by married couples, or religious opposition to use of condoms by unmarried people.

Children and Youth

A majority of new HIV infections occur among 15-24 year-olds. In 1999, it was estimated that 620,000 children less than 15 years old would be newly infected with HIV. In addition, the AIDS epidemic has orphaned around 13 million children since the beginning of the epidemic (from the UNAIDS report).

Advocacy may involve—

- Improving access for youth to information, health care, and means of prevention
- Ensuring that youth are educated about HIV/AIDS
- Speaking against harmful practices which contribute to HIV infection, such as early marriage, female genital cutting, and sexual exploitation and abuse
- Involving young people in development of HIV/AIDS prevention programs

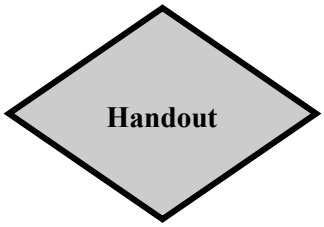
High Risk Groups

Several groups of people engage in behaviors that put them at a higher risk for HIV infection. Multiple partner and/or unprotected sex are common among commercial sex workers, the armed forces, migrant workers, and child hawkers. Sex workers are at risk because of the high number of partners and the lack of condom negotiation skills. Armed forces and migrant workers are separated from their families for long periods and often turn to commercial sex workers. Men who have sex with men are also at a higher risk, including those in prison. Advocacy for these groups may involve—

- Increasing recognition of the vulnerability of high-risk groups
- Promoting protection of sex workers and their clients through 100% protection
- Promotion of condom use, reduction of number of partners
- Encouraging governments to address the issue of high-risk groups
- Encouraging governments to donate funding for projects working with high risk groups
- Working with migrant groups to ensure provision of services and access to services
- Encouraging senior military officials to address the problem of HIV/AIDS in the military
- Encourage senior prison officials to provide condoms and preventative health education to prisoners

Advocates try to build support for issues by influencing public opinion or changing policy or legislation that affects the issue. This is not a task for a few individuals. An advocacy campaign must be developed. Successful advocacy campaigns must be carried out by a committed organization; and often by working with other organizations with the same goals
(See Appendix II, “Developing an Advocacy Strategy.”)

Advocacy and Related Approaches



This chart illustrates the difference between advocacy and several related approaches. Advocacy can usually be distinguished from other approaches by its objective—**to change policy.**

Approach	Actors/ Organizers	Target Audience	Objective	Strategies	Measuring Success
Information Education, Communication (IEC)	Service providers	Individuals Segments of a community (women, men, youth)	Raise awareness and change behavior	Sort (by audience) Mass media campaigns Community outreach Traditional media	Knowledge/ skills acquired and behavior changed Process indicators Focus groups Service delivery statistics
Public Relations	Commercial institutions	Consumers	Improve the company's image and increase sales	Large-scale advertising (radio, TV, print media) Public events	Public perception Sales Market share
Community Mobilization	Community members and organizations	Community members and leaders	Build a community's capacity to prioritize needs and take action	Door-to-door visits Village meetings Participatory Rural Appraisal (PRA)	Issue-specific process and outcome indicators Quality of participation
Advocacy	NGOs Research institutions Universities	Public institutions and policy-makers	Change policies, programs, and resource allocation	Focus on policy makers with the power to affect advocacy objective High-level meetings Public events (debates, protests, other events	Process indicators Media scans Key informant interviews Focus groups Opinion surveys

Notes:

Chapter
7

HIV/AIDS Planning, Evaluation, and Closing

"Come now let us make a covenant, you and I; and let it be a witness between you and me."

—GENESIS 31:44-46, 51-52

Table of Contents

Faith Community Responses to HIV/AIDS

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Key Questions

- What can religious leaders do to combat AIDS in their communities?
- What issues are affecting your community?
- Can you make a commitment to try to change one aspect of AIDS affecting your community?
- What have you learned in this workshop?
- How do we know if the participants have learned the content?
- How do we know if the facilitators have successfully presented the material?
- How do we know if we met the training objectives?

Introduction

This workshop has looked at what AIDS is, how it is prevented, transmitted, and treated, and in the later chapters, how the faith community can respond to HIV/AIDS. In this final chapter, participants will be asked to make a commitment to act and determine a concrete course of action that they can take to fight AIDS in their communities.

Action planning is used in many different situations and by many different kinds of organizations. The first step in an action plan is identifying a need or an issue to be addressed. Then one can determine the goal that needs to be accomplished to address the issue. The steps or objectives needed to reach the goal must be specific and measurable. Each step or objective

should be assigned to a specific person in the organization to be responsible for making sure that it gets done. There should also be a timeline with specific times for each objective to be started and completed. All of these things should be written down, so that the organization's members can refer to the plan and monitor progress toward the ultimate goal. An action plan should be flexible so that one could add steps or objectives, as conditions change or unforeseen opportunities arise.

In any training situation, it is important to evaluate what has been learned both from the content and the process. To assess the degree, to which the participants have absorbed the lessons in this workshop, there is a posttest. To assess the workshop process, there is an evaluation form for participants to complete. This form will be used to assess whether the objectives were met, how well the trainers did their job, and to gain insights as to what can be done better in the future.

Finally, as the end of the workshop approaches, it is important to acknowledge the bonds that have been built in working on this very difficult issue. As a faith community, participants can join together and make a commitment to fighting this disease and working to uplift those who have been afflicted.

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 1: Action Plans

Objectives

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

- List at least three key issues related to HIV/AIDS
- Prepare an action plan to respond to an HIV issue affecting their organization or community
- Describe the steps in action planning
- State the criteria for setting objectives

Chapter 7, Section 1: Action Plans

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 1** Facts about HIV/AIDS *1 hour 30 minutes*	**Chapter 2** Care and Treatment *1 hour 30 minutes*	**Chapter 4** Basics of Counseling, cont. *2 hours*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling, cont. *1 hour* **Chapter 5** IEC —Developing Messages *45 minutes*	**Chapter 5** Integrating Messages into Sermons *1 hour 30 minutes* Sharing homework
Lunch	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*	*1 Hour*
Class	**Chapter 1** Facts about HIV/AIDS, cont. *1 hour 45 minutes* **Chapter 2** HIV/AIDS Transmission and Prevention *30 minutes*	**Chapter 3** Cultural, Social, and Economic Issues *2 hours 5 minutes*	**Chapter 4** Counseling Practicum *2 hours*	**Chapter 5** IEC —Developing Messages *45 minutes* and Integrating Messages into Sermons *1 hour 30 minutes*	**Chapter 7** Action Plans *1 hour 30 minutes*
Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 1: Action Plans

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
1 hour 30 minutes	**Developing an Action Plan for HIV/AIDS**	Small group work	Flipcharts, handouts, pens, paper, tape	Understanding level demonstrated in Action Plans

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 1: Action Plans

Activities and Handouts for Action Plans

- **Developing an Action Plan for HIV/AIDS**

Activity Developing an Action Plan for HIV/AIDS[54]

Objective

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

- List at least three key issues related to HIV/AIDS that were previously covered in the workshop
- Describe some strategies for a faith-based response to those issues
- Prepare an action plan to respond to an issue affecting their organization or community

Time allotted

1 hour 30 minutes

Preparation

Flipchart or handouts with "Issues for HIV/AIDS" from pages 6-32 to 6-36. Flipchart or handouts with "Action Planning Guidelines," on page 7-13, pens, paper and tape. Make handouts of "Sample Action Plan" from page 7-14.

Facilitation steps

1. Review the HIV/AIDS issues covered in the workshop and ask participants to mention some ways that members of faith-based groups can respond to these issues.

2. Ask participants to form groups with their colleagues who are attending the workshop. Participants who came alone should work individually. Post the flipchart or pass out handouts with issues from chapter 6 as a guide.

3. Have each group or individual spend about five minutes identifying and agreeing on an HIV issue in his or her work or organization that he/she would like to address, with the intent of changing the situation. Brainstorming is a good way of identifying an issue.

4. Once they have identified an issue, it is time to make a commitment. Ask the participants, "What can you and your organization do to help tackle the issue you have chosen? In making this commitment, briefly state your goal."

5. Post a flipchart or pass out handouts with the "Action Planning Guidelines." Go over guidelines and answer any questions. Ask the groups or individuals to use the guidelines to make a plan for them to follow when they return to their communities. Hand out Sample Action Plans.

[54] Adapted from *Gender, Reproductive Health, and Advocacy: A Trainer's Manual*, CEDPA, Washington, D.C., 2000

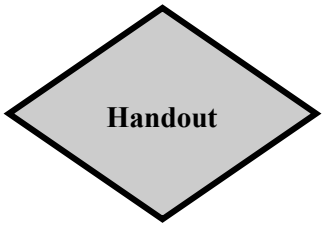
6. Explain that they may not have time or be able to make it as complete as they will be able to when they are back working with the rest of their organization, but encourage them to be as detailed as possible. Circulate among groups to answer any questions. Participants should write their plans on flipchart paper.

7. After about 30 minutes, have each group post their plan around the room.

Wrap-up

Have each group in turn report their plan to the larger group. Suggest that when they get back to their communities and start to implement their plans, they may want to keep in touch with other participants to compare progress and share successes.

Action Planning Guidelines[55]



Once you have identified an issue and made a commitment to do something about it, you need to plan what action you are going to take.

