

**AFRICAN UNION OF THE BLIND (AFUB)
UNION AFRICAINE DES AVEUGLES (UAFA)**

**HIV&AIDS
“TRAIN THE TRAINERS” MANUAL**



**FIRST EDITION
2007**

**North Airport Road
Embakasi
P. O. Box 72872-00200
Nairobi Kenya
Tel: +254-20-823989
Fax: +254-20-823776
E-mail: info@afub-uafa.org
Website: www.afub-uafa.org**

Copyright © African Union of the Blind
Union Africaine des Aveugles
2007

TABLE OF CONTENTS

Foreword	Pg 5
Acknowledgements.....	Pg 6-7
List of Abbreviations and Acronyms.....	Pg 8-9
Introduction.....	Pg 10-12
MODULE 1: <u>Human Sexuality, Gender roles and HIV&AIDS</u>	
Session I: Human sexuality.....	Pg 13-14
Session II: Exploring sexuality and blindness Dispelling the myths and misconceptions.....	Pg 15
Session III: Gender roles and HIV&AIDS.....	Pg 15-18
MODULE 2: <u>Basic facts about HIV&AIDS</u>	
Session I: HIV and me: personal and community attitudes and values towards HIV, AIDS and illness.....	Pg 19-20
Session II: Define and differentiate between HIV and AIDS...	Pg 21-23
Session III: Methods of HIV transmission.....	Pg 24-27
Session IV: Impact of HIV&AIDS in the community.....	Pg 28
MODULE 3: <u>Understanding the HIV Virus</u>	
Session I: The Human Immune System.....	Pg 29-31
Session II: How the HIV virus invades the immune system...	Pg 32-33
Session III: Stages of HIV progression.....	Pg 34-36
Session IV: Understanding Opportunistic Infections.....	Pg 37-40

MODULE 4: TB, STIs and HIV

Session I:	What are STIs?.....	Pg 41
Session II:	General symptoms of STIs.....	Pg 42-50
Session III:	Is there a connection between TB, STIs and HIV?.....	Pg 51-54

MODULE 5: Prevention of HIV infection

Session I	Demonstrating condom use.....	Pg 55-64
Session II:	Encouraging Voluntary Counseling And Testing.....	Pg 65-69

MODULE 6: Management of HIV&AIDS

Session I:	Living with HIV.....	Pg 70-74
Session II:	Anti-Retroviral Therapy (ART).....	Pg 75-77
Session III:	Care and support for people living with AIDS: Home-Based Care.....	Pg 78-85

MODULE 7: Behaviour Change Communication

Session I:	What is Behaviour Change Communication? (BCC).....	Pg 86-89
Session II:	Qualities and competencies of a Peer Educator...	Pg 90-92
Session III:	How to motivate Peer Educators and sustain a Peer Education program in organizations of visually impaired persons.....	Pg 93-94



Appendices

Bibliography.....	Pg 95-96
Sample Training Program.....	Pg 97-100

Foreword

This publication has been developed by African Union of the Blind (AFUB) as part of its HIV&AIDS Awareness and Training Project-October 2005-September 2007. The manual is to be used as a guide during awareness and training seminars for blind and partially sighted persons in Africa. The project has been implemented by AFUB through its member national organizations/associations of the blind in six countries in Africa. These countries are Cameroon, Ghana, Kenya, Malawi, Rwanda and Tanzania. The project was funded and supported by the Canadian Government through the Canadian International Development Agency (CIDA) and the Canadian National Institute for the Blind (CNIB).

The overall objective of this project has been to promote the total inclusion and participation of blind and partially sighted persons into HIV&AIDS programs in their communities. The activities that were carried out in order to achieve this objective include: training 20 blind and partially sighted persons as Peer Educators in each of the six countries, creating a National Lobby Committee (NLC) in each of the six project countries, developing a training manual that includes methods of training that are suitable for training blind and partially sighted persons and conducting HIV&AIDS awareness and training to at least 3,000 blind and partially sighted persons at the grassroots level. Lessons learned and best practices identified have been incorporated in the manual so as to develop and enhance a best practice model which can be practised in other countries in Africa.

Acknowledgements

AFUB thanks the following for their enormous contribution to the production of this manual.

First and foremost, the Canadian International Development Agency (CIDA) for its financial support which made possible to implement the AFUB HIV&AIDS Awareness and Training Project for blind and partially sighted persons in Africa. Many thanks go to the Canadian National Institute for the Blind (CNIB) for co-financing the project and for the technical support to AFUB throughout the two years of the project.

All the Trainers and Facilitators, National Organisations of the Blind in Cameroon, Ghana, Kenya, Malawi, Rwanda and Tanzania, and the HIV&AIDS Service Organisations in respective countries that made contributions to the content of this manual and for their involvement in training workshops in six AFUB member organisations/associations.

Cameroon

1. Association Nationale Des Aveugles Du Cameroun. (ANAC)
2. Cameroon National Association of People Living with HIV&AIDS. (Réseau Nationale des Personnes vivant avec VIH&SIDA du Cameroon)

Ghana

3. Ghana Association of the Blind. (GAB)
4. Ghana Office-West Africa Program on the Control of AIDS and Sexually Transmitted Infections. (WAPCAS)

Kenya

5. Kenya Union of the Blind. (KUB)
6. Kenya AIDS NGO Consortium. (KANCO)
7. National AIDS Control Council. (NACC)
8. National AIDS and STIs Control Program. (NASCOP)
9. National Organisation of Peer Educators. (NOPE)-Kenya

Malawi

10. Malawi Union of the Blind. (MUB)
11. Malawi AIDS Counseling and Resource Organisation. (MACRO)
12. National AIDS Commission. (NAC)
13. Malawi Network of People Living with HIV&AIDS. (Manet plus)
14. National Association for People Living with HIV&AIDS in Malawi. (NAPHAM)

Rwanda

15. Rwanda Union of the Blind. (RUB)
16. Anti-blindness and physical disability program-Ministry of Health.
17. Local Division Head-Masaka.
18. Rwanda-Masaka Clinic and VCT Centre.

19. Masaka Rehabilitation Centre for the Blind. (MRCB)
20. Tanzania League of the Blind. (TLB)
21. African Medical and research Foundation. (AMREF-Tanzania)
22. Focus Girl Child and Women's Development-Kibaha, Tanzania.
23. HIV&AIDS Community Program-Kibaha Town Council.
24. Service Health and Development for People Living Positively with HIV&AIDS.
(SHDEPHA)

Last but not least, many thanks go to all AFUB board members, staff and volunteers for their support during the production of this manual and training resource materials herein.

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANAC	Association Nationale Des Aveugles Du Cameroun
ART	Anti-Retroviral Therapy
ARVs	Anti-Retrovirals
ASO	AIDS Service Organisation
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CD4	Cluster of Differentiation-4
DNA	Deoxyribonucleic Acid
FBO	Faith Based Organisation
GAB	Ghana Association of the Blind
GIPA	Greater Involvement of People Living with HIV&AIDS
HBC	Home-Based Care
HIV	Human Immuno-deficiency Virus
HPV	Human Papillomoma Virus
IEC	Information Education and Communication
KUB	Kenya Union of the Blind
MTCT	Mother to Child Transmission
MUB	Malawi Union of the Blind
NGO	Non-Governmental Organisation
NLC	National Lobby Committee

OI	Opportunistic Infection
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TOT	Trainer of Trainers
VCT	Voluntary Counseling and Testing
VIP	Visually Impaired Person
PID	Pelvic Inflammatory Disease
PMTCT	Prevention of Mother to Child Transmission
RNA	Ribonucleic Acid
RUB	Rwanda Union of the Blind
TLB	Tanzania League of the Blind

Introduction

Rationale for this manual

It is appreciated that there are a great number of Peer Education training manuals. These manuals however do not include training methods that are friendly to blind and partially sighted persons.

This manual deliberately includes training methods that ensure that blind and partially sighted persons participate effectively in HIV&AIDS Peer Education trainings. It also provides guidance on how to make HIV&AIDS Information Education and Communication (IEC) materials and other training resources into accessible formats i.e. Braille, large print or audio.

It is hoped that this will be a great resource for both visually impaired and sighted trainers of trainers who are involved in HIV&AIDS training.

About this Manual

This manual consists of seven modules. The modules have been arranged in sequence in a way that enables participants to build on the knowledge acquired. Each module contains several sessions each with specific and clear objectives. Strategies of how trainers/facilitators can modify training activities to suit the needs of visually impaired participants have been outlined in each session. Sexuality, prevention of HIV, management of HIV&AIDS and care & support of people living with HIV&AIDS are the major themes around which this training manual has been developed. Special attention has been given to issues around gender roles and HIV&AIDS and the risks of HIV infection to visually impaired women.

Participatory approaches to learning and training have been applied in the preparation of this manual to ensure effective learning. This manual does not - and cannot- cover all variations and emerging trends in all the HIV&AIDS thematic areas. However, it is a useful resource to AFUB member organizations in Africa. Other major Peer Education Manuals have been useful references in the preparation of this manual. A list of bibliography, websites and key reference materials that have been useful in the development of content and useful handouts for participants have been provided in the appendices at the end.

How to use this manual

Trainers can select one module to conduct stand alone trainings. A sample training program including all the modules has been provided in the appendices. This training program has been tested and used before in conducting Peer Education training workshops for visually impaired participants. Trainers can use this program in their trainings or can use it as a guide to develop their Peer Education training programs.

Target Audience

This manual is for use by Trainers of Trainers. i.e. trainers of visually impaired Peer Educators. It has been developed to provide awareness and training on HIV&AIDS prevention, treatment, care and support and to equip blind and partially sighted participants with Peer Educations skills. It is hoped that blind and partially sighted participants will become effective Peer Educators in training other visually impaired persons in their communities.

Another expected major outcome of this manual and training activities herein is to sensitize facilitators and TOT trainers from mainstream HIV&AIDS service organisations on the needs of blind and partially sighted persons in as far as HIV&AIDS programs are concerned. It is hoped that these facilitators and TOT trainers will be sensitized on the strategies and methods of how to make HIV&AIDS programs accessible to blind and partially sighted participants.

Six HIV&AIDS awareness and training workshops for visually impaired persons have been conducted using this manual and the sample training program in Cameroon, Ghana, Kenya, Malawi, Rwanda and Tanzania. A total of 28 TOT and facilitators from mainstream HIV&AIDS service organisations attended and facilitated in these workshops.

Training techniques

At the start of each day, the trainer/facilitator should ask one of the participants to recap the previous day's sessions. This helps the participants to link up and help the participants gain more knowledge and understanding on the topics and issues being covered.

Use activities and teasers to remove boredom and monotony during training sessions. Select activities and games that are suitable for visually impaired persons.

In the attempt to mainstream blindness issues into HIV&AIDS Awareness and Training programs it is also important to invite facilitators, trainers and experts from mainstream HIV&AIDS Service Organisations.

Planning for the Training Workshop

Here is a simple way to plan for your training workshop and to share with peer educators.

1. Plan for 20 people per workshop

Experience has taught us that 20 is a good number. First, you will be sitting in a full circle or a half-circle, and a group larger than 20 will pose space problems. Even if you do have the space to accommodate more than 20 people, they may not be able to hear each other clearly because they will be sitting too far apart.

Another reason to stay with a maximum of 20 participants is that each peer educator can have several opportunities to talk during the workshop period. As a result of talking they will grow in confidence and improve their communication skills. The facilitator and the group will have a better sense of each peer educator and his or her capacities.

2. The workshop venue

When you begin to consider the question of where the workshop will take place. Your workshop need not be inside a building. You will also want to make sure that you choose a place that people will not have too much trouble getting to and from, especially when you know participants are visually impaired persons.

The workshop venue should be pleasant, clean, cool and airy. Dirty and poorly ventilated training environments make learning difficult, if not impossible. It is also very disrespectful to participants who are being asked to do serious and important work. Make sure that you visit the training venue beforehand so you know exactly what the accommodation facilities are like.

3. Plan to work in a circle

Working in a circle or U-shape allows for the most effective communication and interaction between participants and the facilitator and among participants themselves.

4. Materials

Develop a guide that will enable participants to conduct small group trainings among their peers in their communities. Plan ahead to have all materials put into accessible formats for Peer Educators and blind and partially sighted beneficiaries in the community. Remember to find out what format is preferred by each participant. Accessible formats include Braille, large print, and audio. Also note that some participants will require their materials to be in soft copy because they can read them using adaptive technology in their computers.

MODULE 1

Human Sexuality, Gender roles and HIV&AIDS

Session I: - Human sexuality

Session objectives:

By the end of this session participants will be:

1. Familiar with human sexuality.
2. Able to define and differentiate between sex and sexuality.
3. Comfortable to talk about sexuality issues.
4. Comfortable enough to refer to human sexual organs by their real names.
5. Able to define and understand sexual and reproductive health.
6. Able to understand the meaning of sexual freedom

Process

1. Share session objectives with participants and inform them that this is an interactive session.
2. Ask participants to define sex and sexuality.
3. Note their responses and fill in the gaps using the following notes.

Facilitator's notes

Sexuality refers to everything that has to do with being sexual, maleness, and femaleness. It also includes intellectual, social, spiritual and moral parts of our being. It includes the ability to make choices and the responsibility of the consequences of our choices. Sexuality is how an individual thinks, feels and acts about his her own body and that of others. It is the totality of an individual as they are expressed.

Sexuality has components such as:

- Sensuality: This is about how people see themselves and how they feel about their body. This includes a sense of attractiveness and how it is displayed through dressing, dancing, and other features.
- Intimacy includes such things as friendship and sexual intercourse.
- Sexual identity indicates maleness and femaleness.
- Sexual behaviour and reproductive health is the process of reproduction and the care and maintenance of reproductive organs.

- Sex refers to whether a person is either male or being female. This is defined by our physical features such as a man's penis and a female's vagina and breasts.
 - Sex refers to the biological differences between men and women. These differences are natural because they are given from birth.
 - Sex also refers to the act of having intercourse between a man and a woman.
4. Explain that many people have difficulties or feel embarrassed to talk about sex and sexual body parts.
 5. Ask participants to name both the male and female body parts and other terms that have to do with sex. Ask participants to put aside their fears of saying taboo words during this exercise, explaining that we must learn to talk about various sexual parts of the body and different sexual acts in order to protect our health.

Facilitator's notes

- Vagina, breasts, menstruation, sperm, penis, intercourse, labia minora, labia majora, clitoris, anus, semen, vaginal fluids, orgasm, climax, pleasure, STI, HIV&AIDS, masturbation, condoms, woman who has various sexual partners; man who has various sexual partners etc.
- Explain that human beings express their sexuality differently and that all people have different sexual preferences and experiences.
- Explain that menstruation is a monthly bleeding that takes place when the egg is not fertilized. Each month, the uterus prepares a lining of blood and tissue, in case the fertilisation of the egg takes place. If no fertilisation occurs, the lining is shed through the vagina along with the unfertilized egg. During and shortly after menstruation, the cervix is opened and the vagina wall is soft and can easily be bruised. It should be noted that if there is sexual activity with an infected person during this period and the sex is "unprotected", there is a much higher risk of transmission of HIV.