Some points to remember when making action plans—

- Plans need to be explicit and detailed. Write an action plan using lots of action words.
- A timeline must be included in the action plan. Be sure to list a start/complete date for each step in the plan. This will help everyone to keep on track. The dates can be changed or adjusted as the plan progresses.
- Assign tasks or steps to specific individuals who will be responsible for making sure that they are done on time.
- Write the action plan. This will allow members to refer to the plan and facilitate sharing information and progress. This does not mean that the plan cannot be changed as needed. Plans need to be flexible.
- Plans also need to be revised to address new or unforeseen challenges or opportunities. Monitor the organization's progress over time against the plan to appreciate what has been accomplished and determine what steps still need to be taken to reach the goal. Action planning is a process.

Action plans are designed to help you reach a goal. How you decide to go about this is your strategy. There may be many steps involved in your strategy. Breaking it down into incremental steps and setting objectives will help. An objective is an incremental step towards your goal. Sound objectives are crucial to the planning process. Depending on its quality, an objective can bring either clarity or confusion to the rest of the planning process. A good objective is SMART.

Criteria for Setting Objectives

S - specific

M -measurable

A - achievable

R - realistic

T - time-bound

[55] Adapted from "Gender, Reproductive Health, and Advocacy: A Trainer's Manual."

Sample Action Plan

Goal	Strategy	Objective	Responsibility	Timeline
Result to be achieved	Steps or objectives that illustrate how to reach the goal	Specific, measurable, achievable, realistic and time-bound	Who will accomplish that objective	When the implementer will accomplish that objective

The action planning process requires cooperation among individuals and groups. Individuals may want work in small groups to determine specific activities. Groups can then meet to negotiate and agree on an action plan. It is important to write down all the steps with start/finish dates and names of the individuals responsible. The plan can be modified over time. When an activity or objective is completed, make sure to monitor the results and adjust the plan if necessary.

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 2: Evaluation and Closing

Objectives

By the end of this class, participants will be able to—

- Demonstrate workshop learning
- Determine whether workshop objectives were met
- Evaluate trainers' skills in presenting the material
- Determine the training quality (materials, structure, venue)
- Determine the workshop's value to his/her work
- Appreciate the work done in the workshop

Chapter 7, Section 2: Evaluation and Closing

Schedule	Day One	Day Two	Day Three	Day Four	Day Five
	Registration *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*	**Recap** *20 minutes*
Class	**Chapter 1** Introductions and Workshop Structure *1hour 40 minutes*	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *2 hours*	**Chapter 4** Behavior Change *1 hour* and Basics of Counseling *30 minutes*	**Chapter 4** Care, Coping, Social and Spiritual Support, and Counseling *1 hour 30 minutes*	**Chapter 6** Advocacy Basics *2 hours*
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Break	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*
Class	**Chapter 2** HIV/AIDS Transmission and Prevention, cont. *1hour 30 minutes*	**Chapter 3** Stigma *1 hour 30 minutes*	**Chapter 4** Introduction to Care and Counseling *1 hour*	**Chapter 5** Integrating Messages into Sermons, cont. *30 minutes* Homework	**Chapter 7** Evaluation and Closing *2 hours*
Evaluation	*15 minutes*	*15 minutes*	*15 minutes*	*15 minutes*	

Sample Lesson Plan

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 2: Evaluation and Closing

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
30 minutes	**Posttest**	Written test	Posttests	Number of correct answers on posttest
20 minutes	**Workshop Evaluation**	Individual questionnaires	Evaluation forms, flipcharts with workshop goal and objectives, envelope or folder for collecting completed forms	Active participation
30 minutes	**Head, Heart, Feet**	Participants state one new learning, one new feeling and one commitment to action that they got out of this workshop	Small pieces of paper in 3 different colors, enough for one of each color for each participant	Statement of learning, feeling and commitment

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 2: Evaluation and Closing

Activities and Handouts for Evaluation and Closing

- **What We Have Learned About HIV/AIDS**
- **Workshop Evaluation**
- **Head, Heart, Feet**

Activity What We Have Learned about HIV/AIDS

Objective By the end of the activity, participants will be able to—

- Demonstrate how much content they absorbed from the workshop

Time allotted 20 minutes

Preparation A pre- and posttest form and key are located in Appendix III on pages III-38 to III-42. Make copies for all the participants. Some participants may not be familiar with a written testing format, so the trainer will have to adapt the testing to meet their needs. Tests should be based on the training content. If the trainer has modified the training content, the trainer will also need to modify the test to reflect the changes.

Facilitation steps

1. Sometimes participants feel intimidated by the idea of testing, so remind participants that this is a test for the trainer—to assess how well the trainer presented the information in the workshop.

2. Distribute the test forms and instruct participants to answer all the questions to the best of their ability, without discussion among themselves.

3. When everyone is finished, collect all the tests.

Wrap-up Emphasize that the purpose of the workshop evaluation is to help the trainer become a better trainer. (The trainer or an assistant may want to compile the test results during the closing exercise. The results can then be compared with the pretest results and can be displayed as a graph or chart to show participants' improvement. Be sure that the results are anonymous.)

Activity Workshop Evaluation

Objective

By the end of the activity, participants will be able to—

- Determine whether the workshop objectives were met
- Evaluate the trainers' skills in presenting the material
- Determine the training quality (materials, structure, venue)
- Determine the workshop's value to his/her work

Time allotted

20 minutes

Preparation

A sample evaluation form is located in Appendix III on pages III-43 to III-45. Make copies for all the participants. The evaluation form may need to be adapted to match the training content. Place the flipcharts with the workshop goal and objectives at the front of the room where participants can see them.

Facilitation steps

1. Ask the participants to think about the workshop goal and objectives. Draw their attention to the flipcharts.

2. Tell the participants that it is important for the trainers to know what worked in this training and what needs to be improved for future training. State that you would like the participants to evaluate the workshop.

3. Distribute the final evaluation forms. Ask participants to be honest and to give as much detail as possible and remind them that the evaluations are anonymous.

4. Provide an envelope or folder in which participants can place their evaluation forms when completed.

Wrap-up

After everyone has put their evaluation forms into the envelope or folder, thank the participants for their feedback. Emphasize that this evaluation will help you to become a better trainer and to improve future training.

Activity Head, Heart, Feet[56]

Objective By the end of the activity, participants will be able to—

- State one new fact that they have learned in the workshop
- State one new feeling, attitude, or emotion that has come out of the workshop
- State one concrete action that they will take as a result of the workshop

Time allotted 30 minutes or more, depending on the number of participants

Preparation Create a very large outline of a person on a number of flipcharts taped together. You may do this very easily by having someone lie down on the flipcharts and then tracing that person's body. Draw a large heart in the chest of the outline. Post the outline in the middle of the wall and arrange a ring of chairs around it. Give three pieces of different colored paper to each participant.

Facilitation steps

1. Summarize the workshop up until this activity. Remind the participants that the group has spent some very intense days together discussing a subject that can often be very difficult for people to address. They have very honestly and candidly discussed many issues associated with HIV/AIDS: the terrible impact it has been having on our families, communities, and countries; how it is transmitted and ways to prevent it; gender and its influence on HIV/AIDS; and about living with HIV/AIDS. They have talked about ways to counsel people affected by AIDS, how to bring the messages of compassion and care to our communities, and how to effect change with regard to HIV/AIDS.

2. State that as the workshop comes to a close, there is some time set aside for everyone to reflect on the past five days. Ask the participants to "Think about all of the sessions, what you learned, and what you felt, and what you feel committed to doing now."

3. Instruct the participants to take out one of the colored pieces of paper. Ask them to think about one new fact or piece of information that they learned in the workshop. There may have been several, but ask them to identify the one that was the most important new learning for them. They should write that idea in bold letters on the piece of paper.

[56] The "Head, Heart, Feet" exercise is reprinted (with permission of Rick Arnold et al.) from "Educating for a Change," p. 106, from *Between the Lines,* the Doris Marshall Institute for Education and Action, n.p., 1991.

4. When all participants have finished, invite them to think about how this workshop made them feel.

    - Have they changed their minds about anything as a result of these three days?

    - Have they formed any new attitudes or opinions?

    Ask them to write their most important new feeling, attitude, or opinion on the next piece of colored paper.

5. Lastly, ask participants to think about one thing that they are committed to doing after this workshop. Participants often come to such sessions, learn a great deal, and leave without allowing our lives to be changed too much by the content of the sessions. But they have discussed very powerful issues in these past several days. Ask the participants, "What do you intend to do with this new knowledge?" Ask the participants to write down the one thing that they are most committed to doing on the final piece of paper.

6. After all participants have finished, refer them to the large outline on the wall. Ask that participants come up to the outline, in turn, and read their statements.

    - First, they should tell us their most important new learning and then stick that piece of paper on the head of the outline.

    - Then they should tell us their most important new attitude, feeling, or opinion and place that on the heart of the outline.

    - Lastly, they should state what one thing they are most committed to doing about HIV/AIDS after the workshop and place that on the feet of the outline.

7. Continue in this way until all participants have had a turn. The facilitator(s) may wish to end the session by discussing their own "head, heart, and feet."

Wrap-up

The "Head, Heart, Feet" exercise often moves participants to a profound or intimate mood. The trainer may wish to end the workshop immediately after this session or go on to any closing ceremony that was planned to officially close the workshop.

Chapter 7: HIV/AIDS Planning, Evaluation, and Closing

Section 2: Evaluation and Closing

Alternate Activities and Handouts for Evaluation and Closing

- **The Question Box**
- **Liturgy of the Casting Out of Stones**

Activity The Question Box[57]

Objective By the end of the activity, participants will be able to—

- Restate lessons learned in the course of the workshop
- Facilitate others in solving problems/answering queries

Time allotted 30 minutes

Preparation Make a box with a hole in the top that is big enough that participants can drop written questions into it. Provide paper and pens.

Facilitation steps

1. Summarize the workshop up until this point. Remind the participants that the group has spent some very intense days together discussing a subject that can often be very difficult for people to address. They have discussed how HIV/AIDS is transmitted and ways to prevent it, gender and its influence on HIV/AIDS, and living with HIV/AIDS. They have talked about ways to counsel people affected by AIDS, how to bring the messages of compassion and care to our communities, and how to effect change with regard to HIV/AIDS.

2. State that as the workshop comes to a close that some time has been set aside for everyone to reflect on the past three days. Ask the participants to, "Think about all of the sessions, what you learned, and anything that you are unclear or still have questions about."

3. Instruct the participants to write any questions they might have on a sheet of paper. The questions should be written anonymously (i.e. without the participant's name). Explain that the questions will be put in a box and will be answered by fellow participants. Pass the box around.

4. When all participants have finished, have them divide up into two teams, explaining that one team will act as facilitators (instructors), the others as participants (trainees). Have each instructor draw one question from the box.

[57] Adapted from "HEDC 606 Training Methodology Student Materials," Tulane School of Public Health and Tropical Medicine, 1999

5. The instructors should take turns asking their questions. Each trainee should answer one question. If the instructor does not agree with the answer given by the trainee, s/he can ask for further clarification, additional opinions from the other trainees, or correct the answer. If an instructor corrects a trainee's answer, s/he should be sure that the other instructors agree with his correction.

6. After the first set of questions drawn from the box have been answered; reverse the roles of the two groups. Those who were to instructors, become trainees and those who were trainees become the instructors and draw the remaining questions from the box. Repeat the process until all the questions have been answered.

Wrap-up

When all the questions have been answered, review any points that were particularly confusing. Remind participants that if they need help or have questions in the future, they can use each other as resources.

Activity Liturgy of the Casting Out of the Stones

Objective By the end of the activity, participants will be able to—

- Appreciate the work they have done in the workshop

Time allotted 15 minutes

Preparation Small stones for ceremony (some with sharp edges), basket for stones, and a small table or altar for closing ceremony.

Facilitation steps

1. Say, "This liturgy originated with the Religious Coalition on AIDS in Allentown, Pennsylvania. I hope you find it an appropriate complement to the work you've just completed."

2. Have everyone gather in a standing circle around the table or altar and ask someone to pass the stones so that everyone gets one. As you light the candle(s) say,

   "You will each receive a stone. During the time that follows, reflect on the stone held in your hand—how it feels, how it could be used. Meditate on the stone imagery in the selected scriptural passages as I read them and how these words apply to your attitudes toward persons living with AIDS.

3. Have one of the participant clergy read, "In Matthew 7:9, we read, 'Or what one of you, if your child asks for bread, will give a stone?'

   "What is a stone anyway? It is cold, hard, dirty, and lifeless; some with sharp edges. This life of mine can sometimes be cold, hard dirty and life-denying. This life of mine also has sharp cutting edges. This life of mine can hurt and bring pain. Sometimes we are much like the stones we hold in our hands.

   "Forgive us, O God, when our only response to the outstretched hand of our neighbor with AIDS is a stone-cold hardness of heart, rather than a warm hug and free outpouring of love, a sharp cutting remark, rather than words of compassion and hope.

   "Forgive us, O God, when we choose ignorance in hopes of protecting our image of childhood innocence rather than choose knowledge to help protect our lives. Forgive our nation, O God, for not quickly tipping our budgetary scale in favor of life: quality health care and education accessible for all and much greater assistance to women, men and children living with HIV/AIDS."

"Ecclesiastes 3.1,5,6 says, 'For everything there is a season and a time for every matter under heaven… a time to cast away stones, and a time to gather stones together… a time to keep, and a time to cast away…."

"A time to clutch our fears, and a time to let go of our fears and walk in faith. Forgive us, O God, for firmly clutching the stones of ignorance and death rather than casting them from our lives."

"The stone which the builders rejected has become the head of the corner," says Psalms 118:22."

"Not all stones are instruments of hurt. That stone in your hand can be used to build a new foundation of love and understanding."

"Genesis 31:44-46, 51-52 says, 'Come now let us make a covenant, you and I; and let it be a witness between you and me.' So Jacob took a stone, and set it up as a pillar. And Jacob said to his kinsmen, 'Gather stones,' and they took stones, and made a heap… Then Laban said to Jacob, "See this heap and the pillar, which I have set between you and me. This heap is a witness, and the pillar is a witness."

"As Jacob took a stone and joined it with the stones of others to create a visible covenantal sign, let us join our stones with the stones of others in this room, as a sign of our covenant with one another to work and pray together on behalf of our brothers and sisters living with and affected by HIV/AIDS."

4. Have each person place his/her stone in the pile. Ask participants to hold hands for a moment and reflect in silence on all the people who have died of AIDS, those living with AIDS, and those who are working to prevent the spread of the disease.

   Say " Let us search our hearts for the YES that comes from commitment to sharing love with others, and let us look within our community for the YES that comes from solidarity and action. Amen."

Wrap-up Thank everyone for coming. Allow time for people to talk informally.

Notes:

Appendices

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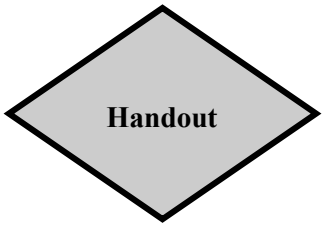


Appendix I: Faith-Based HIV/AIDS Resources

Websites

- http://www.aidsfaith.com: Council of Religious AIDS Networks
- http://www.unaids.org: Joint United Nations Programme on HIV/AIDS (UNAIDS)
- http://www.hivpositive.com/f-Resources/f-17-Newsletters/R-Religion.html: Resources about HIV/AIDS and the Religious Community
- http://gbgm-umc.org: Methodist Global Ministries
- http://www.apcn.org: AIDS Pastoral Care Network
- http://www.thebody.com/religion.htm: Resources on Religion and AIDS
- http://www.balmingilead.org: The Balm in Gilead NGO website
- http://www.aapc.org: American Association of Pastoral Counselors
- http://www.bu.edu/cohis/aids/new/religion.htm: Religion and AIDS/HIV from the CDC, a resource guide
- http://www.ncan.org: National Catholic AIDS Network
- http://www.map.org: MAP International

Print Resources

UNAIDS Publications, available from http://www.unaids.org.

"Comfort and Hope: Six Case Studies On Mobilizing Family And Community Care For and By People With HIV/AIDS." UNAIDS Best Practice Collection, UNAIDS, Geneva, Switzerland, June 1999.

"AIDS Education through Imams: A Spiritually Motivated Community Effort in Uganda." UNAIDS Best Practice Collection. UNAIDS, Geneva, Switzerland, October 1998.

"UNAIDS Summary Booklet of Best Practices in Africa," UNAIDS, Geneva, Switzerland, Issue 2, 2000.

"Activities for Individuals and Churches Developing HIV/AIDS Ministries," 1994, (4 pp.).

Available from: General Board of Global Ministries, United Methodist Church, Health and Welfare Ministries Program Department, 475 Riverside Dr., 3rd Fl., Room 350, New York, NY 10115, USA. (212) 870-3909.

A photocopy of this material is available from: CDC National AIDS Clearinghouse Document Delivery Service, P.O. Box 6003, Rockville, MD 20849-6003, USA. (800) 458-5231. Price: $5.10.

"Affirming Persons, Saving Lives: AIDS Awareness and Prevention Education," 1993.

This training package contains curriculum material for a church-based AIDS-awareness and prevention program for children, youth, and adults. The package is composed of several separate "Learning Series" targeted to different age groups.

Available from: United Church Board for Homeland Ministries, 700 Prospect Ave., Cleveland, OH 44115-1100, USA. (216) 736-3270.

"The African American Clergy's Declaration of War on HIV/AIDS," 1994.

This one-page statement about AIDS in the African American community contains promises to battle fear and ignorance of AIDS through prevention programs, counseling, and sermons.

Available from: Balm in Gilead Incorporated, P.O. Box 86, Lincolnton Sta., New York, NY 10037, USA. (212) 860-7897.

AIDS. Nashville: Abingdon Press, 1993.

This teaching guide is available in both English and Spanish. It explains the reality of AIDS to teenagers from a Christian perspective.

Available from: Abingdon Press, 201 8th Ave., Nashville, TN 37202 USA. (615) 749-6000. ISBN: 0-687-78220-1.

"AIDS and the African American Church: An AIDS Education and Training Guide for African American Church Religious Leaders and Ministers," 1991, (86 pp).

This teaching guide provides religious leaders and ministers with tips and strategies on how to conduct AIDS education. Six modules cover different areas of the AIDS epidemic, beginning with the church's role.