Supplies required: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers, facilitator's notes

Estimated time: 40 minutes

Learning Method: Small group and Large Group Interaction

Session II: - Exploring sexuality and blindness: Dispelling the myths and misconceptions

Objectives

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

1. Identify and clear the myths surrounding sexuality and blindness.

Process

1. Share session objective with participants.
2. Inform participants that this is an interactive group discussion.
3. Ask participants to share their experiences about sexuality and blindness.
4. Note their responses and share them out as follows.
 - Visually impaired persons are not sexually active therefore they cannot be infected with HIV.
 - Visually impaired persons do not need information on HIV&AIDS and reproductive health.
 - If you have sex with a blind woman you will get cured of HIV infection.
5. Inform participants that it is important to clear and dispel myths surrounding sexuality and blindness. Participants should educate others in the community. This will help reduce the risk of infection among visually impaired men and women.

Supplies required: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Estimated time: 30 minutes

Learning Method: Small group and Large Group Interaction

Session III: - Gender roles and HIV&AIDS

Objectives

By the end of this session participants will;

1. Be able to define and understand the term gender.
2. Be able to note the interconnection between gender dynamics and HIV&AIDS.
3. Propose ways by which visually impaired men and women can reduce their risk for HIV infection.

Process

1. Share session objectives with the participants.
2. Inform participants that this is an interactive session.
3. Ask participants to define gender and list some common gender stereotypes.
4. Note their responses on a flip chart and fill in any gaps using the following information.

Facilitator's notes

- The term gender refers to the social relationships between men and women and the way that relationship is made by society. In other words, gender is how we are shaped after we are born into society.¹
- Gender also refers to the roles that women and men acquire by virtue of their sex. Women and men play different roles in society. These roles are shaped by social, ideological, historical, religious and economic determinants.
- However, it must be acknowledged that gender definitions are in a constant state of flux in response to changing social and economic conditions. For example in times many women have taken over as head of households after their husbands have gone to war.
- Gender stereotypes are socially constructed beliefs about men and women. Gender stereotypes about women and men can expose them to the risk of HIV infection. The following are examples of gender stereotypes.
 - a) It is a sign of manhood for a man to be able to have full control of relationships.
 - b) Females are brought up to believe that males are superior in all spheres of life and should be the masters in sexual relationships.

¹ 'Gender HIV&AIDS and Rights: A training manual for the media': Page 21

- c) Traditional cultural practices and the patriarchal behaviour of men and boys make women and girls subservient and more vulnerable to HIV infection.
 - d) 'It is difficult for a woman to say no to a man who is determined to have sex. '
 - e) In some communities girls are expected to be virgins until marriage. Parents prefer their daughters to be ignorant about sexual issues.
 - f) Gender-based cultural expectations assign sexual prowess to males and sexual subservience to females. It is prestigious for males to have multiple sexual partners. This exposes both males and females to HIV infection.
 - g) Males are vulnerable to HIV infection through masculinity norms that expect them to be knowledgeable about sex. Such norms make it difficult for males to admit lack of knowledge or to seek information about sex. ²
4. Inform participants that Gender stereotypes expose women and men to the risk of HIV infection. It is important to note that HIV and AIDS has had a bigger impact on women than it has had on men. Blind and partially sighted women face double exposure to HIV infection because first they are women and secondly because they have a disability.
5. Inform participants that between 12 and 13 women are infected with HIV for every 10 men.³ More young girls are infected at a tender age than men. Their death leaves many orphans or dysfunctional families.

Some contributing factors to high HIV infection rates among women include:

Lack of economic empowerment

Most women in Africa depend on the man as the soul bread winner of the house. Due to this they have to give in to all his sexual demands although he might be having multiple partners.

Poverty

Prostitution is a way of earning a living by exposing the women involved to high risk of infection. At the moment girls of very young age are exposing themselves to this kind of life style in order to make ends meet. Young campus girls who have finished school but have no jobs have resorted to prostitution as a way of earning a living. Poverty has forced many mothers to sell their bodies' in order to get a meal for their children. Poverty throws these women in the way of HIV&AIDS.

Lack of negotiation power

Sometimes women have been beaten for asking their men to use condoms. They suffer

² 'Mainstream Gender into the Kenya National HIV&AIDS Strategic Plan': Page 12-16.

³ 'www.womenandaids.unaids.org: Report on the Global AIDS Epidemic December 2006.'

silently with the constant fear of infection.

Women's open sexual system

Women have an open system as compared to men. They have more openings i.e. the vaginal, urinal and anal openings. Seminal fluid will tend to rest here longer. Women's genital area also has very soft skin which can easily tear creating openings for HIV entry. The mucosal nature of their genital area allows for HIV entry more easily.

Female cutting or circumcision

These practices although slowly dying is still prominent in many African communities the sharing of cutting equipment can easily spread the virus.

Wife inheritance and cleansing ceremonies

This custom lives on in many African cultures. For example in some cultures when a man dies another man or brother from the homestead would inherit all that belonged to the deceased including his. Through this the infected wife infects the brother to the deceased who in turn infects his wives if he is polygamous.

During funeral ceremonies the wife of the deceased may be required to have sex with the deceased older brother or uncles.

Sexual abuse and rape

Unfortunately most women do not report sexual abuse and rape cases and therefore cannot get post exposure prophylaxis which is an ARV treatment after an assault. They live with the emotional, psychological and physical torture, usually when they find out their status as positive it is impossible to reverse the situation. Some communities believe that sleeping with a virgin if you are positive will cure you from the disease. This leaves many girls to suffer at the hands of those seeking a cure in ignorance. Blind and partially sighted women face even a great risk when it comes to sexual abuse and rape.

Lack of knowledge on HIV

Increasing the level of knowledge among women and the girl child on HIV&AIDS is probably the beginning of solving many of the problems the woman is facing today. Visually impaired women must have access to

Supplies required: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers, facilitator's notes, handout on Gender roles and HIV&AIDS in accessible formats for the participants.

Estimated time: 40 minutes.

Learning Method: Small group and Large Group Interaction.

MODULE 2

Basic facts about HIV&AIDS

Session I: - HIV and me: Personal and community attitudes and values towards HIV, AIDS and illness

Objectives

By the end of this session participants will;

- Examine their attitude towards HIV&AIDS.
- Begin to appreciate that HIV&AIDS is our and not “their” problem and begin to recognize the need to take action.

Process

1. Share the title of this session with the participants.
2. Introduce the objectives of this session to participants.
3. Inform participants that this is a small group activity.
4. Form participants into their small groups of five persons each.
5. Inform participants to create in their small groups a 4 line story of how someone got infected with HIV.

Group 1 -A teacher /friend

Group 2 -A pastor/ religious leader

Group 3 -A lover/a man living his family to work in the city

Group 4 -A commercial sex worker

6. Each group will select a representative to present their story; the facilitator will then ask the rest of the participants how they feel about that story using the scale below.

Sympathetic, somewhat sympathetic, non-sympathetic

7. Facilitator should note the responses and reactions from the large group as representatives of each group present their story.
8. Participants will then explore some typical attitudes in the community regarding HIV&AIDS.

Denial

Fear

Depression

Acceptance and Action

Trainer's notes and participants' Handout

- Denial-Many people still do not believe HIV is present in our communities. Stigma is high among many people. People talk in low tones about HIV and AIDS.
- Fear-We fear HIV and do not want anything to do with it. We think it is another person's problem.
- Depression-We get frustrated as we hear how people are getting infected and dying from AIDS related conditions.
- Acceptance and action- This is the phase where people and their communities come to terms that HIV is real, we talk about it openly and take measures to prevent ourselves, our families and those around us from getting infected. We reach out to those living with HIV and provide and support to those who need it.

Supplies required: A list four line Stories.

Estimated time: 20 minutes

Learning Method: Small group and Large Group Interaction

NOTE: Facilitators should note that any materials or handouts presented to blind and partially sighted persons must be put into accessible formats, i.e. braille, large print or audio. Participants will make their preferred format known before hand. Remember to ask participants before hand what their preferred format would be.

Session II: - Define and differentiate between HIV and AIDS

Objective

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

- Define and differentiate HIV&AIDS.
- Understand the importance of knowing the difference between HIV&AIDS.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Ask participants to define and explain the terms "HIV" and "AIDS".
3. Note their responses.
4. Clarify the difference and explain by presenting and explaining the following information.

Trainer's notes

- HIV is the virus that causes AIDS.
- **HUMAN-HIV** affects only humans. The HIV virus does not live in animals, toilets, insects like mosquitoes, cups or spoons, or on bed sheets or towels that people who have HIV might have used.
- **IMMUNO-DEFFICIENCY-HIV** virus attacks, weakens and eventually destroys the immune system. Immuno-deficiency refers to the breakdown of the human body's immune system. The immune system is the body's resistance for fighting off infections. The immune system is usually able to defend the body against many infections-except HIV.
- **VIRUS**-viruses are small /micro organisms that live and reproduce within larger cells. Once inside viruses manipulate the functions of these larger cells for their own survival and growth. The HIV virus lives and reproduces in the human body.
- AIDS means Acquired Immune Deficiency Syndrome.
- **ACQUIRED** – means to get a disease of infection, which is not inherited, but comes from outside the body.
- **IMMUNO** - the body's natural ability to defend itself against infection and disease.
- **DEFICIENCY**- refers to the fact that the body's immune system is weakened and therefore the body has a more difficult time protecting itself from infections.

- **SYNDROME**- This is a medical term that refers to a set or collection of specific signs and symptoms of a disease. For example in the case of a person who has AIDS, syndrome includes; unusual weight loss (more than 10 percent of normal body weight), fever, persistent dry cough, excessive tiredness, diarrhoea for more than a month, swelling of the lymph nodes, respiratory tract infections including pneumonia, thrush, tuberculosis, night sweats, stroke.

Handout

Twenty Important Points about STIs and HIV

1. HIV is a sexually transmitted infection.
2. HIV and many STIs are caused by germs during sexual acts.
3. Other STIs (for example, gonorrhoea and Chlamydia) are caused by bacteria.
4. Some STIs are more infectious at certain stages of the infection.
5. Many STIs can be cured.
6. There is no cure for the STI called HIV. Genital herpes is another STI for which there is no cure.
7. Using home remedies or self-treating with pills can be dangerous. STIs that can be cured but are not treated professionally do not go away. Untreated STIs can lead to serious health problems. Some, like syphilis, can lead to death.
8. Because different bacteria and germs cause different STIs, they need to be treated differently. When a doctor prescribes treatment after an examination, it is important to take the full treatment, even after the signs of the infection seem to have disappeared. Remember that not all STIs can be seen or felt. And some STIs show up sometimes but don't show up at other times. Someone can have an STI and not know it.
9. The overuse of antibiotics and other forms of misuse of antibiotics (black and reds and others) in treating STIs reduce their effectiveness in fighting infection and damage the body. Over time, the STI targeted can become immune to the antibiotic while the person's general health can be dangerously compromised. Antibiotics are serious medications, to be prescribed for specific purposes, and are not to be taken lightly.
10. Some STIs have no symptoms. That is, a person can have an STI and not know it.
11. Many girls and women with STIs have no symptoms.
12. Mothers can pass some STIs on to their newborn babies. Some STIs can affect babies' eyes.
13. The condom does not offer protection against several STIs.
14. STIs affect not only the sexual organs; they can also infect the area around the mouth and around the rectum (the behind or anus).

Supplies required: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers, Handout 2-Defining HIV and AIDS

Estimated time: 40 minutes

Learning Method: Large Group Interaction

NOTE: Facilitators should note that any materials or handouts presented to blind and partially sighted persons must be put into accessible formats, i.e. braille, large print or audio. Participants will make their preferred format known before hand. Remember to ask participants before hand what their preferred format would be.

Session III: - Methods of HIV Transmission

Objectives

By the end of this session participants will;

- Have information and understanding of how the HIV virus is transmitted.
- Have information and understanding of how HIV is not transmitted.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Inform participants that you will begin with a small group activity.
3. Each small group of five people will have 10 minutes to prepare a small skit/drama on how the HIV virus can be transmitted.
4. Ask each group to present their skit/drama to the large group.
5. After each of the groups has presented their skits/drama ask the large group what method of HIV transmission they think the group was presenting.
6. Note their responses and write them on a flip chart.
7. Read all these responses out aloud to the large group.
8. Ask participants to state other methods of HIV transmission that they know of and that were not presented during the group skits/dramas.
9. Note their responses.
10. Clarify any differences and explain by presenting and explaining the following information.

Trainer's notes and participants' Handout

The HIV virus is primarily spread through direct contact with infected body fluids. There are three main methods of transmission:

1. Blood on blood contact

- Sharing an infected needle for ear piercing or tattooing.
- Sharing an infected needle for drug injection and /or immunizations.
- Re-using infected instruments for circumcision.
- Infected and unsterilized instruments used in dental work.
- Medical workers can get infected through a needle prick from someone who is HIV infected.
- Handling infected blood with an open wound.
- In the birthing process from the infected blood of a mother to the new baby.

2. Mother To Child Transmission of HIV (M.T.C.T.)

MTCT occurs:

- During pregnancy through the placenta.
- Through blood contamination during childbirth.
- Through breastfeeding.

MTCT can be reduced:

- By using anti-retroviral therapy for mother and baby. Drug commonly used is called 'Nevirapine'.
- By medically cleansing the vagina.
- By avoiding unnecessary rupture of membranes during the birthing process.
- By avoiding an episiotomy when it is not necessary.
- By minimizing trauma to the foetus (by avoiding procedures such as foetal scalp monitoring, forceps delivery and vacuum extraction-each which may cause tears
- By carrying out a caesarian section if possible.

Handout

MTCT AND INFANT FEEDING

Get the Facts

All women considering pregnancy or who are already pregnant or breastfeeding should know that breastfeeding carries a risk of HIV transmission to the baby.

Women with HIV infection have the virus in both their blood and considerable amount in the breast milk. If HIV positive women have access to breastfeeding alternatives and the means to use them, the risk of illness and death from HIV and other infections can be kept to a minimum.

Keep in mind that HIV positive women may face stigma from their families and communities if they do not breastfeed their babies.

If breastfeeding alternatives are not available, the health risk to infants who are not breastfed is six times greater than the health risk to those who are, so breastfeeding remains the better option.

The risk of MTCT of HIV during breastfeeding is greater when an HIV positive woman does not exclusively breastfeed for the first six months, or if complications develop (e.g. mastitis, cracked and bloody nipples) from poor breastfeeding techniques.

Risk of transmission also increases if the mother becomes infected with HIV while breastfeeding.

The duration of breastfeeding is also associated with the level of transmission risk; after six months, the risk of HIV transmission may be greater than the benefits of breastfeeding.

If no other options are available for infant feeding, women should continue breastfeeding exclusively for six months. During this six months period, the baby should not be fed or made to drink other foods and drinks. During this period, the mother should seek prompt medical checkup and treatment for any breast problems, and treat any case of thrush in the infant.