Available from: Jackson State University, National Alumni AIDS Prevention Project, P.O. Box 18890, Jackson, MS 39217-0154 USA. (601) 968-2519.

A photocopy of this material is available from: CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003 USA. (800) 458-5231. Price: $9.20.

AIDS and the Church: The Second Decade. Louisville: Westminster/John Knox Press and Belleville: Spring Arbor Distributors, 1992.

This monograph provides a Biblical and theological analysis of the HIV/AIDS epidemic, proposing that the epidemic is a call to respond compassionately to everyone touched by the illness (238 pp.).

Available from: Westminster/John Knox Press, 100 Witherspoon St., Louisville, KY 40202 USA. (800) 227-2872, and Spring Arbor Distributors, 10885 Textile Rd., Belleville, MI 48111 USA. (800) 395-5599.

"AIDS and Your Religious Community: A Hands-On Guide for Local Programs," 1991, (108 pp.).

This manual tells how to establish a ministry program for persons with HIV/AIDS and includes 27 proven models for these ministries.

Available from: Unitarian Universalist Association, AIDS Action and Information Program, 25 Beacon St., Boston, MA 02108 USA. (617) 742-2100 and AIDS National Interfaith Network, 110 Maryland Ave., NE, Suite. 504, Washington, DC 20002 USA. (202) 546-0807.

"AIDS in the Church," 1993.

This 8-page brochure suggests ways in which church leaders can help educate African-American church congregations about AIDS.

Available from: Resource Development Center, Inc., AIDS Outreach Walk-In Project, P.O. Box 964, Brownsville, TN 38012 USA. (901) 772-4012.

"AIDS: A Covenant to Care," 1990.

This 9-page paper invites congregations of the United Methodist Church to develop Covenant to Care statements, committing themselves to welcome persons with AIDS from their communities. The paper also outlines components of pastoral counseling and patient support that churches might adopt.

Available from: General Board of Global Ministries, United Methodist Church, Health and Welfare Ministries Program Department, 475 Riverside Dr., 3rd Fl., Room 350, New York, NY 10115 USA. (212) 870-3909. Focus paper no. 6.

A photocopy of this material is available from: CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003 USA. (800) 458-5231. Price: $5.35.

"The AIDS Ministry Handbook: A Resource Guide for Faith Communities and AIDS Ministries," June 1994.

AIDS National Interfaith Network. Washington, DC.

"AIDS Pastoral Care: An Introductory Guide," 96 pp., 1994.

This book familiarizes caregivers with pastoral care techniques for a prospective AIDS ministry. Suggested readings are included.

Available from: ARC Research Company, 11595 State Rd. 70, Grantsburg, WI 54840 USA. (715) 689-2153. ISBN: 0-9636183-1-8; Price: $7.95 per copy in 8/94.

"The American Religious Community and Its Response to AIDS: AIDS Ministry Then and Now: Parts I & II," 1995.

Part I of this paper summarizes the history of the American religious response to AIDS since 1980 and gives an overview of the present status of AIDS ministries. Part II consists of source material for Part I.

Available from: AIDS National Interfaith Network, 110 Maryland Ave., NE, Ste. 504, Washington, DC 20002 USA. (202) 546-0807.

A photocopy is available from: CDC National AIDS Clearinghouse Document Delivery Service, P.O. Box 6003, Rockville, MD 20849-6003 USA. (800) 458-5231. Price: $8.85.

"Assisting Hispanic Community-Based Organizations to Understand and Work Effectively With the Religious Community," 1993.

This 8-page report focuses on collaboration between Hispanic community-based organizations (CBOs) and the religious community to expose a larger audience to HIV education and prevention efforts.

Available from: National Council of La Raza, 1111 19th St., NW, Ste. 1000, Washington, DC 20036 USA. (202) 785-1670.

Byamugisha, Gideon, Lucy Y. Steinitz, Glen Williams and Phumzile Zondi. Journeys of Faith: Church-based responses to HIV and AIDS in three Southern African Countries. TALC, July 2002.

This is number 16 in the Strategies For Hope series by that TALC publishes (116 pp.). ISBN 0 9543060 0 7

"Choose Life So That You May Live; A Jewish Family HIV/AIDS Educational Experience," 1993.

This is the leader's manual for a three-session AIDS education workshop for the Jewish community (90 pp.). The three workshop sessions are learning about AIDS, learning about risk reduction, and communicating with children and adolescents.

Available from: Michigan Jewish AIDS Coalition, 21550 W. 12 Mile Rd., Southfield, MI 48076-2399 USA. (810) 356-2123.

A photocopy of this material is available from: CDC National AIDS Clearinghouse Document Delivery Service, P.O. Box 6003, Rockville, MD, 20849-6003 USA. (800) 458-5231. Price: $9.40.

"Choose Life: Taking Action to Be Fully Alive With HIV/AIDS," 1994.

This brochure discusses the importance of living positively with HIV/AIDS and suggests activities to nurture religious faith and maintain self-esteem.

Available from: Universal Fellowship of Metropolitan Community Churches, AIDS Ministry, 5300 Santa Monica Blvd., Suite 304, Los Angeles, CA 90029 USA. (213) 464-5100.

The Church with AIDS: Renewal in the Midst of Crisis. Louisville: Westminster/John Knox Press, 1990.

This monograph was developed from a National Council of Churches study group' work, which met in 1986. It supplements essays written for the monograph with the text of sermons, letters, and personal stories of PLWHA (223 pp.).

Available from: Westminster/John Knox Press, 100 Witherspoon St., Louisville, KY 40202 USA. (800) 227-2872.

"The Color of Light: Daily Meditations for All of Us Living With AIDS," 1988.

This monograph provides daily meditations for persons with HIV/AIDS, their families, and friends (193 pp.).

Available from: Hazelden Foundation Educational Materials, P.O. Box 176, Center City, MN 55012-0176 USA. (612) 257-4010. Order no. 5056.

"Congregation-Based Care Teams: A Guide and Resource Manual for Practical Support and Pastoral Care of Persons With AIDS," 1992.

This manual enhances and supplements the Care Team training program of the Regional AIDS Interfaith Network (RAIN), which provides pastoral counseling and patient support related to AIDS (149 pp.).

Available from: HIV/AIDS Ministry - Catholic Charities, 1000 Howard Ave., Suite 1200, New Orleans, LA 70113 USA. (504) 523-3755.

A photocopy of this material is available from: CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003 USA. (800) 458-5231. Price: $12.35.

Creating Compassion: Activities for Understanding HIV/AIDS. Cleveland: Pilgrim Press, 1994.

This guide presents activities designed to enable people of all ages, especially children, to learn about HIV and AIDS. The activities are geared for use by teachers in Christian education programs and in public, private, and parochial settings. (175 pp.)

Available from: Pilgrim Press, 700 Prospect Ave., Cleveland, OH 44115-1100 USA. (216) 939-6064. ISBN: 0-8298-0996-1; Price: $13.95 per copy in 1995.

"Developing Your Church AIDS Policy," 1994.

This manual provides assistance to churches that are developing AIDS policies (27 pp.).

Available from: AIDS Information Ministries, P.O. Box 136116, Fort Worth, TX 76136 USA. (817) 237-0230.

A photocopy of this material is available from: CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003 USA. (800) 458-5231. Price: $6.25.

Dobbels, W.J. An Epistle of Comfort: Scriptural Meditations and Passages for Persons Suffering From AIDS. Kansas City: National Catholic Reporter Publishing, 1990.

This 123-page monograph contains 11 meditations in the form of letters from the author with accompanying Scriptural passages. The author is a Jesuit priest and psychotherapist who has AIDS.

Available from: National Catholic Reporter Publishing, Incorporated, Sheed and Ward, P.O. Box 419492, Kansas City, MO 64141-6492. (816) 531-0538.

An Early Journey Home: Helping Dying Children and Grieving Families. Grand Rapids: Baker Book House Company, 1992.

This monograph is directed to pastors, chaplains, Christian health-care professionals, lay ministers, and friends of suffering families and offers strategies on ministering to parents who are losing, or who have lost, a child to death (205 pp.).

Available from: Baker Book House Company, P.O. Box 6287, Grand Rapids, MI 49516-6287. (616) 676-9185.

"Episcopal Guide to TAP," 1994.

This manual provides guidelines for implementing a Teen for AIDS Prevention (TAP) peer education program, customized for Episcopal use (184 pp.).

Available from: Episcopal Church Center, Education for Mission and Ministry Youth Ministries Office, 815 Second Ave., New York, NY 10017 USA. (212) 867-8400.

Reamer, F.G., editor. *AIDS & Ethics.* New York: Columbia University Press, 1991.

This collection of essays addresses the ethical issues created by the AIDS epidemic (317 pp.).

Available from: Columbia University Press, 562 W. 113th St., New York, NY 10025 USA. (800) 944-8648.

Addendum to Appendix I

Additional HIV/AIDS Resources

The Internet provides a rich resource to supplement the materials provided in this packet. The catch is to discern the sites that are both accurate and insightful. Here are some valuable sites. Items can be downloaded and photocopied from this list for use by your group.

The Washington Office on Africa (WOA) and the WOA Board

The WOA site, www.woaafrica.org includes the most recent action alerts and documents. WOA maintains a page that lists all of its AIDS-related documents at www.woaafrica.org/AIDS12.htm.

The national churches represented on the WOA Board also have some useful sites. Here are some good sites:

- The Presbyterian Church (USA) provides personal stories, statistics and a list of projects they support around the world. http://www.pcusa.org/health/international/aids/aids.htm
- The Lutherans' *Stand with Africa* Campaign on the Evangelical Lutheran Church in America (ELCA) site provides copies of the *Stand with Africa* newsletters, facts and figures, maps, stories of people living with and affected by AIDS, and videos. http://www.loga.org/standwithafrica.html
- The United Methodist Church has a timeline on AIDS, news, background and other links. http://www.gbgm-umc.org/programs/aidsafrica/

Other Web Sites

Among many good reports, the Global AIDS Alliance provides a briefing document on President Bush's 2003 budget request to combat the global AIDS pandemic. The site also has links to more information. http://globalaidsalliance.org/missed_opportunity.html

A Broken Landscape, referred to elsewhere, can be found as a book and as a website. It tells the story of AIDS in Africa through pictures and word and is an excellent way to put a face on the epidemic. This site also has many good links to other websites dealing with AIDS. http://www.abrokenlandscape.com/

The Doctors Without Borders (Médecins sans Frontières) website is especially helpful with information about its campaign for access to essential medicines. There are good articles that explain why people in developing nations and economies cannot get the medicines they need. http://www.accessmed-msf.org/prod/morepublications.asp?catid=1&subcatid=173&status=172

The Global Treatment Access Campaign (sponsored by Health GAP's Global Access Project) website provides articles that discuss what is currently happening with AIDS in countries around the world. Subjects include public health and how it is affected by agreements made by the World Trade Organization, the UN's effort to make medicines more accessible to people living with AIDS, and how much money the US is sending to the Global Fund. http://www.globaltreatmentaccess.org/

The UNAIDS website is a key source of information and statistics about HIV/AIDS, including 2001 country reports, press releases, and articles about what is being done by UN agencies to address HIV/AIDS. http://www.unaids.org/

- Note especially its December 2001 "Global Report" http://www.unaids.org/epidemic_update/report_dec01/index.html
- The "UNAIDS International Partnership Against AIDS in Africa" http://www.unaids.org/africapartnership/whatis.html

In association with the Global AIDS Alliance, the Artists Against AIDS Worldwide (AAAW) re-recorded Marvin Gaye's song "What's Going On?" The AAAW website includes the song lyrics, audio, and video. There is also a ticker counting AIDS deaths since January 1, 2002 and a place to write to the president and your senators calling for more to be done http://www.aaaw.org/index.html.

The Stop Global AIDS campaign website provides specific points to demand from the US Congress and background on why dropping the debt and treating people living with AIDS are both necessary to eradicate AIDS. There is specific information on how HIV and AIDS work and what each one of us can do to prevent the spread of AIDS. It provides excellent links to over twenty other organizations, both national and international, committed to stopping global AIDS. http://www.stopglobalaids.org/

The Ecumenical Advocacy Alliance (WOA is a member) launched its HIV/AIDS campaign on World AIDS Day, December 1, 2001. Its campaign details, action plan, photos and a toolkit of AIDS information are available on its website. The toolkit is a fully downloadable list of resources that explores more about the AIDS epidemic and what can be done. http://www.e-alliance.ch/hivaids/download.htm

AIDS in Africa: A Generation at Risk is a four-page study/action resource by the Church World Service that highlights the staggering dimensions of the African AIDS crisis. It suggests to church groups, private agencies, and caring people how to respond to this catastrophe in an active way. It also lists websites and other sources for deepening one's understanding of the pandemic. The resource can be downloaded from http://www.churchworldservice.org/FactsHaveFaces/aidsfactsheet.htm.

Macroeconomics and Health: Investing in Health for Economic Development. This report, prepared by the WHO Commission on Macroeconomics and Health details why it is important to raise the health levels of the world's poor. There is a strong focus on the AIDS epidemic. The report can be downloaded from http://www3.who.int/whosis/cmh/cmh_report/e/report.cfm?path=cmh,cmh_report&language=english

Videos

The documentary from the United Methodist Church, "A Generation of Hope," is the inspiring story of how Zimbabwe's children, orphaned by AIDS, fight to keep their families together, and struggle to make a future for themselves. It can be viewed or ordered online from http://gbgm-umc.org/aidschildren/

The Lutheran World Relief video, "Braving Aids: Senegal's Way," illustrates how Senegal has responded to AIDS. Produced by Lutheran World Relief for the Stand with Africa campaign, the video can be ordered online from http://www.lwr.org/swa/video.html

From the Evangelical Lutheran Church in America's video magazine, *Mosaic*, the video "From Coffins to Hope: AIDS in Africa" can be ordered online from http://www.elca.org/co/mosaic/fall01.html

The Reformed Church in America (RCA) produced "Battling AIDS in Africa and America," and the video shares the inspiring story of how a number of RCA churches in North America—and a number of their partner churches in Africa—have responded to the tragedy of AIDS. An accompanying study guide is designed to help think about AIDS and respond to it from a Biblical perspective. To order, contact the RCA Distribution Center/TRAVARCA at 1-800-968-7221 or by email at orders@rca.org

The Washington Office on Africa compiled this information for the HIV/AIDS Educational Packet as part of the Millennial Campaign for Africa, and it is intended to encourage education, reflection and action. The WOA has given its permission for reproduction of this information. http://www.woaafrica.org/AIDS30.htm

Appendix II: Developing an Advocacy Strategy

Appendix to Chapter 6

Key Questions

- What is advocacy?
- What topics, related to HIV/AIDS, could we advocate on?
- What steps do we follow in creating an advocacy plan

Introduction Faith Community Responses to HIV/AIDS

Advocacy is the act or process of supporting a cause or issue. Advocacy is much more than dissemination of information and education. In addition, advocacy is central to Christian life and witness. Information and education educates individuals and the community about a topic or service. Advocacy goes beyond this by seeking support for a cause or issue, influencing others to support it and/or, influencing or changing policy or legislation that affects it. An advocacy campaign is a set of targeted actions in support of a cause or issue.

Advocacy on HIV/AIDS must be based on factual information. Groups who intend to advocate should collect current studies such as baseline studies and situational analyses. HIV/AIDS advocacy work should focus on—

- Creating awareness of the magnitude and seriousness of the problem
- Diminishing discriminatory practices

- Removing policy and other barriers to prevention and care activities
- Campaigning for effective and sustainable action

Advocacy work aims to influence the highest authorities in the church and/or the country to provide leadership, political support, and commitment. Advocacy work is important because groups can form partnerships to achieve what one organization could not achieve alone.

Faith Community Responses to HIV/AIDS

Appendix II: Developing an Advocacy Strategy

Objectives

By the end of this class, participants will be able to—

- Select several issues as the focus of an advocacy campaign
- Draft a mission statement and goals for an advocacy campaign
- Set two advocacy objectives for the selected issue
- Use a power map as a tool for exploring power dynamics around an advocacy issue (alternative activity)

Overview

An **advocacy campaign** is a set of targeted actions in support of a cause or issue. People advocate for a cause or issue because they want to—

- Build support for that cause or issue
- Influence others to support it, and/or
- Try to influence or change legislation that affects it

Certain steps must be followed to begin an advocacy campaign. These include—

1. **Identify a specific issue** to advocate for and define it precisely
2. **Decide who is needed to support your cause or issue**—Who are you trying to influence or change so that they support the cause?
3. **Decide on the outcome** of the advocacy efforts—what concrete result do you want to achieve?

A few individuals cannot implement an advocacy campaign. Advocacy involves the commitment and support of everyone in the organization and often requires the help of outside organizations as well.

Advocates try to build support for issues by influencing public opinion or changing legislation that affects the issue. This is not a task for a few individuals. An advocacy campaign must be developed. Successful advocacy campaigns must be carried out by a committed organization, often by working with other organizations with the same or similar goals.

Mission Statements

Before an advocacy campaign can be implemented, the mission must be defined. (Defining the campaign's mission is different from an organization's "mission statement.") **An advocacy mission statement identifies the campaign goal and explains its purpose**. The mission statement guides the campaign activities and states **what it is the campaign hopes to achieve**, and therefore must be worded carefully.

When writing mission statements—

- Clearly convey who you are and what you are doing, stressing long-term goals and end results
- Try to be as descriptive as possible, keeping it to a maximum of four sentences
- Make sure the statement is interpreted the way you intended. Have someone review it from an opposing point of view

Sample Mission Statements

- ORGANIZATION 1: To empower youth to make informed sexual and reproductive health choices in the context of HIV/AIDS.
- ORGANIZATION 2: To meet the needs of vulnerable children by the achievement of quality educational services.
- ORGANIZATION 3: To enable all individuals affected by and living with HIV/AIDS to live their lives to the fullest, free of discrimination, and with full access to their human rights.

Establishing Goals, Objectives and Activities

The mission statement identifies the overall aim or ultimate goal. To reach this goal, the organization will need to define intermediate goals that are stages in reaching the mission statement. Advocacy goals are medium or long-term visions for change. These goals must be defined at the beginning of the advocacy campaign. Goals are statements of the general result you want to achieve.

Goals should be specific and precise. The goals should be realistic and achievable. The following questions can be answered to help set goals.