Feeding the baby on breast milk only significantly reduces the risk of HIV transmission. After six months the mother should stop breastfeeding it directly and only give other food and drinks.

3. Sexual Contact

The most frequent way HIV infects people is through sexual contact.

- Mainly through full private-part sex when body fluids are mixed.
- Unprotected heterosexual and homosexual intercourse carries the risk for HIV transmission.

Sexual activities that have no risk, low risk, some risk and high risk of HIV infection

No risk

- Abstinence-avoidance of sex
- Erotic massage
- Hugging and body rubbing
- Dry kissing
- Bathing or showering together with someone infected with HIV.
- Masturbation
- Mutual masturbation
- Sexual fantasies
- Personal sex toys.

Low risk

- Oral sex with a man wearing a condom
- Oral sex with a woman wearing a female condom.

Some risk

- Oral sex with a man or woman without condoms.
- Vaginal penetrative sex with a condom.
- Anal penetrative sex with a condom.

High risk

- Vaginal penetrative sex without a condom.
- Anal penetrative sex without a condom. (very high risk)
- Sharing uncovered sex toys.
- Contact with infected menstrual blood.

HIV is not transmitted through the following ways

- Hugging someone who is infected with HIV.
- Handshakes, touching, swimming or bathing with an infected person;
- Sharing utensils (cups, plates, spoons) with an infected person; toilet seats;
- Mosquito bites.
- Using an infected person's towels and clothes.
- Sitting next to an infected person.
- Talking and having a casual conversation with someone who is infected with HIV.
- Sharing a bed with an infected person. (HIV cannot live outside the body. In order to survive, the virus needs the food supply of the cells in body fluids.

Supplies required: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers, Handouts- 'Methods of Transmission', 'MTCT and Infant Feeding'- in accessible format.

Estimated time: 60 minutes

Learning Method: Large Group Interaction.

Session II: - Impact of HIV&AIDS in the community

Objective

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

- Understand the impact HIV&AIDS has had in our communities.
- Understand the role they can play to reduce the impact of HIV&AIDS in our communities.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Inform participants that this is a small group activity.
3. Ask participants to list the impact of HIV&AIDS in their communities.
4. Ask participants to select a group representative to present their list.
5. Note their presentations and compare and contrast them.
6. Put the lists on a flip chart and inform participants that the list will be made available into accessible formats after the session.

Facilitator's notes

The following are some of the impacts of HIV&AIDS in the community. After participants make their presentations, the facilitator can read to them some of the aspects that they may have left out.

- Many orphans have been left behind as a result of their parents dying of AIDS related illnesses.
- Many workplaces have lost skilled employees and managers as a result of the HIV&AIDS scourge.
- Many hospitals have been overwhelmed by patients suffering from HIV&AIDS related cases.
- New approaches in the provision of care, support and treatment of HIV&AIDS. Such as Home-Based and community approaches.
- HIV&AIDS has provided employment to many people. Such as skilled HIV&AIDS counselors, program managers and community mobilisers.
- Life expectancy in many countries has been greatly reduced as a result of HIV&AIDS.

Supplies required: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers, facilitator's notes

Estimated time: 40 minutes

Learning Method: Small group and Large Group Interaction

MODULE 3

Understanding the HIV Virus

Session I: - The Human Immune System

Objective

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

- Describe and understand the human immune system.
- Describe and understand how the immune system works to defend the body.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Inform participants that this is a small group activity.
3. Participants will read and discuss the text provided in their small groups. This text illustrates how the human immune system works.
4. After participants read and discuss the text, facilitators should ask them to answer the questions below.
5. Ask participants to choose a representative to read out the answers to their questions to the large group.
6. Note participants' responses and how they demonstrate their understanding of how the immune system works.
7. Clarify any differences and explain any concepts that participants do not understand.

Handout

ANALOGY OF HOW THE HUMAN IMMUNE SYSTEM WORKS

Let's imagine that the body is a mining company that has to be protected from invaders who want to harm the company. Meet the security people working in this company; which is called 'the body'.

Mr. Phagocyte (a type of white blood cell) is the company's spy. While he is doing his rounds and removing dust and smoke particles, he sees a really bad customer – the flu virus. Mr. Phagocyte immediately calls the company's public relations officer – Mr. Macrophage (another white blood cell) to come and check out the situation. Mr. Macrophage confiscates the invaders identity document (the antigen). He then takes this information to the company's most important person in the company- the company's CEO- Mr. CD4. Mr. CD4 takes one look at the identity and immediately recognizes the flu

virus. He realizes that the company is in trouble, and that he should immediately give command to attack. Mr. CD4 joins forces with Mr. Macrophage and together they activate the body's defense system. They call more CD4 cells, phagocytes to the scene and they send messages to B white cells and T white cells to join them ready for attack.

While the white blood cells are getting ready, the flu virus is hiding in the body's cells where it tries to multiply itself as quickly as it can. Killer T- White blood cells drive the flu virus out of its hiding place; while this is happening B- White blood cells are busy manufacturing antibodies. Antibodies grab the exposed flu viruses, cling to them and make them easy targets for the phagocytes to attack, puncture and destroy them. When all the viruses are destroyed, the company- the body now slowly begins to return to normal once again.

Once the situation is under control a special type of white blood cell called Suppressor T- white blood cell, orders the B- white blood cell to stop manufacturing the antibodies and also orders the phagocytes to stop the attack.

But this incident is not forgotten, Memory T and Memory B- cells will always remember Mr. Flu virus and any of his relatives; if they ever again try to invade the company, these memory cells will recognize them immediately and stop them in their tracks. The company now is immune to attacks by Mr. Flu virus.

Small Group exercise

1. Explain how the body's immune system works.
2. Describe the immune system in one sentence.

Facilitator's notes

Summary of how the body's Immune System works

Phagocytes: body's spy, looks out for any invaders, and takes information to (macrophage)

Macrophage: Takes the identity of the disease causing agent to the CD4 cell

CD4 Cell: Is the commander- in- chief of the white blood cells. Organizes the rest of the white blood cells and gives the command to attack disease causing germs.

Killer T – Cells: drive the disease-causing agent out of its hiding place.

B – Cells: Manufacture antibodies; these act like sign posts to mark the disease causing agents so that phagocytes attack and destroy them.

Phagocytes: Attack and destroy the disease causing agents.

Suppressor T cells: Orders the B cells to stop the manufacture of antibodies, and also orders the phagocytes to stop the attack once the disease causing agent has been destroyed.

Phagocytes: They clean up the dirt and destroyed cells after the attack. Then the body begins to heal

Memory T and memory B Cells: They always remember the disease causing agent so that next time it attacks the body they stop it before other white blood cells are informed.

Facilitator's notes

Immunity and the role of the CD4 Cell in the Immune System

- Immunity: The ability to attack or overcome infection by invading disease-causing germs.
- Immunity is based on the proper functioning of the body's immune system.
- Types of immunity include;
 1. *Acquired immunity*: Received through vaccination and immunization.
 2. *Natural immunity*: what a baby inherits from its mother at birth.
- White blood cells defend the body against infections and disease causing germs.
- There are different types of white blood cells, each of them has a role to play and they work together as a team to remove disease-causing organisms from the body.
- The CD4 cell is a type of white blood cell that has a central role in the functioning of the human immune system. It organizes and coordinates the other types of white blood cells (the immune system).

Supplies required-Facilitator's notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers, handout out in Braille/large print/audio formats

Estimated time: 60 minutes

Learning Method: Large Group Interaction, small group activity

Session II: - How the HIV virus invades the Immune System

Objective

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

- Have some understanding on the structure of the CD4 cell.
- Understand how the HIV virus attacks the immune system.
- Understand why HIV is so dangerous to the body.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Remind participants of the CD4 cell; that they came across when they were learning about the human immune system.
3. Presents some short notes on how the HIV virus attacks the body as follows.

Facilitator's notes and handout

- Step 1: The HIV virus attaches to the CD4 cell's receptor.
 - Step 2: The CD4 cell and the HIV virus join membranes
 - Step 3: The HIV virus injects its RNA into the CD4 cell.
 - Step 4: The viral RNA is changed into viral DNA through a process called reverse transcriptase.
 - Step 5: The viral DNA joins with the cell's DNA at the centre/or core of the cell causing it to produce more viral RNA.
 - Step 6: The viral RNA produces more HIV viruses.
 - Step 7: The new viruses break free from the CD4 cell killing it and infecting more cells.
4. Ask participants if they have any queries or issues that need to be clarified.
 5. Note their questions and respond accordingly.
 6. Ask participants why they think the HIV virus is dangerous to the body.
 7. Note their responses.
 8. Clarify and explain any differences using the following notes.

Why the HIV virus is so dangerous to the body

- The virus hijacks the most important defensive cell and turns it into a factory to reproduce itself. HIV attacks the CD4 cell and forces it to manufacture more HIV viruses.
- The CD4 cells are unable to do what they are supposed to do; to organize and coordinate the body's defense system.
- Antibodies are formed to fight the disease, but many are rendered ineffective as the HIV viruses hide inside the CD4 cells themselves.
- The virus mutates very quickly. As it mutates, it changes its outer layer, fooling the body into thinking that this is not the target it is looking for. It is very difficult for the body to fight something it does not recognize as a threat.

The health of an infected individual depends on the condition of their immune system at any given time. A healthy adult has a CD4 count of around 1000-1200 per milliliter of blood. This count varies from person to person depending on several factors.

As a person gets infected with HIV and the disease progresses, it is possible to determine the extent of the progression of the disease by checking the CD4 count.

Supplies required- facilitator's notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Estimated time: 40 minutes

Learning Method: Large Group Interaction

Session III: - Stages of HIV progression

Objective

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

- Describe the stages of HIV virus progression.
- Understand the symptoms and conditions in the various phases of HIV progression.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Ask participants to give examples of opportunistic infections that they know of.
3. Present some notes on the various stages of HIV virus progression as follows.
4. Ask participants if they have any queries or issues to be clarified.

Facilitator's note and Handout

Phases of Infection

1. Primary Infection Phase

This is the stage where a person's HIV status changes from HIV negative to HIV positive.

It usually occurs 4-8 weeks after an individual has been infected with HIV. About 30%-60% of people infected with HIV will develop a flu-like illness which lasts 1-2 weeks. Symptoms include sore throat, headache, mild fever, tiredness, muscle and joint pains, swelling of lymph nodes.

Because of the rapid, unchecked multiplication of the virus, there are many viruses in the body.

2. Silent Stage

In this stage the body recognizes the infection as a threat and responds by producing a large number of antibodies.

The body's response results in a drop of the number of viruses in the body and the rise in the number of CD4 cells.

There is a massive battle going on inside the body. The virus is still active in the body, but there are no outward symptoms of disease.

HIV test is the only way to know if one is infected.

The body mounts an effective counter attack on virus by deploying multiple white blood cells to fight the infection and prevent the virus from multiplying.

The virus is infecting and destroying many CD4 cells, but the body's immune system is back to normal and replaces the destroyed CD4 cells and restricts the rapid multiplication of the virus. During this time there are many CD4 cells in the body and few viruses.

In this stage a person has between 500 and 800 CD4 cells per mm of blood. This stage may last anywhere from 3-10 years.

3. Minor Symptoms Stage

After a few years, the body begins to lose the battle and it's unable to replace CD4 cells and other virus fighting cells as quickly as they are being destroyed by the HIV virus. Both the quality and quantity of the CD4 cells and other virus fighting cells produced go down and the virus level starts to rise.

This stage begins when the person infected begins to display some of the following symptoms;

1. Mild to moderate swelling of lymph nodes in the neck, armpits and groin
2. occasional fever
3. skin rashes, very itchy skin, fungal nail infections
4. mouth ulcers
5. chest problems that keep coming back
6. weight loss of up to 10% of the persons usual body weight
7. the person feels tired most of the time

In this stage a person usually has between 50 and 500 CD4 cells per millimeter of blood. He/she is still able to carry out his daily activities.

4. Major symptomatic stage and the beginning of opportunistic diseases

As HIV progresses;

1. The number of CD4 cells decreases.
2. The number of viruses in the body increases
3. More and more AIDS symptoms begin to develop in the body

The higher the viral load, the faster the patient moves towards full-blown AIDS and death. The number of CD4 cells is very low and the number of viruses becomes very high.

Major symptoms and opportunistic diseases/ infections begin to appear as the immune system continues to deteriorate.

5. AIDS defining conditions stage

In this stage a person is moving towards AIDS. Also in this stage symptoms become more and more as compared to before and they become much more serious. Patients

become infected by rare and unusual diseases that do not respond to antibiotics. The immune system is much damaged and more persistent and untreatable opportunistic conditions begin to show. The person is usually bedridden for more than 50% of the day. Patients usually die within 2 years unless they are treated with Anti-Retroviral Therapy and opportunistic infections are prevented.

In this stage a person usually has a very high number of viruses and the number of CD4 cells is below 200 per millimeter of blood.

Supplies required- facilitator's notes and handout in accessible formats

Estimated time: 40 minutes

Learning Method: Large Group Interaction

Session IV: - Understanding Opportunistic Infections

Objective

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

- Define and understand the meaning of opportunistic infections.
- Describe and list some examples of common opportunistic infections.

Process

1. Introduce the title of the session and share the objective of this session to participants.
2. Ask participants define what opportunistic infections are.
3. Note their responses.
4. Present some notes and clarify any differences on the opportunistic infections as follows.
5. Ask participants if they have any queries or issues to be clarified.

Facilitator's notes

- An Opportunistic Infection (OI) is a disease that takes advantage of the weak body immune system.
- Note that in the previous session, we learnt that opportunistic infections begin to invade the body of a person infected with HIV during the major symptomatic stage of HIV progression.
- Opportunistic infections enter a weakened body the way the rain enters a house that is falling apart.
- Opportunistic infections cause serious problems when a person's immune system is weakened by HIV and AIDS.
- Just as a house that is well maintained lasts longer, a person who takes good care of the body will live longer. That is why it is important to protect your body from opportunistic infections.

Handout

Understanding opportunistic infections: What visually impaired peer educators need to know

Infections that attack the body when its immune system is weak are called opportunistic infections. This is because the body is not able to fight off germs that it normally could

were it not so weak. Any infectious disease can become opportunistic, from T.B. to oral thrush to skin diseases.

Some Signs and Symptoms of Opportunistic Infections include:

1. Feeling dizzy
2. Pain when swallowing
3. Trouble breathing
4. Frequent or very bad headaches
5. Problems seeing
6. Feeling more and more tired
7. Fever or feeling hot for more than a day
8. Your sweat soaks your bed
9. Shaking, chills
10. Problems with balance, walking or speech
11. Loss of weight for no reason
12. More than four watery or soft bowel movements a day
13. Vomiting
14. Sore mouth or tongue
15. Stiff neck
16. mood changes, depression
17. Loss of appetite
18. Other more serious opportunistic infections include, Tuberculosis, Kaposi's sarcoma-a form of skin cancer, pneumonia.

Opportunistic infections can be avoided by taking care of one's hygiene through:

1. Taking baths everyday to keep your body clean.
2. Wearing shoes to avoid small injuries that may result in infections.
3. Brushing your teeth after eating.
4. Washing your hands with soap after going to the toilet.