- What are the short-term and long-term goals needed to meet the organization's ultimate goal as described in the mission statement?
- How can these be stated so that they are clearly understood?
- What would constitute a "success" or victory? And how will it be measured?
- Who will help us achieve our goals? Who are our allies/opponents?
- Are our goals achievable, given our resources (financial, staff, facilities, reputation, past experiences, etc.)?
- What problems may arise from achieving these goals? And can they be overcome?

Examples of Organizational Goals

ORGANIZATION 1 had the ultimate goal to empower youth to make informed sexual and reproductive health choices in the context of HIV/AIDS. As steps toward that aim, it might choose other goals such as—

- Establishing a network of youth clubs/organizations to demonstrate the demand for improved education and skills building on sexual and reproductive health (SRH)
- Educating the public and opinion leaders about the benefits of SRH education for youth
- Persuading government members of the importance of supporting and expanding funding for programs aimed at preventing HIV infection among youth

ORGANIZATION 2 wanted to meet the needs of vulnerable children (children affected by HIV/AIDS) by achieving quality educational services. Its intermediate goals might be—

- To ensure all vulnerable children have access to basic education
- To ensure that basic education services integrate counseling, HIV/AIDS education and vocational skills
- To ensure government programs address the barriers to education for vulnerable children

ORGANIZATION 3 had the goal of enabling all individuals affected by and living with HIV/AIDS to live their lives to the fullest, free of discrimination, and with full access to their human rights. It might consider its short-term goals as—

- Informing the general public and people affected by HIV/AIDS of their basic human rights
- Creating widespread public acceptance of PLWHA
- Education of service providers, community leaders, local elected officials, and political leaders about discrimination of PLWHA

Objectives

Objectives are incremental steps toward achieving a goal that should be—

- Specific
- Measurable
- Achievable
- Realistic
- Time-bound

Objectives are descriptions of quantifiable activities that are undertaken to meet goals. Objectives should be specific and as measurable as possible so that one can see when the objectives have been met. Objectives should have a timeframe in which they should be achieved to monitor progress.

Examples of Objectives

ORGANIZATION 1's objectives for goal one (establishing a network of youth clubs/organizations) might include—

- Establish contact with other groups/agencies that have youth organizations
- Develop, test and produce information materials on SRH benefits for youth
- Create guidelines for SRH and HIV/AIDS education with the input of youth and youth–serving organizations

ORGANIZATION 2's objectives for goal three (to ensure government programs address the barriers) might include—

- Develop a "education bank" for local vulnerable children for donation of school supplies, school fees, and school uniforms
- Negotiate with local government and private schools to give grants or waive tuition for vulnerable children
- Promote the establishment of after-school programs for HIV/AIDS, vocational training, and counseling for both in-and out-of-school youth

ORGANIZATION 3 might have the following objectives for goal one (informing the general public and people affected by HIV/AIDS) —

- Integrate messages on basic human rights into church/local media
- Train local religious leaders and PLWHA to do community outreach on HIV/AIDS, stigmatization and human rights
- Develop a television or radio show about a family dealing with HIV/AIDS that illustrates issues of discrimination and how to solve them
- Lobby local and national leaders on basic rights for all, especially for those living with HIV/AIDS

Activities

Activities support the attainment of objectives. They should also have a time frame so that progress can be tracked. Activities further specify and quantify objectives.

Appendix II: Developing an Advocacy Strategy

Sample Lesson Plan

Sample Session Design

Time	Content	Methodology	Materials Needed	Evaluation
45 min	**Selecting HIV/AIDS Advocacy Issues**	Discussion	Flipcharts, note cards	Active participation
1 hour 30 minutes	**Advocacy Mission Statement**	Group work	Tips for "Mission Statement" flipcharts, blank flipcharts, markers	Understanding level reflected in mission statements
1 hour	**Developing Advocacy Objectives**	Group work	Flipchart with "Elements of Advocacy Objective," blank flipcharts, markers, handouts	Understanding level reflected in policy actor and policy action clearly identified in each objective

Important Terms

Activities	Descriptions of quantifiable activities that are undertaken to meet objectives
Advocacy campaign	A set of targeted actions in support of a cause or issue
Goal	A statement of the general result to achieve
Issue	The problem that requires a policy action
Mission statement	Identifies the advocacy campaign goal and explains its purpose. The mission statement guides activities and states what it is to be achieved (the ULTIMATE GOAL)
Objectives	Incremental steps toward achieving the goal, which are specific, measurable, achievable, realistic, and time-bound
Target Audience	The policy-makers that the campaign is trying to influence to support the campaign issue, e.g., parliamentarians, local officials, ministry officials

Appendix II: Developing an Advocacy Strategy

Activities and Handouts for Developing an Advocacy Strategy

- **Selecting an HIV/AIDS Advocacy Issue**
- **Drafting a Mission Statement and Advocacy Goals**
- **Developing Advocacy Objectives**

Activity Selecting HIV/AIDS Advocacy Issues

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

- Identify specific advocacy issues related to HIV/AIDS

Time allotted 45 minutes

Preparation One blank flipchart, blank note cards at each table.

Facilitation steps

1. Explain that having defined advocacy, the group will now discuss the ways in which one can advocate for HIV/AIDS. Lead participants in a brainstorming exercise to identify issues around HIV/AIDS in their country, region, or organization (you may want to use the topics from chapter 6, pages 6-32 to 6-35). Ask participants to think about the issues they face in their daily work and that are most relevant the their organizations. What are the concerns and problems of the clients and communities they serve? Record all responses on the flipchart at the front of the room.

2. The next step is to prioritize and group issues. As the participants consider the issues, they should try to define a *policy solution* for each issue.

3. For example, for the topic of sexual subordination of women (an HIV/AIDS gender issue), a policy solution may be for FBOs to persuade the federal government to enact gender training for all new military or national service recruits.

4. Work with participants to prioritize and group issues by having participants come to the flipchart and check off three issues that are most urgent/relevant to their work.

5. Give the group several minutes to approach the board and check off their issues.

6. At the end of the process, tally up responses and identify three issues that get the most responses.

7. Have the participants organize themselves into three or four working groups, according to the issues identified. They should select an area that interests them and, preferably, in which they have expertise. The purpose is to determine which issues are most critical to the work and lives of the participants. Advocates are most successful when they feel a deep concern or passion for their advocacy issue. An easy way to facilitate this process is to ask each participant to write her or his name on a slip of paper and rank the three issues as first, second, and third choice.

   For example—

> **Participant's Name**
>
> - Stigmatization of those affected by HIV/AIDS
> - Lack of education for vulnerable children
> - Lack of clear government guidelines on SRH and HIV/AIDS prevention for youth

8. Collect the slips of paper and, if possible, have the participants take a break so that you have time to arrange the groups. In addition to trying to give participants their first or second choice, it is important to seek a balance in terms of gender, age, and expertise represented in each group.

9. After the issue teams are organized, list them on a flipchart. Let the participants know they will be working in these groups until the end of this session.

Wrap-up

After participants return to their seats, discuss some barriers to advocacy for each issue. Examples may include legislation, lack of political will among leaders and decision-makers, cultural barriers such as taboos against talking about sex, lack of resources, etc. Ask participants to think about the issues we have identified and start to decide which topic they would be interested in advocating for if their organization created an advocacy campaign.

Activity Drafting a Mission Statement and Goals

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

- Draft a mission statement and advocacy goals based on the issues identified in the previous activity

Time allotted 1 hour 30 minutes

Preparation Notepaper, pens and flipcharts for each group

Write out tips for writing mission statements from Step 3 below on a flipchart. Make flipcharts with a "Sample Mission Statement" from Step 4, and "Goal Writing Tips" from Step 8.

Facilitation steps

1. Ask participants to remain grouped according to their advocacy issue from the previous activity.

2. Explain the advocacy mission statement definition and how it differs from an organization's mission statement. The advocacy mission statement identifies the ultimate goal or goals of the advocacy campaign and answers the most important question, *What is the purpose of this campaign?*

3. Explain to participants that a mission statement is extremely important because it will guide all of the advocacy activities (including staff needs, volunteers, what is to be achieved). Time is needed and words must be chosen carefully to develop a mission statement.

4. Review the following tips for developing mission statements on a flipchart with participants.

Tips For Writing Mission Statements

- Clearly convey who you are and what you are doing. Stress larger long-term goals. Don't get mired in detailing specific projects or activities. Think about what the desired end result of your campaign is.
- Try to be as descriptive as possible and as concise as possible. Mission statements should be no longer than three or four sentences.
- Make sure the words you choose can only be interpreted in the way you mean them. Have someone look a the statement from the opposing point of view to make sure there is nothing in it that can be interpreted in a way that reflects badly on you or the campaign.

5. Walk participants through an example of the need for counseling about HIV/AIDS.

Sample Mission Statement

To enable all couples to receive quality HIV/AIDS counseling prior to marriage

6. Ask each team to draft a mission statement based on the issue they are grouped by. Walk around the room and monitor progress. Each group member may have a different idea of how to approach advocating for his or her topic. Ask groups to come to a consensus, as this is a sample exercise only.

7. Have a representative from each group share the mission statement with the larger group. Go back to the tips for mission statements and clarify and refine statements with the assistance and feedback of other participants.

8. Have each group write their finalized mission statement on a blank flipchart.

   Ask participants what the next step would be.

   The next step is to write goals, objectives and activities that support the achievement of the ultimate goal. Remember that, in the last section, an **advocacy goal was defined as a long-term (5- to 10-year) vision for change.**

Offer the following tips for writing goals—

Goal Writing Tips

- What landmarks do you want to achieve on the way to the ultimate goal?
- How can these be stated so that they are clearly understood?
- What constitutes a success and how will it be measured?
- What resources does your organization bring to meet goals?
- What kind of budget do we need to achieve these goals?
- Who are our allies/opponents, what resources do they have?

9. Ask participants to come up with at least two goals, and write them on the flipchart under the mission statement.

Wrap-up

Discuss the goals and mission statements for each issue. Review the tips for each and solicit changes that can be made to improve the statement and goals from the participants.

Activity Developing Advocacy Objectives

Objective

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

- Develop two advocacy objectives for the selected issue
- Analyze the objective to determine its soundness

Time allotted

45 minutes

Preparation

Prepare flipcharts under steps 2 and 4 below.

Make copies of "Checklist for Selecting an Advocacy Objective" on page Appendix II-389.

Facilitation steps

1. Many participants will have wide experience in establishing programmatic objectives. This experience will be very helpful for setting advocacy objectives. Begin by pointing out the importance of a sound objective to the planning process—whether one is planning a reproductive health program or an advocacy campaign. Depending on its quality, the objective can bring either clarity or confusion to the rest of the planning process.

2. Ask participants to list the criteria they use when developing programmatic objectives. Note their responses on a flipchart. Many groups mention the SMART objectives, shown below. Participants may have other criteria to add to the list.

CRITERIA FOR SETTING OBJECTIVES

Possible responses include.

S ⇨ specific
M ⇨ measurable
A ⇨ achievable
R ⇨ realistic
T ⇨ time-bound

3. Ask participants how they would modify the list to include criteria for setting advocacy objectives. Refer back to the activity where participants sorted the advocacy cards. An advocacy goal is a long-term (5- to 10-year) vision for change. **An advocacy objective is a specific, short-term, action-oriented target.** Participants may add criteria such as the following to the brainstorm list—

    - Likelihood that the objective will generate public support

    - Likelihood that other churches and community groups will rally around the objective

4. A good advocacy objective contains several other elements. Draw the following on a flipchart and present it to the group.

ELEMENTS OF AN ADVOCACY OBJECTIVE				
Policy **Actor** or Decision Maker	+	Policy **Action** or Decision	+	Timeline and Degree of Change

5. As the participants prepare to write advocacy objectives, they should do the following three things—

    - Identify the policy actor or decision-maker that has the power to convert the advocacy objective into a reality (for example, bishop or church leader, a Minister of Health or Chair of a Parliamentary Subcommittee).

    - Identify the specific policy action or response required to fulfill the objective (for example, adopt a certain policy or allocate funds to support an initiative).

    - Stipulate the time frame and degree of change desired. Advocacy objectives usually focus on a one-to-two-year period. Can the policy be formulated and adopted in that period? Also, some advocacy objectives—but not all—indicate a quantitative measure of change. Participants should be as specific as possible as they articulate advocacy objectives.

    For example—

    - To get the Church hierarchy to allow condom promotion for the prevention of HIV/AIDS in church clinics by the end of next year.

    - Within six months, the pastor of our church will require that PLWHA participate in all home care activities in our parish.

6. Ask participants to work in their teams to develop **two distinct advocacy objectives** that outline a policy response to their issue. Allow 15 minutes for the groups to draft two objectives.

7. Next, distribute and review the checklist for selecting an "Advocacy Objective" handout. The groups should take their first objective and analyze it according to the nine criteria in the handout. They should then repeat the process with their second objective. After comparing the two objectives, the groups should prepare a brief explanation of the objective they elect to pursue and why. Allow 20 minutes for the issue teams to analyze their objectives using the handout.

Wrap-up

Invite each group to present the results of its analysis. While observing each group, be sure that the policy actor and policy action are clearly identified in each objective.

Handout

Checklist for Selecting an Advocacy Objective[58]

This checklist is designed to help advocacy groups develop and choose sound objectives for policy change.

Criteria	Objective 1	Objective 2
Do qualitative or quantitative data exist to show that the objective will improve the situation?		
Is the objective achievable? Even with opposition?		
Will the objective gain the support of many people? Do people care about the objective deeply enough to take action?		
Will you be able to raise money or other resources to support your work on the objective?		
Can you clearly identify the target decision-makers? What are their names or positions?		
Is the objective easy to understand?		
Does the advocacy objective have a clear time frame that is realistic?		
Do you have the necessary alliances with key individuals or organizations to reach your advocacy objective? How will the objective help build alliances with other NGOs, leaders, or stakeholders?		
Will working on the advocacy objective provide people with opportunities to learn about and become involved with the decision-making process?		

[58] Ritu Sharma. "Advocacy Training Guide." Adapted from Kimberly Bobo, Jackie Kenfall, and Steve Max, *Organizing for Social Change*, (Santa Ana, Minneapolis, and Washington, DC: Midwest Academy, 1991.)

Appendix II: Developing an Advocacy Strategy

Alternate Activities and Handouts for Developing an Advocacy Strategy

- **Creating a Power Map**

Activity Creating a Power Map

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

- To use a Power Map as a tool for exploring power dynamics around an Advocacy Issue

Time allotted 1 hour 30 minutes

Preparation Place the scissors, tape, colored paper, or magazines on a centrally located table. Prepare flipcharts in Step 2. Make copies of the Power Map handout on page Appendix II-394.

Facilitation steps

1. In this activity, participants will build on their work with HIV/AIDS issues and advocacy objectives. They will create power maps to identity power relationships and sources of support and opposition. The result will be a dynamic, visual "road map" that will guide the teams in the development of their advocacy strategies.

2. Present the blank power map handout on page Appendix II-394 on a flipchart or an overhead transparency along with the task below—

Creating a Power Map

Working in issue teams—

- Copy the power map onto a piece of flipchart paper.
- Write down your advocacy objective in the first box.
- Write the name/position of the target audience (key policy-maker) in the second box.
- Brainstorm all the institutions and individuals that have an interest in the advocacy issue—whether it is positive or negative.
- For each actor (institution or individual), cut a symbol out of paper and label it.
- Tape that symbol on the map in the appropriate place (support, neutrality, or opposition) to reflect that actor's stance regarding your issue.

Time: 45 minutes

3. As you review the task, several steps on the flipchart will require more elaboration.

4. Participants should think of traditional as well as non-traditional actors in the policy process including community leaders, celebrities, and business leaders.

5. The groups can be creative in selecting a symbol or magazine image to depict the different actors. If the actor has broad power or influence over the issue, they should create a large symbol. If the actor is interested in the issue but has little influence over the target audience or general public, they should use a small symbol.

6. If the actor is highly supportive of the issue/objective, its symbol should be placed to the far left of the map. If the actor represents strong opposition, its symbol should be placed on the right side. The line of neutrality runs up the center of the map.

   If two actors are closely linked (for example, a school principal and the teachers' union), the symbols can overlap or touch each other to reflect the interconnection.

7. Take an example and go through several steps in the mapping process.

   For example—

   Objective: Within the next year, persuade the Minister of Health to institute a training program on HIV/AIDS for religious leaders in Nigeria.

   Target audience: Minister of Health

   Mention several allies, such as faith-based NGOs or religious medical associations, and show where they would be placed on the map. Mention several possible opponents (in this case, lower-level ministry officials who don't see the value of involving religious organizations in the fight against HIV/AIDS), and place them on the map.

8. Allow the issue teams 45 minutes to complete their power maps.

9. When the teams have finished working, ask each one to present its power map to the group. Following each presentation, pose several questions to the whole group to maximize learning.

   - Are there any additional allies that belong on the map? Any additional opponents?

   - Does the map capture the interconnections between different actors?

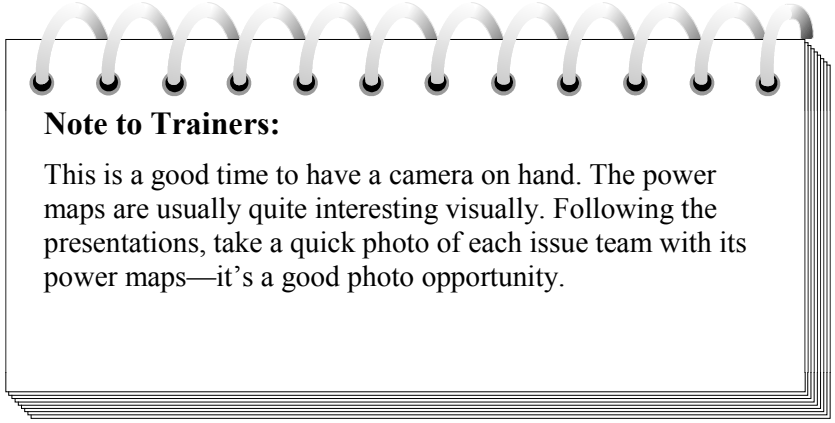
- Where on this map does most of the power and influence reside?

- Based on these power dynamics, how would you focus your advocacy effort? Would you build on the support, neutralize the opposition, or try to convince the undecided?