Opportunistic infections can be avoided by using and drinking clean water, therefore;

1. Draw water from recommended sources such as taps, clean wells or running rivers.
2. Use clean containers such as buckets, pots or cooking oil containers.
3. Avoid contaminating the water by washing hands in it.
4. Boil water until it steams hot. Boiling water for at least at 15 minutes kills most infectious organisms.
5. Store in a clean covered container.

6. Draw and drink water with clean cups.

Opportunistic infections can be avoided by observing cleanliness when preparing and serving food through:

1. Washing your hands with soap and plenty of clean water before you start preparing food.
2. Washing fruits and vegetables before you start to eat or to cook them. Peel them if possible.
3. Using a clean table or chopping board to prepare the food.
4. Serving food and water in clean and well-dried utensils e.g. bowls, plates, spoons and glasses.

Opportunistic infections can be avoided by observing cleanliness when preparing and storing food:

1. Ensure that meat is well cooked i.e. until it is no longer pink in the center.
2. Wash eating utensils and dry them in the sun or with a clean dish cloth
3. Cover food or put it in a cupboard or refrigerator away from flies.

Opportunistic infections can be avoided by maintaining cleanliness around domestic and farm animals:

1. Keep animals and pets outdoors.
2. Ask someone else, if possible, to clean up after animals especially cats, dogs, chickens and other birds.
3. Always wash your hands after handling pets and other animals.
4. Avoid contact with young animals, especially animals with diarrhoea.

Opportunistic infections can be avoided by keeping safe outdoors through:

1. Washing your hands with soap after working in the farm to get rid germs that can cause opportunistic infections.
2. Avoid swallowing water anywhere you swim. This water may be contaminated with germs that can cause opportunistic infections.

Protect yourself from HIV re-infection.

1. If you have unprotected sex, you can be infected with a different strain of HIV even if you are already HIV positive. This is called re-infection.
2. Antiretroviral Therapy (A.R.T.) does not protect against HIV re-infection.

3. If you get re-infected again with a different strain of HIV, your immune system gets weaker.
4. Protect yourself and your partner-always use a condom, or don't have sex.

Take good care of your body

There are a number of ways of keeping your body healthy and avoiding opportunistic infections.

1. Eat a balanced diet.
2. Do regular exercise moderately.
3. Get enough sleep.
4. Avoid smoking.
5. Avoid taking alcoholic drinks.

Only take medicines given to you by your doctor. Ask your doctor about medicines that help prevent opportunistic infections.

Supplies required- facilitator's notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers and handouts in accessible formats

Estimated time: 40 minutes

Learning Method: Large Group Interaction

MODULE 4: Tuberculosis, Sexually Transmitted Infections and HIV

Advance Preparation

Inform Resource Persons and facilitators in advance (HIV and AIDS and STIs experts) to prepare their presentations and handouts for the session. They should forward these handouts so that they can be adapted into accessible formats for visually impaired participants. Remember to find out from participants what format they prefer their materials to be in. Informing experts on time also gives them enough time to look for the latest illustrated videos on HIV and AIDS and STIs.

For session 1, prepare index cards (in large print or Braille) for the learners as follows:

Write in large print or Braille three cards with the message, 'After you read this, don't follow any of my instructions until I say return to your seats'

Write the remaining cards with 'Follow all my instructions' including three cards with a small 'c' in the upper right hand corner, one card with a small 'z' and one card with a small 'x'.

For Session B, prepare index cards (or slips of paper) with a Myth or Fact Statement.

For Session E, prepare three signs that say 'High risk,' 'Low risk,' 'No risk'.

Objective

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

- Define STIs.
- Give examples of STIs.

Process

1. Introduce the title of the session and share the objective to participants.
2. Ask participants to define STIs.
3. Note their responses.
4. Present some notes and clarify any differences as follows.

5. Explain that STIs are infections that are spread through sexual contact through an exchange of body fluids such as semen, vaginal fluids and blood and through contact with infected skin. Also explain that high rates of HIV infection are paralleled by high STI rates.
6. Ask learners if they know the common signs and symptoms of STIs in both men and women. List their responses on the flip chart and read them out aloud for them to hear. Then present the following points on the common signs and symptoms of STIs and explain as you present:

Signs of STIs in Men

A wound or sore, ulcers, rash or blisters on or around the penis

A discharge, like pus, from the penis

Pain or a burning feeling when passing urine

Pain during sexual intercourse

Pain and swelling of the testicles

Abnormal swelling or growths on the genitals

Signs of STIs in Women

a discharge from the vagina that is thick, itchy or has a funny smell or colour

pain in the lower abdomen

pain or a burning feeling when passing urine

pain during sexual intercourse

abnormal, irregular bleeding from the vagina

abnormal swelling or growths in the genitals

7. Now divide the group into four teams (or fewer depending upon number of participants). Ask each team to stand in one corner of the room. Explain that you are going to play a game and the team with the most points wins. Give the following instructions for the game:
 - Each team will draw a statement from the basket. (*provide the statements in Braille or large print for visually impaired participants*) The team must decide if the statement is true or false.
 - One team member reads the statement and gives the team's answer.
 - If the answer is correct, the team scores two points. If they can explain why the answer is correct, they get an extra point.
 - If the team cannot explain their answer, another team can try for the extra

point.

- When all statements have been answered, announce the winning team.
 - Agree with the larger group how to motivate the winning group.
8. Distribute Handout 4.1 and 4.2 on Sexually Transmitted Infections and tell the learners to read through it during their free time and ask any questions. End this session using the following discussion points.

Discussion Points

1. What are the three most effective ways to avoid STIs?

[Answers:]

- 1) Be faithful to one partner who is also faithful to you.
- 2) Use condoms every time you have any kind of intercourse, and
- 3) Abstain from sexual intercourse of any kind.

2. What three things should you do if you think that you have been infected with an STI?

[Answers:]

- 1) Seek proper medical treatment right away,
- 2) Inform your sexual partner(s) and
- 3) Abstain from sexual contact until there is no evidence of infection and you have finished all the prescribed medicine.

3. How could you raise the issue of condom use with your partner if you were about to have sexual intercourse with a partner you cared about? How would you feel if your partner brought up condom use when you were about to have sex? What would you say to him or her?

Handout

Sexually Transmitted Infections: Facts: True or False?

1. ***A person can always tell if she or he has an STI....30 minutes***

False

People can and do have STI without having any symptoms. Women often have STIs without symptoms because their reproductive organs are internal, but men infected with some diseases like Chlamydia also may have no symptoms. People infected with HIV generally have no symptoms for some time, even years, after infection.

2. ***With proper medical treatment, all STIs except HIV can be cured.***

False

There are two types of herpes. One, herpes zoster, is not sexually transmitted. The other is genital herpes and is an STI. It is caused by a virus and, currently, cannot be cured.

3. ***Condoms are the most effective safeguard against the spread of STIs.***

False

Abstinence from sexual intercourse is the best way to prevent the spread of STIs. Condoms used with spermicide are the next best thing, but only abstinence is 100% effective.

4. ***Using condoms will help prevent the spread of STIs.***

True.

Condoms can help prevent the spread of STIs but they must be used correctly. Condoms are not 100% effective because of improper use. They occasionally break or come off during intercourse when not used properly.

5. ***The organisms that cause STIs can only enter the body through either the woman's vagina or the man's penis.***

False

STI bacteria and viruses can enter the body through any mucus membranes, including the vagina, penis, anus, mouth, and in some cases, the eyes. HIV can also enter the body when injected into the bloodstream from shared needles.

6. ***Women who have regular PAP smears will also find out if they have the most common STIs.***

False

The Pap smear is a test specifically designed to detect cervical cancer (or pre-cancerous cells). It will detect HPV, one STI, and candidiasis, a yeast infection, but it will not indicate the presence of other STIs.

7. ***You cannot contract an STI by masturbating, or by holding hands, talking, walking or dancing with a partner.***

True

STIs are only spread by close sexual contact with an infected person. Anyone can be infected by having oral, anal or vaginal intercourse with a partner who is infected. In the case of HIV, a person can be infected by sharing needles with an infected partner or getting a transfusion with infected blood.

8. ***Practicing good personal hygiene after having intercourse should be encouraged.***

True While personal cleanliness alone cannot prevent STIs, washing away you and your partner's body fluids right after intercourse is good hygiene. Washing does not, however, prevent pregnancy or stop HIV from entering the body through the mucus membranes in the mouth, anus, penis or vagina.

9. ***It is possible to contract some STIs from kissing.***

True It is rare but possible to be infected by syphilis through kissing, if the infected person has chancres (small sores) in or around the mouth. The herpes virus can also be spread by kissing, if active lesions are present.

10. ***The most important thing to do if you suspect you have been infected by an STI is to inform your partner(s).***

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

11. ***Only people who have intercourse can contract an STI.***

False Infants can contract STIs such as syphilis, gonorrhoea and HIV infection in the uterus and during the birth process or during breastfeeding.

12. ***A woman using oral contraceptives should still insist that her casual partner use a condom to protect against STIs.***

True Oral contraceptives do not prevent STIs, so a condom would be necessary for protection unless both partners know they are faithful to one another and are currently infection-free.

Handout

Sexually Transmitted Infections

1. Chlamydia

Symptoms: Although it is very prevalent today, Chlamydia is difficult to diagnose because the disease often coexists with others. In addition to gender-specific symptoms

described below, the eyes may become infected, producing redness, itching and irritation. Infection of eyes can result from an infected person touching her or his genitals and then her or his eyes. A mother can infect her baby's eyes during delivery if she is infected.

Males: Twenty-five percent of men have no symptoms; when they have symptoms, men may experience a painful or burning sensation when they urinate and/or a watery or milky discharge from the urethra.

Females: Seventy-five percent of women have no symptoms; for women with symptoms, these may include abnormal vaginal discharge, irregular vaginal bleeding, abdominal or pelvic pain accompanied by nausea and fever. May also cause painful urination, blood in the urine, or a frequent urge to urinate.

Diagnosis: A sample of genital excretions is cultured to detect Chlamydia.

Damage: If left untreated, Chlamydia may cause severe complications, urethritis in men and pelvic inflammatory disease (PID) in women. If untreated, PID often leads to infertility. If a baby's eyes become infected, the baby can become blind if left untreated.

II. Gonorrhoea

Symptoms: May occur 2 to 10 days after contact with infected person.

Males: A cloudy (thick, greyish-yellow) pus-like discharge from the penis and a burning sensation during urination. Some males show no signs. Many young boys and men mistakenly believe that having an STI is a rite of passage to manhood.

Females: Usually show no signs. Some women have a pus-like vaginal discharge, irregular bleeding, painful urination and lower abdominal pain 2 to 10 days after contact.

Damage: Sterility; pelvic inflammatory disease (PID) in women which can recur even after the gonorrhoea and original PID have been cured. A baby can become blind if infected.

Diagnosis: The client should inform the health worker of all points of sexual contact (genitals or mouth).

Males: Medical practitioner examines genitals, mouth and/or anus for signs of irritation, soreness or discharge and may take a bacteria culture from any infected area (if lab equipment is available).

Females: Medical practitioner examines genitals, mouth, lymph glands and cervical discharges and takes a bacterial culture from any infected area. Note: These days

many health workers diagnose based on symptoms and a flow chart that advises them what medication to prescribe for which symptoms. This is true for most STIs; but HIV AND AIDS is one important exception.

III. Genital Herpes

Symptoms: Caused by the herpes simplex virus and transmitted through direct skin-to-skin contact during vaginal, anal or oral sex. Although some people have no symptoms, most experience an itching, tingling or burning sensation, often developing into painful blister-like lesions on or around genitals or in anus; first symptoms appear 2-10 days after exposure and last 2-3 weeks. Some people have no symptoms.

Damage: Recurring outbreaks of the painful blister occur in one third of those who contract herpes. Herpes may increase the risk of cervical cancer and can be transmitted to a baby during child birth.

IV. Syphilis

Symptoms: Painless chancre sore on or in genitals, anus, mouth or throat. Appears 10 days to three months after contracted. If left untreated, the sore will disappear and a skin rash will develop, often on the hands and soles of feet, 3-6 weeks after the chancre appears. It then usually disappears. Other symptoms may include hair loss, sore throat, fatigue or mild fever.

Damage: If left untreated after a rash appears, it can eventually, after many years, cause heart failure, blindness and damage to the brain and spinal cord.

Diagnosis: Health worker examines chancre site, throat, eyes, heart, lungs and abdomen; performs a microscopic examination of chancre pus and a blood test. Or the health worker follows the syndromic approach and treats via a diagnosis/observation of symptoms.

V. Human Papilloma Virus: There are many types of HPVs. In human beings they cause different diseases depending on the type.

A. Genital Warts

Symptoms: Genital warts are the result of a virus spread during sexual contact. They often grow together in little clusters on and inside the genitals, anus and throat. Depending on location, they can be pink, brown or grey and soft, or small, hard and yellowish-grey.

Damage: Genital warts disfigure the genitals and are ugly looking. It is, however, possible to treat them without having permanent damage. They are not common.

Diagnosis: Usually made by direct eye exam. A nurse or doctor may ask for other laboratory investigations when not certain about the diagnosis.

B. Cancer of the cervix

Symptoms: Early precancerous changes on the cervix are usually without symptoms. However, established cancer presents a vaginal discharge, usually foul smelling or irregular bleeding, especially during intercourse. This disease is rare in adolescents and occurs later in life.

Damage: Although early cancer is curable, later cancer cannot be cured. Cervical cancer will spread and damage other body organs, if left untreated. It eventually leads to death.

Diagnosis: Precancerous changes in the cervix can be detected through regular pap smears. Established cancer can be seen by the naked eye using a speculum. Diagnosis is confirmed by taking pieces of suspicious tissue for laboratory examination.

VI. Pelvic Inflammatory Disease (PID)

An infection that affects the fallopian tubes, uterine lining and/or ovaries. It is usually caused by sexually transmitted diseases that enter the reproductive system through the cervix and which have not been treated (Chlamydia or gonorrhoea).

Symptoms: While the symptoms vary from person to person, the most common identifying factor is pain in the pelvic regions. Other symptoms may include frequent urination and/or burning with urination, sudden fevers, nausea or vomiting, abnormal vaginal discharge, and/or pain or bleeding after intercourse.

Damage: If left untreated, PID can cause infertility or ectopic pregnancy. This is where the fertilised egg attaches itself to the fallopian tubes.

Diagnosis: In order to make a diagnosis, it is necessary to determine the original source of the infection. It can also be diagnosed and treated via reported symptoms.

VII. Yeast Infections (Monilia, Candida or Fungus) Note: These infections are often NOT transmitted sexually.

Symptoms: A yeast infection caused by an imbalance of the vaginal organisms.

Females: Itching, burning, dryness of the vagina, whitish and lumpy (cottage cheese-like) discharge that smells like yeast.

Males: Inflammation of the penis.

Diagnosis: Microscopic analysis of vaginal secretions.

Treatment: Locally applied cream or vaginal insertions.

VIII. Trichomoniasis

Symptoms: A vaginal infection that is most often contracted through intercourse, but can also be transmitted through moist objects such as wet clothing, towels, washcloths and so on.

Females: A burning sensation at urination and an odorous, foamy discharge, along with a reddening and swelling of the vaginal opening.

Males: Usually have no symptoms but might have a slight discharge, itching and/or lesions.

Damage: Can cause urinary infections.

Diagnosis: Usually diagnosed by microscopic analysis of vaginal discharge.

IX. HIV and AIDS

HIV&AIDS as discussed earlier in modules 2&3. Kindly refer to these modules on facts about HIV&AIDS and how HIV is transmitted.

Symptoms: One to two months after infection, some people experience a brief illness similar to a cold or the flu. An average of 5 - 10 years later, symptoms such as weight loss, yeast infections, night sweats, swollen lymph glands, persistent cough, diarrhoea, fatigue and loss of appetite may begin to occur.

Damage: People with HIV infection eventually develop AIDS and become ill with one or more serious diseases called referred to in module 3; session 4 as opportunistic infections that target individuals whose immunity has been weakened. The long-term outcome is gradual debilitation and, ultimately, death.

Supplies required- facilitator's notes and handouts in accessible formats, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Estimated time: 100 minutes

Learning Method: Large Group Interaction

Teaching Aids/ materials: Illustrated video show on STIs, Flip Charts & permanent markers, note taker, writing frame if trainer is blind/partially sighted, recorded audio cassettes.

***Handouts: Handout 4.1: Sexually Transmitted Infections
Handout 4.2: How do STIs transmit HIV?***

Session III: Is there a connection between TB, STIs and HIV?

Objective:

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

- Understand the connection between TB, STIs and HIV.

Process

1. Share the specific objective of this exercise.
2. Organize participants into three groups. Ask each group to come up with:
 - 10 reasons why knowing about STIs is important;
 - The connections between STIs, TB and HIV.
3. Ask the groups to select one person to share their reasons. Each new presenter from the subsequent groups should only add new points to those already made.
4. Note the presentations.
5. Make some of the points that are listed in the following sections.

Facilitators' quick notes

How do other Sexually Transmitted Infections promote the transmission of HIV?

Two types of STI's contribute to the transmission of HIV. One type causes ulcers on the genitalia or external sexual organs; these are syphilis, chancroid and herpes simplex Type 2. The other type which includes gonorrhoea, Chlamydia and trichomoniasis causes injury and inflammation (redness, pain, heat, irritation) of the delicate tissues of the external sexual organs. When HIV-infected individuals are co-infected with ulcer-causing STI's, their genital ulcers usually also contain HIV. The ulcers bleed easily during sexual intercourse readily releasing HIV onto the mucous membranes of their partners (vaginas, cervixes and/or rectum).

Handout

Am I at risk?

Participants will answer each question by writing 'Y' for yes, 'N' for no or 'U' for unsure or don't know. (Braille or provide these questions in Large Print)

1. You hug, kiss or massage your partner/spouse/friend. _____

2. You don't protect yourself when handling blood. _____
3. Your partner has sex with others. _____
4. You drink beer or other kinds of alcohol. _____
5. You masturbate yourself. _____
6. You are bitten by mosquitoes. _____
7. You allow semen or vaginal fluid to touch your skin near the pubic area.

8. You have sex with more than one person. _____
9. You or your partner has had an STI in the past. _____
10. You share a razor with a person with HIV or AIDS. _____
11. Your partner has sex only with you. _____
12. You live, work or play with a person with HIV and AIDS. _____
13. You don't always use a condom for sexual intercourse. _____
14. You don't know if your partner is HIV+ or has an STI. _____
15. You never have unsafe injections or tattoos. _____

Handout

20 Questions to Ask Yourself if You Think You Are at Risk

1. Do you have a wife/husband (girlfriend/boyfriend)? Yes____ No____
2. How many partners have you had in the last 6 months?
3. How often do you have a new partner?
4. What concerns, if any, did you have about having sex with this person?
5. How concerned are you that you could become infected with HIV from this partner?

6. Would you have engaged in this same behavior if you knew this person had HIV?
7. Would knowing have made a difference?
8. Where do you meet your partners?
9. How well do you know your partners?
10. How often do you use condoms?
11. With what partners are you more or less likely to use a condom?
12. How do you decide with which partners to use condoms?
13. How does drinking alcohol influence your decision to have sex?
14. Do you know if your partner has had sex with anyone else?
17. Have you and your partner talked about HIV/STD risk?
18. Have you discussed whether either of you had been HIV tested?
19. How did you and your current partner decide to stop using condoms?
20. Have you ever been diagnosed with an STD? When was that?

Handout

Six Connections between Tuberculosis and HIV

1. Before the late 1980s, Tuberculosis was considered to be at the brink of elimination. Then, new HIV-related TB cases and multi-drug-resistant tuberculosis began appearing.
2. Most TB patients in high HIV-prevalent countries are infected with HIV.
3. Today, HIV is known to be an important risk factor, contributing to the development of active TB from latent TB infection.
4. HIV also makes individuals with a recent TB infection more likely to progress rapidly to active TB disease.
5. Increasing TB cases put more pressure on medical resources, thereby reducing the availability of adequate medical facilities.
6. HIV-related stigma may prevent TB patients from seeking medical care.

Supplies required- facilitator's notes and handouts in accessible formats, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Estimated time: 40 minutes

Learning Method: Large Group Interaction

MODULE 5

PREVENTION OF HIV INFECTION

Session I: - Condom use

Objectives:

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

- Explore feelings, attitudes and perceptions about condoms.
- Demonstrate correct female and male condom application.
- Describe care, use and disposal of condoms.
- Describe advantages and disadvantages of using condoms.
- Distinguish fact and myths about condoms and condom use.
- Demonstrate partner negotiation for condom use.
- Discuss ways by which visually impaired persons can interact with condoms more effectively.

Process:

- Step 1** Explain to participants that you are going to play the condom line-up game. Ask everyone to join you in an open field or a spacious room. Ask participants to stand in a circle but if you are in a room could ask the group to sit in a circle.
- Step 2** Explain the task that; you will give one or two cards with the steps in condom use to each participant. Ask the learners to arrange the cards in a logical sequence.
- Step 3** Ask the group to let the person who feels that the step in their card is the first one to start the discussions by explaining to the large group the reason (s) they believe so. Each person should determine in a sequence when the step they hold should be applied.
- Step 4** Note the sequence for each group. Provoke members to explore all aspects in each step and finally the sequence should appear as shown in the table below.

Handout**Condom Line up exercise**

- Card:** Get a male condom from the facilitator.
- Card:** Practise on your own/Play with it.
- Card:** Check the expire date.
- Card:** Buy a condom.
- Card:** Store the condom.
- Card:** Meet someone you feel attracted to.
- Card:** Take contact, flirt and show interest.
- Card:** Agree to have sex.
- Card:** Agree to use condom.
- Card:** Hug, kiss and cuddle.
- Card:** Undressing.
- Card:** Foreplay.
- Card:** Oral sex.
- Card:** Erection.
- Card:** Lubrication.
- Card:** Carefully open condom wrapper
- Card:** Put condom on top of penis.
- Card:** Squeeze out the air in the small reservoir.
- Card:** Roll the condom down to base of penis
- Card:** Roll down the condom further
- Card:** Penetration
- Card:** Intercourse
- Card:** Orgasm
- Card:** Ejaculation
- Card:** Loss of erection
- Card:** Hold condom on to base of penis
- Card:** Withdraw penis
- Card:** Dispose condom
- Card:** Hug kiss and cuddle

Facilitators' notes

- Step 5** Explain that the condom is named after a 17th Century British Colonel who was supposed to have invented it. Initially it was used to prevent conception among the army in Britain. However, with the advent of STIs the condom has been a significant item in the prevention of STIs.
- Step 6** Tell the learners that the condom is a protective sheath worn on the male penis or inserted into the female vagina, if it is a female condom. The condom is a mechanical barrier, against the sperm, keeping it from coming into contact with the inside of the vagina and therefore from reaching the egg.
- Step 7** Explain that male condoms are usually made out of latex while female condoms are made out of polyurethane material. Condoms come in a variety of shapes. Most have a reservoir tip although some do have a plain tip.
- Step 8** Explain that there also are some condoms that are ribbed; that is they have bumps which increase sensation for both partners. They also have different brand names in different countries. The lubrication on condoms also varies. Some are not lubricated at all, some are lubricated with a silicon substance and some have a water based lubricant. The lubrication on condoms helps to make the condom easier to put on and more comfortable to use. Some condoms also contain a spermicide known as Nonoxynol 9.
- Step 9** Explain that a spermicidal lubricant helps to provide additional protection if some semen happens to leak out of the condom. This help to reduce likelihood of pregnancy.
- Step 10** Inform participants that we are going to have a skit/drama. Ask for two volunteers from the audience. One male and one female.

Instructions for the skit/drama (Should take about 15 minutes)

- Tell the man to assume he has seen an attractive woman.
- The man wants to have sex with the woman and begs her for it.
- The woman says that they should use a condom. That's the only way they have sex.
- The man reaches to his pocket and finds the condom is dried out. He runs to the shop to get another one. The shopkeeper asks him which one he wants and he says; 'GIVE ME ONE'.
- He runs back tries to open it and rips the condom! So he runs back to get another one. Because the woman will not have sex. When he comes back he fumbles with the condom, it falls on the ground and it gets

dirty. By this time the woman gets angry and impatient and says she wants to go home.

Step 11: Ask the audience what was happening in the skit/drama.

Step 12: Note their responses, moderate the discussion and explain that it is important for men and women to talk about condoms together. The decision whether to use or not use condoms is made by both sexual partners. Talking about condoms, learning about condoms and handling condoms can be difficult and embarrassing. Comfort must be learned. Talking about, learning about and handling condoms becomes comfortable and natural with practice. Sexually Transmitted Infections, including HIV are preventable. Condoms if used correctly and consistently will prevent STIs and HIV.

Step 13: Demonstrate male condom use as follows.

Note:

- That for this session to be most useful to visually impaired participant, the facilitator needs to issue each participant one penile model and one male condom.
- Explain each step slowly ensuring that all participants follow. Have sighted assistants to help.

Procedure of using a male condom

1. Remove condom from packet without damaging it. Explain to participants to feel the zigzag edges. These edges are used to tear the packet.
2. Place condom on the tip of an erect penis/penile model.
3. Squeeze air out of tip of condom.
4. Roll condom down penis/penile model.
5. Smooth out air bubbles.
6. With condom on insert penis into the vagina for sexual intercourse.
7. After ejaculation, hold on to condom at the base of the penis.
8. Withdraw from vagina while still erect.
9. Remove condom from penis.
10. Tie condom to prevent spills or leaks.
11. Dispose condom safely.

Point to note before using a male condom

1. Ask the condom provider for the expiry date of the condom.
2. Do not use condom after expiry date.
3. Condoms should be stored in a cool, dry and dark place. Heat, light and humidity all damage rubber.

The Condom User

1. Must make sure the condom size is correct.
2. Must use a water based lubricant (e.g. KY jelly).
3. Vaseline, baby oil, cooking oil, margarine are all oil- based and will cause the condom to break if used.
4. Must put the condom correctly on the male penis before sexual intercourse.
5. Must not take off the condom before sex is finished.
6. Must not use the condom again.
7. Must leave some space at the end of the condom when putting it on and not breaking when taking it off
8. Must take off the condom before the erection is lost.

Some reasons why condoms fail

1. If a condom tears before or during intercourse, then it will fail to perform its task.
2. If semen pours while removing it.
3. Manufacturers defect.
4. If air gets into a condom it may tear during sex.
5. If the penis comes into contact with the vagina before a placement of a condom.

Myths and misconceptions about the male condom

1. **Condoms reduce pleasure:** Condoms may reduce feeling for the man, but with peace of mind, one is likely to relax and enjoy sex to the fullest. It may take longer to ejaculate which may make sex more enjoyable.
2. **Condoms break easily:** If worn properly, stored under the right temperature, and used within the expiration date, condoms do not break easily.
3. **Condoms have small holes and can allow semen to filter though:** There are no small holes. Latex rubber is very tight rubber which cannot allow sperm, or other small things like HIV to go though. This has been proven though laboratory tests and has not been found to be porous.

4. **Condoms are not effective:** Condoms are 98% effective when used correctly and at all acts of intercourse. The failure rate is usually attributed to the other factors like poor storage and inconsistent use. The condom has been researched widely among couples where one partner is infected with HIV and the other is not. It has proven effective in preventing infection⁴.
5. **Condoms irritate the skin:** The lubricant in the condom is water base which is unlikely to cause irritation. Only in a small number of cases does skin irritation occur.
6. **Condoms make a man lose erection (impotence):** Condoms themselves do not cause this. Instead the problem may be physical or emotional (in the mind) due to embarrassment.
7. **HIV can pass through a condom:** Although HIV is small, it cannot pass through an unbroken latex condom. Condoms can prevent HIV and other S.T.Ds and are the only known barrier method to these infections outside of abstinence.

What contributes to failure?

1. Inconsistent and incorrect use.
2. Poor storage.
3. Use of expired condoms.
4. Poor handling resulting in breakages, e.g. long nails or tearing.

Female condom

Step 1 Explain to participants that the female condom is a thin sheath or pouch worn by a woman during sex. It entirely lines the vagina and helps to prevent pregnancy and sexually transmitted diseases (STDs) including HIV.

Step 2 The female condom is a polyurethane sheath or pouch about 17cm (6.5 inches) in length. At each end there is a flexible ring. At the closed end of the sheath, the flexible ring is inserted into the vagina to hold the female condom in place. At the other open end of the sheath, the ring stays outside

⁴ CDC (2003) 'Male latex condoms and sexually transmitted diseases', Fact sheet for public health personnel.

- o CDC (1999) 'Condoms and their use in preventing HIV infection and other STDs', September.
- o www.avert.org/condoms

the vulva at the entrance to the vagina. This ring acts as a guide during penetration and it also stops the sheath getting stuck inside the vagina.

Step 3 Female condoms have different brand names in different countries. They have a lubricant on the inside, but additional lubrication can be used if need be.

Procedure of using a female condom

1. Open the package carefully.
2. Choose a position that is comfortable for insertion - squat, raise one leg, sit or lie down.
3. Make sure the condom is lubricated enough.
4. Make sure the inner ring is at the closed end of the sheath, and hold the sheath with the open end hanging down.
5. Squeeze the inner ring with thumb and middle finger (so it becomes long and narrow), and then insert the inner ring and sheath into the vaginal opening.
6. Gently insert the inner ring into the vagina and feel it go up.
7. Place the index finger inside the condom and push the inner ring as far as it will go.
8. Make sure the condom is inserted straight, and is not twisted inside the vagina. The outer ring should remain on the outside of the vagina.
9. The penis should be guided into the condom in order to ensure that the penis does not slip into the vagina outside the condom.
10. Use enough lubricant so that the condom stays in place during sex.