10. As a learning point for this exercise, it is important to emphasize that many successful advocacy campaigns opt to build their support base and convert the undecided to their viewpoint. Sometimes direct engagement with the opposition turns into a heated conflict. Unless the advocacy group desires this conflict level—to raise mass media attention, for example—it may be advisable to focus on supporters and neutrals. In all cases, however, it is essential to forecast and anticipate your opponent's argument or message. Effective advocates are pro-active in framing an argument, rather than reactive to the opposition's stance.

Wrap-up

Point out that the completed power maps can serve as advocacy road maps on an ongoing basis. For example, if a neutral actor joins the support base, its symbol can be moved to represent the new position.



Note to Trainers:

This is a good time to have a camera on hand. The power maps are usually quite interesting visually. Following the presentations, take a quick photo of each issue team with its power maps—it's a good photo opportunity.

Handout

Power Map

Advocacy Objective:

Target Audience:

Support | *Neutrality* | **Opposition**

Appendix III: Evaluation

Key Questions

- How do we know if the participants have learned the content?
- How do we know if the facilitators have successfully presented the material?
- How do we know if we met the training objectives?

It is important to evaluate training sessions to have meaningful input into programs. Facilitators need to determine if they have done their job and how well. They need to know if the participants have learned the information and skills that were taught to them. This is crucial to improving training in the future. In an effort to capture that information, this appendix contains an example of a pre- and posttest and a final evaluation for a workshop. The trainer will need to adapt these to cover the specific training content.

ANSWER KEY KEY KEY KEY KEY KEY KEY KEY KEY KEY KEY KEY

What We Know About HIV/AIDS

Answer Key

Name _____

Today's Date _____

Training Site _____

For true/false questions, read and circle true or false. For questions followed by blanks, fill in answers on the lines provided.

1. **true** [ ] As of the year 2001, approximately 28 million sub-Saharan Africans (adults and children) are living with AIDS.
2. **true** [ ] Nigeria has the second largest population of people living with HIV/AIDS in all of Africa
3. [ ] **false** You can cure AIDS by drinking local gin.
4. [ ] **false** People with AIDS in the United States have medicines that can cure them.
5. [ ] **false** There is no role for the church to play in the fight against AIDS.
6. **true** [ ] The World Council of Churches has affirmed that a response to the challenges of HIV/AIDS is a top priority on the ecumenical agenda.
7. List at least **three** ways HIV can be transmitted

   Unprotected sexual intercourse, birth, breastfeeding, blood (tattoos, body piercing, scarification, circumcision, transfusion, injection, etc.)
8. List at least **three** ways HIV can be prevented

   Use a condom, abstinence, mutual fidelity with an HIV-negative partner, blood screening, avoid practices which involve sharing of bloody instruments, such as needles, knives and razors.
9. [ ] **false** You can always tell when someone is infected with HIV by looking.
10. List at least **three** treatments available to persons living with HIV

    ARVs, counseling, good nutrition, rest, exercise, traditional herbs, etc. (see chapter 1.4, treatment plan for the whole person)
11. **true** [ ] Women and girls are more vulnerable to HIV due to their low social status
12. [ ] **false** Laws to prevent sexual and spousal abuse could contribute to a rise in HIV infections.

Answer Key

Answer Key

13. List at least **three** steps of behavior change

    Awareness or knowledge, approval, intention, practice, advocacy

14. **true** ☐ In order to maintain changes in sexual behavior over time, interventions must be continuous and repetitive in nature.

15. **true** ☐ One way the church could respond to the HIV/AIDS crisis is to organize guide groups to protect human rights and women's rights for people living with HIV/AIDS.

16. List at least **five** ways that clergy/churches can become involved in HIV/AIDS prevention, care and treatment

    Integrate HIV prevention messages into sermons, counseling, form support groups, advocacy, IEC, financial assistance to PLWHA, spiritual care, home-based care teams, etc.

17. **true** ☐ The goal of HIV/AIDS counseling is to promote behavior change to prevent HIV infection and its transmission to other people.

18. List at least **three** basic skills of counseling

    Listening, open questioning, attending, paraphrasing, reflecting feelings, reframing, confrontation, self-disclosure.

19. List at least **three** components of an information, education and communication campaign

    Decide what you want to educate about regarding HIV, determine the audience, determine the message, determine the medium, monitor and evaluate

20. List at least **three** components of a message

    Content, presentation, tone, benefits.

21. ☐ **false** AIDS is a punishment from God.

22. **true** ☐ Positive AIDS messages in sermons can combat stigma.

23. List at least **four** steps in the advocacy

    Issue, goal and objectives, target audience, message development, channels of communication, building support, fundraising, implementation, data collection, monitoring and evaluation.

ANSWER KEY KEY KEY KEY KEY KEY KEY KEY KEY KEY KEY KEY

Answer Key

What We Know About HIV/AIDS

Name_____

Today's Date_____

Training Site_____

What We Know About HIV/AIDS

For true/false questions, read and circle true or false. For questions followed by blanks, fill in answers on the lines provided.

1. true false As of the year 2001, approximately 28 million sub-Saharan Africans (adults and children) are living with AIDS.

2. true false Nigeria has the second largest population of people living with HIV/AIDS in all of Africa

3. true false You can cure AIDS by drinking local gin.

4. true false People with AIDS in the United States have medicines that can cure them.

5. true false There is no role for the church to play in the fight against AIDS.

6. true false The World Council of Churches has affirmed that a response to the challenges of HIV/AIDS is a top priority on the ecumenical agenda.

7. List at least **three** ways HIV can be transmitted

   _____

   _____

   _____

8. List at least **three** ways HIV can be prevented

   _____

   _____

   _____

9. true false You can always tell when someone is infected with HIV by looking.

10. List at least **three** treatments available to persons living with HIV

_____

_____

_____

11. true false Women and girls are more vulnerable to HIV due to their low social status

12. true false Laws to prevent sexual and spousal abuse could contribute to a rise in HIV infections.

13. List at least **three** steps of behavior change

_____

_____

_____

14. true false In order to maintain changes in sexual behavior over time, interventions must be continuous and repetitive in nature.

15. true false One way the church could respond to the HIV/AIDS crisis is to organize guide groups to protect human rights and women's right for people living with HIV/AIDS.

16. List at least **five** ways that clergy/churches can become involved in HIV/AIDS prevention, care and treatment

_____

_____

_____

_____

_____

17. true false The goal of HIV/AIDS counseling is to promote behavior change to prevent HIV infection and its transmission to other people.

18. List at least three basic skills of counseling

_____

_____

_____

19. List at least **three** components of an information, education and communication campaign

_____

_____

_____

20. List at least **three** components of a message

_____

_____

_____

21. true false AIDS is a punishment from God.

22. true false Positive AIDS messages in sermons can combat stigma.

23. List at least **four** steps in the advocacy

_____

_____

_____

_____

Faith Community Responses to HIV/AIDS

Workshop Final Evaluation Form

Location: _____ **Date:** _____

The final evaluation form consists of several questions intended to get your assessment of the workshop, including the training content, structure and methodology. Please answer the questions as fully as possible. We welcome your honest and candid opinions. Your input will be important for improving future workshops.

Below are the workshop objectives. Please rate how well you think the objective was achieved on a scale of 1 to 10, with 10 being "fully achieved" and 1 being "did not achieve."

1 … … 4 … … 7 … … 10

Did not achieve Partially achieved Fully achieved

By the end of the workshop, the participants will be able to—

a. Explain why religious response is needed in HIV/AIDS

   Rating ____

b. Appreciate the situation of the HIV/AIDS pandemic

   Rating ____

c. Define HIV/AIDS, state how it is transmitted, describe the signs and symptoms of AIDS, and state ways that HIV/AIDS can be prevented

   Rating ____

d. List current HIV/AIDS treatments

   Rating ____

e. State cultural and social factors that contribute to HIV/AIDS transmission and list solutions to each factor

   Rating ____

f. Describe the behavior change steps

   Rating ____

g. Describe five ways that clergy/churches can become involved in HIV/AIDS prevention, care and treatment

   Rating ____

h. Counsel people affected by HIV/AIDS

Rating ____

i. Educate communities about HIV/AIDS

Rating ____

j. Develop a sample sermon that integrates discussion of HIV/AIDS

Rating ____

k. Demonstrate basic knowledge of advocating on HIV/AIDS

Rating ____

Satisfaction Rating

1. Overall, I found the workshop (Please check one.)

Very Useful _____

Useful _____

Not Useful _____

Comments _____

_____

2. Which topics did you find most helpful?

a _____

b _____

c _____

Comments _____

_____

3. Which topics did you find least helpful?

a _____

b _____

c _____

Comments _____

_____

4. Which training activities helped you learn the most?

a _____

b _____

c _____

Comments _____

_____

5. Was the time adequate for the workshop objectives?

Just Adequate _____

Too Short _____

Too Long _____

Comments _____

_____

6. List the training materials that were most useful.

a _____

b _____

c _____

Comments _____

_____

7. List the training materials that were least useful.

a _____

b _____

c _____

Comments _____

_____

8. Are there specific ideas, tools or skills that you did not get from this training workshop that you need to improve yourself? (Please check one.)

Yes _____ No _____

If yes, please list them. (Please feel free to use the back of this form.)

Appendix IV: References

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