Note:

1. The female condom should not be used at the same time as a male condom because the friction between the two condoms may cause the condoms to break.
2. If the condom slips during intercourse, or if it enters the vagina, then you should stop immediately and take the female condom out. Then insert a new one and add extra lubricant to the opening of the sheath or on the penis.

3. To remove the condom, twist the outer ring or frame gently and then pull the condom out keeping the sperm inside.
4. Wrap the condom in the package or in tissue and throw it away.
5. Do not put it into the toilet.

Facilitator's notes

Step 4 Explain the benefits of the female condom in the following way.

1. It offers opportunity for women to share the responsibility for condom use with their partners.
2. A woman may be able to use the female condom if her partner refuses to use the male condom.
3. The female condom will protect against most STDs and pregnancy if used correctly.
4. The female condom can be inserted up to 8 hours before intercourse so as not to interfere with the moment.
5. Female condoms are made of polyurethane which can be used with oil based as well as water-based lubricants. No special storage requirements are needed because polyurethane is not affected by changes in temperature and dampness. In addition, these materials are thin and conduct heat well, so sensation is preserved.

Step 5 Explain the disadvantages of the female condom in the following way.

1. The outer ring is visible outside the vagina, which can make some women feel self-conscious.
2. The female condoms can make noises during intercourse (adding more lubricant can lessen this problem).
3. Some women find the female condom hard to insert and to remove.
4. It is expensive and relatively limited in availability in many countries.

Can I reuse the female condom?

It is believed that limited availability and high cost have led some women to reuse female condoms in some countries. The World Health Organisation (WHO) recommends use of a new male or female condom for every act of intercourse.

WHO does not recommend or promote reuse of female condoms but has released a document together with guidelines and advice for programme managers who may consider reuse of female condoms in local settings.⁵

Step 6 Discuss with participants some tips of how they as visually impaired persons can interact with condoms more effectively. Note their points from the discussion and add that other than asking the shopkeeper/pharmacist to inform him/her what the expiry date on the condom is;

A visually impaired person can detect if a condom has expired if it feels sticky or if it very dry (i.e. lubrication has dried out) you shouldn't use it as the packaging has probably been damaged.

A visually impaired person can tell if condom in good condition also moves around easily while it is inside the wrapper.

How can I protect myself from getting infected with HIV?

HIV is a disease that can be prevented.

There are three ways you can protect yourself from getting infected with HIV. These methods are known as the ABCs of safer sex.

Abstinence	This is total avoidance of sex. Total avoidance of sex is the surest way to avoid getting infected with HIV. This is because there is no risk involved.
Fidelity	This means being faithful to one uninfected sexual partner.
Condom use	This means using a condom each and every time you have sexual intercourse.

⁵ WHO (2002), 'The safety and feasibility of female condom reuse': Report of a WHO consultation

Supplies required- facilitator's quick notes. Materials: note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers and masking tapes, Braille /large print cards with the steps, sample female and male condoms, penile for each participant and pelvic models.

Estimated time: 120 minutes

Learning Method: Large Group Interaction

Session II: - Voluntary Counseling & Testing (VCT) (Counseling and Testing for HIV)

Objectives

By the end of this session:

1. Find out participant(s) experiences as regards VCT
2. participants will know what an HIV test is
3. Participants will have answers to the question 'why test?'
4. Participants will understand the concept 'window period'.
5. Participants will be motivated to go for an HIV test and encourage other visually impaired persons to do so too.
6. Participants will discuss ways that visually impaired persons can access VCT services more easily.
7. Participants will appreciate that knowing one's HIV status is an important step in the fight against HIV&AIDS.

Process

Step 1: Introduce the title of the session and share the objectives with participants.

Step 2: Ask participants to volunteer to share their experiences as regards VCT.
Note: You want to find out whether they know what VCT means, whether they have ever been to a VCT centre, you also want to find out whether they felt welcomed and if the services were modified to suit their needs as visually impaired people.

Step 3: Ask participants to define VCT. Note their response, clarify and add other points using the following notes.

Facilitator's notes

VCT stands for Voluntary Counselling and Testing

All these activities are confidential.

VCT assists individuals to make better decisions about sexual behaviour and so reduce the risks of getting infected or of transmitting HIV.

What is VCT not?

- It is not for clinical diagnosis. It is not a medical event

- It is generally for adults. 18 years old and above
- VCT is exceptionally also for those are below 18 years but above 12 years old who are at risk of HIV, for example those who are pregnant or sexually active.
- It is not to find out who is HIV positive within the community
- It is not to compile statistics on HIV infection in the community
- It is not mandatory testing. (Employment, Visa and or for insurance)

Step 4 Ask participants to list benefits of VCT that they know of.

Step 5 Note their responses, clarify and add using the following points.

Facilitator's notes

Why is VCT important?

- Reduce stigma. If people are able to get good information and if they consider their own risk taking they are less likely to stigmatize others. Stigma is fear and ignorance about HIV.
- If people know they are HIV negative and have accurate information about HIV, they are more likely to protect themselves in future.
- If people know they are HIV positive and have accurate information about HIV, they are more likely to adopt to safer sex and so reduce transmission to others.
- If pregnant women know they are HIV positive, they take early steps to reduce the risk of passing on the Virus to their baby.
- If people know they are HIV positive, they can seek early access to care, such as for opportunistic infections and Tuberculosis and therefore reduce their likelihood of ill health.

Step 6 Explain the process of Voluntary Counseling and Testing to the participants as follows.

Facilitator's notes

VCT involves the following steps;

1. decision to take the test
2. Pre-test counselling
3. Blood taking
4. HIV testing
5. Post- test counselling
6. Follow-up service

The procedures of VCT

1. Pretest counselling

This is counseling done before the HIV test. It involves:

- Assessing one's risk of contracting HIV.
- Discussion on the test and expected results.
- Thinking through the possible results.
- Discussing basic HIV facts.
- Discussing risk reduction methods.
- Process takes 15 to 20 minutes.

2. Testing.

- This is done using the rapid test kits.
- They look for HIV virus antibodies. These kinds of tests are commonly used in a VCT centre.
- They are called rapid because they work fast.
- The process takes 15 to 20 minutes.

Possible Test Results

Negative results

- Means that no HIV was not found in the given sample.
- Also referred to as sero-negative.
- Could be that one is in the window period.

Positive result

- HIV was present in the sample and that one is infected.
- Also referred to as sero-positive.

Discordant result

That one test is positive and the other is negative. If this happens, a tie-breaker has to be used. This means that something went wrong in the testing time. The test then has to be repeated.

3. Post-test counseling

The process takes 15 to 20 minutes.

This is done after the test.

The client is first assessed for readiness to receive the results.

This is done depending on the result received.

If negative

Discuss the window period.

Explore the implications of being HIV negative.

Review risk reduction.

Refer appropriately.

Give out condoms if requested.

Offer space for any questions.

Encourage follow-up counseling.

If positive

Explore and acknowledge the person's fears and feelings.

Explore and identify immediate concerns.

Revisit risk reduction.

Discuss medical follow-up care and referral to appropriate services.

Discuss positive living.

Allow room for questions and check that information is understood.

Help the person to establish priorities and plan of action.

Encourage follow-up counseling.

NOTE: VCT is person-centred, that is it focuses on each person's unique issues and circumstances related to HIV risk. VCT is based on the risk- reduction model and the intervention is designed to reduce risk, not necessarily eliminate it. The emphasis of VCT is to initiate small incremental behaviour change steps to reduce risk.

Step 7: Ask participants if they know the meaning of the term 'window period'. Note their responses, clarify and explain the term using the following information.

Explaining window period

If the infected person has an HIV test soon after becoming infected, the antibodies may not yet show up in the blood test. This is because the person's body might not have produced antibodies, or the person does not yet have sufficient antibodies in his/her blood to show on the blood test. Although this infected person has had an HIV test, the test can come back HIV negative, meaning the antibodies are not detected.

Step 8: Explore with the participants ways in which VCT can be made more accessible to blind and partially sighted persons.

Supplies required- facilitator's quick notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Estimated time: 100 minutes

Learning Method: Large Group Interaction

MODULE 5

MANAGEMENT OF HIV&AIDS

Session I: - Living with HIV

Objectives

By the end of this session:

1. Understand the concept of positive living with HIV.
2. Understand the needs of persons living with HIV.

Process

Step 1: Introduce the title of the session and share the objectives with participants.

Step 2: Go through the feelings that come with testing positive for HIV. Note participants' responses and explain that once someone has tested positive for HIV they need to talk to a counselor.

The counselor will listen to your fears and anxieties and will give you support and information on how to care for yourself. You can come back to talk to a counselor any time you feel like talking to someone. Talking to a counselor is part of the follow up counseling that was discussed in module 4, session II on 'post-test counseling'.

Step 3: Explain that before getting to the stage of accepting once HIV positive status, a person may go through all or some of these stages. They happen at different times in different people.

These stages include the following;

Denial: It's common to deny your status the first time you hear about your results. It is also common to be gripped with confusion and fear. Speak to your counselor about how to cope with these emotions.

Anger: You become angry and hate yourself and everybody around you. Take a deep breath in and out a few times to give yourself enough air to cope with the stress. Do not rush into decisions which will put you in a worse situation, like wanting to avenge yourself by having unprotected sex with anyone on sight.

Depression; Withdrawal: Sometimes you may go into withdrawal and not want to talk to anyone. You may become depressed and worry about many things – how long you have to live, who will care for your children, what you will do if your immediate family and community find out. You may fear that others will stigmatize you, the community will discriminate against your family, you will not be able to afford food and medication, and you will not be able to work any more. Do not be too hard on yourself. Take time to reflect. You are human.

Acceptance: This is the stage now you start confiding in some friends and relatives. You may be looking for information, understanding and support. Be aware that many other people could be in the same situation. Try and open up; you may make a lifetime friend. Remember AIDS is now just another chronic disease that can be managed with medication and a healthy lifestyle, just like diabetes and other chronic diseases.

Step 4: Explain some steps to help someone living positively with HIV using the notes below.

Get more information on HIV so that you will be able to reduce your worries and make positive decisions about your life, especially how to protect yourself and your family.

Dealing with depression

Laughing with people helps strengthen your body and is very healthy. Try and not be alone. Be in the company of your friends and talk about your situation. If you need more help, see a counselor.

Continue to work if possible

Work will keep you busy and your mind occupied. You will be able to provide for yourself and your family and that will leave you with a high self esteem that you are able to do something.

Diet

Good nutrition is very important. A lot of traditional foods here in Africa contain vital vitamins and food nutrients. Green leafy vegetables and fruits are particularly good for your body. You can eat well without having to buy expensive food. Eat a balanced diet; eat at least three times a day or more often if you need to.

Opportunistic infections

Seek medical treatment promptly for any illness or opportunistic infections you may have. Avoid getting infections such as T.B., other chest infections and S.T.Ds. Protect yourself from getting malaria and colds. Involve your friends and family in helping you to prevent diseases. Most people who are HIV-positive do not need antiretroviral therapy (A.R.T.). A healthy diet and lifestyle is all they need. Talk to your doctor about treatment options.

Exercise

Exercise regularly. Walking, cultivating the garden and even housework are some exercises you can do. However, do not strain yourself. You should get enough rest as well.

Practice safer sex

Abstain, if possible. If you cannot, stick to one partner and use condoms every time you have sex. Persuade him or her to also get tested so both of you are aware of each others' HIV status. Should you want to have children, seek the help of a counselor on your options.

Get involved

Talk about being HIV-positive to other visually impaired people and other people in the community as well and how they can prevent infection. Speak out in your associations/organisations of the blind, church, and community. In particular, educate other visually impaired persons, and encourage them to get tested. Also educate your family members, both children and adults.

As an HIV-positive person, you may feel you are not ready to go public. This is fine; you should not feel coerced. But try and not make things worse by speaking negatively about others who are affected or infected. Sometimes silence can be more helpful than harmful words.

Where they exist, join a support group for visually impaired people living with HIV. Advocate for the formation of one if none exists. Such groups can welcome both HIV-positive and HIV-negative members whether sighted or not and need not be just for those who are infected.

Where to get more information

Persons living with HIV and AIDS can adopt a healthier lifestyle and good eating habits to live positively. To learn how to live positively. If you or anyone you know is living with HIV and AIDS contact your nearest hospital, health centre, dispensary or clinic or VCT centre and talk to your health provider.

Handout 5

Principles of positive living

1. **People living positively** understand and accept the reality of the AIDS diagnosis, but also refuse to believe that the syndrome is an automatic, imminent death sentence.
2. **People living positively** believe that they can cope actively with the disease, and refuse to succumb to a "helpless-hopeless state.
3. **People living positively** make appropriate, individualized adjustments in personal habits and behavior in order to accommodate living with the disease.
4. **People living positively** see the physician as a collaborator and take an active part in decisions related to their own treatment. There is a sense of personal responsibility for health, and a belief that they personally can influence the outcome of the disease.
5. **People living positively** show a "commitment to life"; there are unfulfilled goals, dreams and unfinished business that they commit themselves to.
6. **People living positively** find meaning and purpose in life and even in the disease itself.
7. **People living positively** have usually had a previous experience with overcoming a life-threatening illness or overcoming previous difficult situations and events.
8. **People living positively** report the importance of support and information from other persons with HIV, and furthermore, are usually involved in active service to other persons with HIV.
9. **People living positively** are assertive, can say "NO" and withdraw from involvements when self-care becomes necessary.

10. **People living positively** develop an ability to listen to their own body, and to sensitively care for it, and to communicate openly about their concerns without feeling selfish.

Supplies required- facilitator's quick notes

Handout: Principles of positive living in Braille/large print

Estimated time: 100 minutes

Learning Method: It would be most preferred to have a facilitator living positively with HIV to conduct this session. This also goes a long way in promoting Greater Involvement of People Living with HIV (GIPA)

Session II: - Anti-Retroviral Therapy (ART)

Objectives

By the end of this session:

1. Participants will be able to have some information about Anti-Retroviral Therapy.
2. Participants will be able to understand the use of Anti-Retroviral Therapy in the management/treatment of HIV&AIDS.

Process

Step 1: Introduce the title of the session and share the objectives with participants.

Step 2: Find out if participants know what A.R.T and ARVs mean. Note their responses and clarify that A.R.T. is the technical term for AIDS treatment. The full name of A.R.T. is Antiretroviral Therapy. The drugs involved are called Anti-retrovirals, abbreviated as A.R.V.s. If your immune system is very weak, the doctor may advice you to consider taking A.R.V.s.

Explain that if your immune system is still strong, there may be no need for A.R.V.s. A visually impaired person living with HIV can talk to a doctor for advice. Most people living with HIV just need to live a healthy lifestyle, exercise, and avoid opportunistic infections. Ask your doctor how to do this.

Step 3: How A.R.V.s works

Explain that different drugs work differently. Some prevent HIV virus from entering the cell; others prevent it from multiplying once it is inside the cell. Thus A.R.V.s slow down the virus so that fewer viruses attack the immune system. Currently, ARVs come in the form of only 1 tablet. All these drugs have been combined into one pill that is easy to take.

A.R.V.s. helps the immune system get strong so it can keep out opportunistic infections. Just like repairing a house to keep out the rain.

When people take A.R.Vs they get sick less often and feel better for longer periods of time.

CD4 test

Even if you do not feel sick, your doctor may advise you to take a CD4 test. This test measures the strength of your immune system. After this test is done, the doctor is able to advise you on how to keep your body healthy.

Step 4: Making a commitment to A.R.Vs.

Explain that someone should start A.R.Vs only when they are ready to make a life-long commitment.

Stopping and starting, and missing tablets stops them from working. A counselor will advice on how to adhere to therapy.

Device a way to help you remember to take your medicines.

As is the case with other medicines, people may inquire why you are taking them. It is your choice who, if anyone, to inform. At the same time, it can help to have someone you trust, a family member or friend, to help you cope with HIV, and to remind you to take your medicine. You can also use your talking watch with an alarm to help you remember when to take your medicine.

Plan ahead for how you will take the A.R.T. when you are at work.

If you travel away from home, pack more tablets than you need. This will give you enough tablets if you stay away longer.

Step 5: A.R.Vs. do not cure HIV.

Clarify that if some is on the therapy, they can still give HIV to someone else. A.R.Vs. only reduce the amount of viruses in the blood, they does not eliminate them.

A.R.V.s. do not prevent re-infection from HIV

If you are taking A.R.Vs., you can still get HIV again with a different type of the virus. This is called re-infection. This may make your immune system weaker.

Protect yourself from more HIV

While you are taking A.R.Vs., continue to protect yourself and others by using a condom or not having sex. Remember by engaging in unprotected sex you can still infect others or get re-infected yourself.

Step 6: A.R.Vs. and Pregnancy

Explain that while the decision to have a baby rests on you and your partner, it is very important to tell your doctor if you are pregnant or want to have a baby. He or she can provide you with appropriate advice.

You can get pregnant while you are using A.R.Vs. If this happens, there is a small chance that you will give HIV to your baby unless you and the baby are given special medicines. Visually impaired persons planning to have children can talk to a doctor and ask about a program called Prevention of Mother to Child Transmission (P.M.T.C.T.) of HIV.

Explain that one should never share their A.R.Vs with someone else. The A.R.Vs will not be of help in the body if not taken as recommended by the doctor. If you share they won't work for you or the other person.

Step 7: Emphasize that ARVs must be accompanied by proper nutrition and moderate exercise.

Step 8: Conclude by saying that a person taking ARVs is not alone! There are over a million people around the world taking A.R.Vs. Everyday, you too can take them successfully.

Supplies required- facilitator's quick notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Learning Method: Large Group Interaction

Estimated time: 60 minutes

Session III: Care and support for people living with AIDS: Home-Based Care.

Objectives

By the end of this session:

1. Participants will discuss and understand comprehensive care and support.
2. Participants will learn how to take care of someone living with AIDS at home.

Process

1. Introduce the title of the session and share the objectives with participants.
2. Find out from participants if they understand the following
 - What home-based care is;
 - How we take care of someone with AIDS at home.
 - What the advantages of Home-based Care are.

Step 1: Begin by explaining that home based care is the care given to persons infected by HIV/AIDS. It extends from the hospital or health facilities to the patients home through family participation and community involvement within available resources.

Home based care has four main components.

1. Clinical Care
2. Nursing care
3. Counselling and physical- spiritual care
4. Social Support.

Step 2: Explain the various components as follows;

Clinical Care

- 1) Includes care to promote and maintain good health, hygiene and nutrition.
- 2) Early diagnosis, rationed treatment and follow up care of HIV related illness.

Nursing care

Includes care and promotion of living

Counselling and physical- spiritual care

- 1) Includes reducing stress and anxiety
- 2) Promote positive living
- 3) Helps individuals in making informed decisions on HIV testing.

- 4) Helps individuals make plans for the future and behaviour change; while involving sexual partners in such decisions.

Social Support

- 1) Includes information about referral services and support groups
- 2) Includes information on welfare services
- 3) Legal advice for individuals and their families
- 4) Provision of material assistance

Step 3: Who provides care and where?

1. The patient provides his/her care if not very sick
2. Family members, friends and community members.
3. Health workers-community based workers and traditional healers.

The principal areas for home based

1. At home and within the community
2. At clinic for medical problems where is a lot of privacy
3. Within the patients home. This is a patient who does not need isolation.
Standard guidelines fro controlling infection should be followed. Home based care training promotes compassionate care for a person living with HIV.

In home based care,

1. The patient is encouraged to live life normally.
2. The care giver should keep confidentiality. He/she should not reveal the private matters of the patient.
3. Show love to the patients by bathing and feeding them. Love makes the patient have hope.
4. Material support and donation of clothes, food, and drugs make the patient feel loved and cared for.
5. Give the patient time to express his/her views and to make their own choices.
6. The care giver enlightens the patient on good nutrition

Step 4: Basic home nursing skills

Define nursing as follows- nursing is an act of assisting individuals, it includes values and aspects of personal hygiene such as bathing and nail care.

Qualities of a home based care giver

1. Good communicator
2. Courageous
3. Empathetic
4. Observant and able to monitor the client

5. Friendly
6. Gives his/her own time
7. Caring
8. Humble and gentle

How to handle person during home based care

1. Introduce yourself
2. Be punctual: if you tell the client you will come at a particular time, be there at that time.
3. Treat the patient with respect, dignity, with sensitivity and kindness.
4. Do not blame or discriminate the client.
5. Patient privacy must be respected
6. Strict and absolute confidentiality is required
7. Be accepting and dependable.
8. Do not judge the moral values of your patient

The care giver can learn about their patient in the following ways;

1. Have the power of observation. The care giver can prevent a lot of problems by being aware of the following things and report to the doctor in case of any abnormalities.
 - I. Patient's mood, happy, jumpy, sad.
 - II. Look at the color of their eyes.
 - III. Eyes should be white,
 - IV. observe whether they have any skin rashes, blisters,
 - V. body temperature
 - VI. ulcers
 - VII. breathing: sometimes a patient would breath too fast, or slow noisy

Step 5: How to give care to a person living with AIDS at home

Explain how to give care in the following way;

Bed bathing

Explain that the reason to bathe the patient is to ensure personal hygiene, get rid of harmful bacteria and to refresh the patient.

Outline the resources required for bathing the patient as follows;

Gloves or plastic bags, large basin, warm water, towels, soap, container for dirty beddings, tooth brush/ paste, razor blade/ scissors, comb, chair, clean clothes.

Explain that if the person is conscious and able to move the care giver should inform the patient what they will do.

- I. Gather all the resources to the patients reach.
- II. Explain to the family members and the patient what you want to do.
- III. Close the curtains, doors and windows to provide privacy.
- IV. Undress the patient and cover them with a sheet. Expose only the area you want to clean.
- V. Put the patient in a suitable position protecting the bed with a plastic sheet.
- VI. Place the basin of warm water on the chair where he can reach.
- VII. Permit the patient to wash him/her self. Leave the room for a short time.
- VIII. When the patient has finished wash their back and feet. Cut the nails Spread the bed and comb her hair
- IX. Clean the materials and items used and remove them from the area.
- X. Pour the water away.
- XI. Clean the dirty clothes and hang them.
- XII. Wash and dry your hands

If the patient is unconscious or too weak to move;

Gather all the resources you need to bath them, involve family members and the patient's privacy must be observed.

Mouth care

Keeping the mouth clean helps to prevent diseases and sore gums. The care giver helps to attend to the mouth in order to promote the flow of saliva. The items needed for mouth care include; gloves, cups, water, tooth paste/brush, piece of cloth, Vaseline, cotton wool and a spoon.

For a conscious patient;

- I. Prepare the items needed
- II. Wash and dry your hands
- III. Explain to the patient what you want to do
- IV. Place the towel / piece of cloth or plastic paper across the patient's chest and under the chin
- V. Bring all materials within his reach.

Provide the tooth brush /stick with paste and water in a cup. Offer container onto while rinsing the mouth.

If the patient is unconscious;

- I. Put on the gloves or plastic bag
- II. Wind some cotton wool around the spoon to make a swab or fold a piece of cloth to clean gently between the lips and upper gums and between the lips and lower gums; the roof of the mouth, tongue floor of the mouth and lips.
- III. Move the swab from back to the front of the mouth in each area and change the cotton wool when necessary.

- IV. Gently brush the teeth, rinse, apply Vaseline to the lips if dry and leave the patient comfortable.
- V. Clear the place and throw away the cotton.

Nail care

Explain that keeping the finger nails and toe nails clean and neatly trimmed should be done for the following reasons; it reduces the collection of germs and prevents self injury

Resources for nail care include; soap, water in a basin, towel, Vaseline/ lotion

Explain the steps to follow in nail care as follows;

- I. Prepare the patient by explaining the procedure. Obtain the patient's permission to trim the nails.
- II. Gently wash the hands with soap and water scrub the nails with brush, rinse and dry the hands using clean cloth/ towel.
- III. Trim the nails with a razor
- IV. Apply Vaseline or lotion to both hands.
- V. Repeat the procedure for cleaning for the toe nails.
- VI. Leave the patient comfortable and thank him/her for their cooperation. Ask the patient if he/she is comfortable.

Cleaning the used articles and materials

Explain that it is important to keep used articles and materials clean. The care giver should collect the nail cuttings into a piece of paper and throw them into a pit latrine. Clean all the articles used, then wash and dry your hands.

Hair care

Help to maintain personal hygiene in order to keep the person living with HIV healthy and maintain their well being. The following are the resources needed for hair care; water, basin, soap, comb, towel, plastic paper gloves and oil. After you have cleaned the hair clean all the materials used.

Pressure sores

Explain what pressures sore are in the following way. These are sores caused by breakdown of the skin and constant pressure. They occur on the buttocks, back, hips, elbows, feet and ankles.

The patient should be turned after every two hours to prevent the development of pressure sores as a result of lying in the same position for a long time.

Use gloves if the patient has wounds or is soiled. Ask a family member to work with you.

Explain the steps in taking care of pressure sores

- I. Prepare the patient. Explain to him/her what you are doing if he/she is conscious.

- II. Remove the beddings; loosen the sheet so as to allow the patient to move freely.
- III. Turning the patient in the bed bring one hand and leg across to the side of the patient's face.
- IV. One person brings the patient's shoulder on the other while the other rolls the pillow, lift the patient to the centre of the bed, adjust the pillow under the cheek and put the patients hands in a comfortable position, bend the legs slightly, remake the bed leave the patient comfortable; clean the articles used, disposing those that will not be used again.
- V. Wash and dry your hands
- VI. Patients are emotionally very vulnerable and can be hurt by careless remarks and uncaring behaviors.

When care giver is taking care of a patient he should take note of the following;

- I. Caring behaviour
Gentleness, appropriate smile, sense of responsibility, ask open ended questions, listen actively, positive body language.
- II. Uncaring behaviour
Rudeness, roughness, shouting, ignoring, blaming language, negative body language

To prevent pressure sores from becoming worse or infected, to promote healing and reduce suffering of the patient; apply pawpaw fruit juice on the sores twice or thrice daily. Honey and sugar mixture is used to kill germs and speeds the healing.

Requirements for caring for pressure sores

Gloves, stool, chair, container, basin, plastic paper and piece of cloth

Steps to follow;

- I. Collect all the items to be used place them near the bed
- II. Explain to the patient if conscious what you are going to do
- III. Ensure the privacy of the patient
- IV. Pour warm water and make it soapy with mild soap
- V. Place plastic paper under the part where the pressure sores are and expose. Wash around the edge of the sores first then wash from the centre to the end till clean. For each wiping use separate cloths. If the sore is dry leave it open to the air. Rinse the area with soapy water.
- VI. Change the patient's position from time to time. Clear the materials used in dressing the sores. Strengthen the bed remove the gloves. Wash the soiled clothes with soap and water boiling for a short time. Hang them in the sun to dry. If the sore is very bad and the care giver cannot manage it she should inform the supervisor/ trainer for they will refer further care. Check the patient for all parts that may be swollen. This could be boils. Where gloves if there is pus. Cover the

lump with a piece of cloth that is loosely tied. If the lump becomes painful a health worker or trainer should be seen.

Step 6: Decontamination procedure

Explain that decontamination involves removing harmful substances from a place.

- 1) Care givers should exercise caution and protect the hands with gloves
- 2) Rinse soiled items in cold water, pour water in the latrine.
- 3) Soak the items in cold water and bleaching agent for 10 minutes.
- 4) Put soiled items into a large pot of water with some soap or detergent as though you are going to wash them. Stir with a heavy stick. Boil for ten minutes, rinse and hang them to dry.

Handling body fluids

Body fluids include pus, blood, urine, stool, vomit, semen, vaginal fluids and saliva.

Precaution- Explain that a care giver should always wear gloves to prevent direct contact with fluids. Visually impaired care givers can get assistance from a trusted friend or family member to ensure they do not expose themselves to contamination. Any materials that are to be used should be kept clean and any material used should be burned, buried or thrown in a pit latrine. Fresh blood/ pus from wounds should be carefully handled to prevent contamination and infection spread by these fluids.

Resources needed for this exercise include; gloves, container for soiled clothes, water, clean clothes/ pad, cotton wool, bandages, soap.

If body fluids spill on the floor they should be cleaned immediately to avoid contamination.

Step 7: Psycho-spiritual care and social support

Emphasis that psycho-spiritual care and social support is very important for any person with a chronic illness; this includes people living with AIDS.

Explain to the participants that home-based care presents the best opportunity to offer to the person living with AIDS psycho-spiritual care and social support.

Family, friends and community are the best health care givers.

- Ask the participants why this may be so.
- Note their responses and explain that family, friends and community are already known to the person living with AIDS; hence the person may feel more comfortable with them. This is the greatest advantage of home-based care. The person living with AIDS is taken care of in an environment that he is already used to; his/her home by people who care and show him/her love.

Care givers can help someone to cope with negative feelings by listening, talking and spending time with them.

Step 8: Referral for clinical care

Explain to the participants that if the person falls sick they should be referred to the clinic/hospital.

Referral for clinical care provides continuity for the needed care; it also provides linkage between the clinic and the patient and to provide support for him/her.

Step 9:

Conclude by distributing to the participants the handout on basic Home-Based Care skills for Care givers. Remember to note the preferred format for each participant.

Supplies required- facilitator's quick notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Learning Method: Large Group Interaction, small group discussions

Estimated time: 120 minutes.

MODULE 7: Behaviour Change Communication

Session I: -What is Behaviour Change Communication (BCC?)

Objectives

By the end of this session: -

1. Participants will understand the concept of Behaviour Change Communication.
2. Participants will know the role of a Peer Educator in Behaviour Change Communication.

Process

Step 1: Begin by defining Behaviour Change Communication (BCC) as the process by which information and skills are shared and disseminated to people in the specific target audience with the intention of influencing them to adopt sustained changes in sexual behaviour or attitude, or to engage in other health-seeking behaviour.

Step 2: Explain the process of behaviour change and the role of Peer Educators in BCC as follows;

Stages of behaviour change

1. Unaware: The responsibility of peer educator to a client at this stage to provide basic information.
2. Informed: The responsibility of a peer educator at this stage is to encourage them to adopt positive steps and present them with behaviour change options.
3. Concerned: The responsibility of a peer educator at this stage is to tell them what to do next in changing their own behaviour, such as going to the clinic to receive STI treatment.
4. Knowledgeable- The responsibility of a peer educator at this stage is to motivate the client to act, for example, by informing them of the benefits of using services.
5. Motivated to change- The responsibility of a peer educator at this stage is to point or direct client to services and encourage their use.

6. Ready to change- The responsibility of a peer educator at this stage is to tell client the benefit of using services.
7. Trail/assessment of new behaviour. The responsibility of peer educator to a client at this stage is to provide an opportunity to practice new skills and reinforce what the client will do to continue the new behaviour.
8. Sustained behaviour change. The responsibility of a peer educator to a client at this stage is to tell the client they are doing the right thing. Create an environment that promotes the new behaviour and encourage them to follow through. A Peer educator can also encourage the person to join a group of people with similar experiences. This will encourage sustained behaviour change.

Step 3: Inform participants that behaviour change is a process. It takes time for people to move from one stage to another as listed above.

Step 4: Explain to participants to understand Behaviour Change Communication: BCC has many different but related roles to play in HIV and AIDS programming.

An effective BCC strategy should:

- Increase knowledge by making sure that all people have the basic facts about HIV and AIDS in the language or medium they understand.
- Promote essential attitude change. It can lead to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, greater open-mindedness about gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS. It can also encourage visually impaired persons to visit mainstream HIV&AIDS service organisations to seek HIV&AIDS prevention, treatment, care and support services.
- Stimulate community dialogue on the underlying factors that contribute to the epidemic, such as risk behaviour, risk setting and the environment that creates these conditions.
- Promote advocacy to ensure that policy makers and opinion leaders approach the epidemic seriously. Advocacy takes place at all levels, from the local community to the national level.⁶

⁶ Peer-to-Peer HIV & AIDS Peer Educators Trainers' Guide for IMPACT Implementing Agencies: Page 95.

- Reduce stigma and discrimination through effective communication on HIV and AIDS. An effective BCC strategy can greatly reduce stigma and discrimination among visually impaired persons. Visually impaired Peer Educators should continuously educate themselves and others about HIV&AIDS. They should also target other people in their communities. This will help to raise awareness that HIV&AIDS infected and affects visually impaired persons in the community.

Step 5: Explain that there are different methods employed in a Behaviour change Communication strategy. There are a number of methods that are used to communicate information to others. These include:

- Group discussions
- Role plays
- Lecture
- Drama
- Audio visual presentation
- One-to-one method
- Demonstrations

Most of these methods are suitable for training visually impaired persons. However it should be noted that visual presentations are not accessible to them.

When working with visually impaired adults, it is vital that you use a variety of methods. You must also consider the goal or desired outcome of each session and match the method to the goal. Many times, you need to use several strategies to achieve your goal.

Effective delivery of information requires the facilitator to:

- Be enthusiastic about the information /training you are about to deliver.
- Be calm and relaxed.
- Use simple and appropriate language. Do not be afraid to use sight words like 'see' or 'look', this is not offensive to visually impaired persons.
- Provide clear guidance and instructions.
- Speak loudly. Visually impaired persons cannot see you; they cannot see the gestures you are making, hence they rely on listening.
- Present materials at a good pace so that participants are able to follow.
- Present accurate information. If you are unsure about certain issues, kindly inform the participants. You can further inform them that you will research on it and get back to them at a later date with information that you are certain about.
- Present information that will be of interest to the peer. It would be prudent to use examples that are relevant to the environment of the participants.
- Present well-organized information in a simple, easy-to-understand manner and clarify difficult information.

- Show confidence. Participants will believe what you inform them if you as a facilitator exudes enthusiasm and self confidence.
- Make good use of communication materials. For example use audio materials/tapes to explain a point / phenomenon. This will help you to break monotony especially if you are using the lecture method to deliver some information.
- Note down responses from group discussions and read them out loud to the participants. This enables them to follow the discussions more effectively.
- Listen to the peer and respond to feedback appropriately.
- Hold the group's attention and encourage the group to actively participate.
- Make the peers feel comfortable.
- Set up a comfortable environment. When working with visually impaired participants ensure that there are no barriers/ items that block pathways as these could cause injuries.
- Talk less, ask more questions.
- Acknowledge good responses.

Supplies required-facilitator's quick notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Learning Method: Large Group Interaction, small group discussions
Estimated time: 60 minutes.

Session II: - Qualities and competencies of a Peer Educator

Objectives

By the end of this session: -

1. Participants will understand the rationale of Peer Education program.
2. Participants will be able to link peer education to the continuum of prevention, care and support.
3. Participants will learn the qualities and skills that Peer Educators need to apply in peer education work.

Process

- Step 1** Share session objectives with participants.
- Step 2:** Begin by asking participants to define Peer Education. (Link/make reference to the previous session on Behaviour Change Communication.
- Step 3:** Note their responses and fill in the gaps using the following notes.

Facilitator's notes

- Peer Education is the art of disseminating knowledge to people of the same age bracket and interests in a given setting.
- Peer Education is a process that involves similar people learning together in a given community.
- Explain that a Peer Educator in the community is someone trained to facilitate discussions on HIV&AIDS, risky behaviour and facilitates his or her peers in the examination of solutions.
- Peer Educators are people selected for their leadership potential in helping others and in most cases they are well known in the community. They are trained to disseminate knowledge by being role models, encouraging peers, listening and influencing healthy decisions and behaviour.
- Explain that Peer Educators influence behavior change. People are most likely to listen to and follow the advice of their peers. Peers also have greater influence on each other than non-peers, a significant factor in lending credibility to behaviour change messages.
- Note that 'Peers' are;

- a) People with whom you have similar interests
 - b) People of similar age bracket (usually within a five-year range),
 - c) People of similar world view,
 - d) People whose views on issues almost always mirror your own,
 - e) People you are likely to imitate and listen,
 - f) People who grew up with you,
 - g) People who share the same experiences.
- The main purpose of Peer Education is to proactively train and educate on all issues surrounding HIV&AIDS awareness, prevention treatment, care and support in both formal and informal settings.

Step 4: Role of Peer Educators in our organizations and in the communities we live in include the following;

- a) To influence healthy decisions and behaviors.
- b) To promote the welfare of their peers.
- c) To offer lay-counseling and support. To listen to their peers.
- d) To boost the self-esteem of their peers.
- e) To make referrals to appropriate health, welfare and psycho-social facilitators.

Step 5: Examine the qualities of a Peer Educators as follows.

First begin by forming participants into two groups.

Ask them to list down the qualities and skills of a good visually impaired Peer Educator.

Note their responses and fill in the gaps using the following information.

Facilitator's notes

Qualities of a good Peer Educator

- a) Excellent communication skills.
- b) Approachable and easy to talk to.
- c) Well respected.
- d) A problem solver.
- e) A good planner and well organized.
- f) A team player

Step 6: Conclude by saying that visually impaired Peer Educators are generally trained to;

- a) Provide one to one counseling.
- b) Conduct advocacy and influence visually impaired women and men to access mainstream HIV&AIDS programming.
- c) Facilitate discussions on risky behaviour and other risk settings
- d) Disseminate basic facts on HIV&AIDS and other sexually transmitted infections, repeated infections and treatment failure and motivate them to seek prompt and competent treatment delivered by competent health workers in their community.
- e) Make referrals to services such as HIV counseling and testing, Anti-Retroviral Therapy, prevention of mother to child HIV transmission, orphan care and treatment for tuberculosis and other opportunistic infections.
- f) Link visually impaired people infected by HIV to support groups in their community.
- g) Promote HIV prevention through abstinence, mutual fidelity or condom use.
- h) Demonstrate and teach condom use skills to visually impaired people in their communities.

Supplies required- facilitator's quick notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Learning Method: Large Group Interaction, small group discussions
Estimated time: 45 minutes.

Session II: -How to motivate Peer Educators and sustain a Peer Education program in organizations of visually impaired persons

Objectives

By the end of this session: -

1. Lead participants in understanding possible approaches that will ensure sustainability in peer education.
2. Lead participants in suggesting specific efforts to enhance the sustainability of HIV&AIDS training and Peer Education programmes in their own organisations.

Process

1. Inform participants that this will be a small group activity.
2. Form them into two groups of 10 each.
3. Tell the groups to identify factors that can hinder effective Peer Education and propose innovations to improve peer education.
4. Each group presents to all participants.
5. Note the presentations and add to this discussion using the following notes.

Facilitator's notes

Factors that hinder effective Peer Education:

- Lack of resources to get the message out (materials, finances, transport, etc.)
- Poor grasp of a community's language.
- Lack of skills to create innovative messages and presentations.
- Lack of personal motivation (both Peer educators and their clients), due to a lack of materials and the means to do their jobs.
- Socio-cultural and religious factors.

Suggested innovations to improve Peer Education:

- Use a participatory methodology that lets clients decide the way and manner in which they get information.
- Explore cost-sharing and networking with mainstream NGOs and organisations of visually impaired persons.
- Use the appropriate local language in presentations and materials. If you cannot speak the language, look for a local translator.
- Carry out continuous evaluation of the modes of communication. This will help to improve the quality of training methods.
- Provide incentives and opportunities to motivate peer educators (such as participation in conferences, workshops, etc.)

- Solicit the support of opinion leaders and influential people in the community.

Issues of sustainability

- Ownership. Organisations of the visually impaired must own the HIV&AIDS Peer Education Programs that they initiate.
- Incentives.
- Training or re-training of Peer Educators and organisations of the visually impaired for sustainability.
- Adaptability of the training manual: Organisations of the visually impaired and their Peer Educators should give suggestions, contributions and modifications on this manual. For example is the manual user–friendly, does it address issues of visually impaired men and women?
- Economic empowerment: It would be important for organisations of visually impaired persons to link their HIV&AIDS initiatives to income generating projects for Peer Educators.
- Clearly defined goals and objectives.
- Capacity building:
- Coordination and networking.
- Managerial process: a management information system that includes feedback on the activities of Peer Educators.
- Direct involvement of peer educators in all aspects of the programme.
- Multi-sectoral approach and integration with other sectors.
- An enabling environment: Visually impaired Peer Educators must be accorded the necessary support by their organisations.

Supplies required- facilitator's notes, note taker, writing frame if trainer is blind/partially sighted, flip chart & permanent markers

Learning Method: Large Group Interaction, small group discussions
Estimated time: 40 minutes

Appendices

Appendix 1

Bibliography

1. Double Exposure: Disability and HIV/AIDS in sub-Saharan Africa
A thesis submitted to the University of Manchester for the degree of M.A in Poverty, Conflict and Reconstruction in the Faculty of Social Sciences and Law, 2004 (Jacinta M Sweeney): Institute for Development Policy and Management (IDPM)
2. HIV/AIDS and Disability: Capturing Hidden Voices: April, 2004 (The World Bank and Yale University Global Survey on HIV/AIDS and Disability.)
3. Disability and HIV&AIDS: Including persons with disabilities in HIV&AIDS programs: 2006 SHIA Program-Kenya: solidarity, human, rights, inclusion.
4. Disability and HIV&AIDS: Including persons with disabilities in HIV&AIDS programs: 2006 SHIA Program-Rwanda: solidarity, human, rights, inclusion.
5. Disability and HIV&AIDS: Including persons with disabilities in HIV&AIDS programs: 2006 SHIA Program-Tanzania: solidarity, human, rights, inclusion.
6. Peer Education Training of Trainers Manual-Youth Peer Education Electronic Resource, 2002.
7. Peer-to-Peer HIV/AIDS Peer Educators Trainers' Guide for IMPACT Implementing Agencies
8. Peer Education and HIV/AIDS: Concepts, uses and challenges: UNAIDS Best Practice Collection, December 1999.
9. Gender, HIV/AIDS and rights: A training manual for the media: IPS- Inter Press Service International Association: www.ipsnews.net and/ www.ipsenespanol.org
10. Understanding and Challenging HIV Stigma: Toolkit for Action: Trainers Guide, September 2003. (Ross Kidd and Sue Clay-International Centre for Research on Women-ICRW)

11. How to create an Effective Peer Education Project: Guidelines for AIDS Prevention Projects: (AIDS Control and Prevention-AIDSCAP-Behaviour Change Communication Unit-Family Health International-FHI)
12. Overcoming HIV&AIDS AIDS: The 'next Agenda': 2004 UNAIDS report on the global AIDS epidemic.

Useful references and websites

1. The impact of AIDS on People and Societies: Women are more Vulnerable to HIV than men: 2004, report on the global AIDS epidemic-Page 40.
2. http://www.cnib.ca/eng/publications/pamphlets/accessible_events.
3. www.unaids.org
4. www.who.int/hiv
5. www.avert.org
6. www.aidsalliance.org
7. www.fhi.org

DAY 2:

- 6:45-7:45 Breakfast
- 7:45-8:00 Participants seated in the seminar hall
- 8:00-8:15 Recap of previous day's sessions

Session 3

- 8:15-9:30 HIV& the immune system

Session 4

- 9:30-10:30 Sexuality, Blindness and HIV&AIDS

- 10:30-11:00

Tea Break**Session 5**

- 11:00-1:00 Condom use

- 1:00-2:00

Lunch**Session 6**

- 2:00-3:30 Testing for HIV (Counseling and Testing)
(VCT Centre)

- 3:30-4:00

Tea Break

- 4:00-5:00

- Continuation of session 6

DAY 3:

- 6:45-7:45 Breakfast

- 7:45-8:00 Participants seated in the seminar hall

- 8:00-8:15 Recap of previous day's sessions

Session 7

- 8:15-10:30 Living with and Management of HIV&AIDS
(GIPA)

- 10:30-11:00

Tea Break**Session 8**

- 11:00-1:00 Home-Based Care

1:00-2:00

Lunch**Session 9**

2:00-4:00

Role-Play on HIV transmission

4:00-5:00

Tea Break**DAY 4:**

6:45-7:45

Breakfast

7:45-8:00

Participants seated in the seminar hall

8:00-8:15

Recap of previous day's sessions

Session 10

8:15-10:30

Peer Education: Strategies, motivating Peer Educators Experiences.

10:30-11:00

Tea Break**Session 11**

11:00-1:00

Qualities of a Peer Educator
(Counseling, Self Esteem, Negotiation,
Communication)

1:00-2:00

Lunch**Session 12**

2:00-3:30

accommodating the needs of blind and partially
sighted people into HIV&AIDS Programs-Rwanda
Experience
(RUB)

3:30-5:00

Continuation of session 12

DAY 5:

6:45-7:45

Breakfast

7:45-8:00

Participants seated in the seminar hall

8:00-8:15

Recap of previous day's sessions

8:15-10:30

Evaluation of Training: **Post –training
evaluation**

10:30-11:00

Tea Break

11:00-1:00

developing an Action Plan for community trainings

1:00-2:00

Lunch

2:00-4:00

Closing

END