SWAZI WOMEN4HEALTH

A STANDARDISED MODULE FOR INTERPERSONAL COMMUNICATION

COMMUNICATING ABOUT HIV RISK REDUCTION STRATEGIES WITH WOMEN AGED 25 TO 39

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

USAID
FROM THE AMERICAN PEOPLE

HEALTH COMMUNICATION CAPACITY COLLABORATIVE

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Comments and requests for information related to obtaining the Swazi Women4Health Guide and training on how to use the resource can be directed to:

The Chief of Party
Health Communication Capacity Collaborative Project
Johns Hopkins Center for Communication Programs
P.O. Box 6343, Mbabane H100, Swaziland
Tel: +268 24 04 77 20/55 21/55 48

Or

info@healthcommcapacity.org

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretrovirals
CCP	Johns Hopkins Center for Communication Programs
eNSF	Extended National Strategic Framework 2014–2018
FP	Family Planning
GBV	Gender-Based Violence
HC3	Health Communication Capacity Collaborative
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
NERCHA	National Emergency Response Council for HIV and AIDS
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PSS	Psychosocial Counselling
SHIMS	Swaziland HIV Incidence Measurement Study
SNAP	Swaziland National AIDS Program
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision

ACKNOWLEDGEMENTS

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The guide is aligned to needs revealed by the HIV epidemiology Swaziland HIV Incidence Measurement Study (SHIMS, 2011). It consists of interactive sessions using a diverse range of participatory methods to enable individuals to become more aware of their own personal risks for HIV infection, learn about strategies to reduce their risk and make decisions to adopt appropriate risk reduction strategies to avert HIV acquisition and/or transmission.

The discussion guide is an outcome of hard work by communities and the HC3 team. In addition, the invaluable technical contribution and support that HC3 received from its collaborators cannot go without mention.

We are immensely grateful to community volunteers, HC3 field staff at all levels and our collaborating partners, notably the Swaziland National AIDS Program (SNAP) in the Ministry of Health and the National Emergency Response Council for HIV and AIDS (NERCHA) for their insights from various interactions that informed the development of this guide.

Several individuals, too numerous to mention one by one, made invaluable contributions. The core team involved Glory Mkandawire, Sibongile Mndzebele, Chris Mzembe, Bheki Vilane, Tengetile Hlophe and Beth Mallalieu. The team is greatly inspired by the technical experience and methodical approach of Jane Brown (CCP) because of the workshop she facilitated in April 2015 that gave birth to the structure and content of this discussion guide.

Finally, the discussion guide is made possible by the generous support of the American people through USAID. The contents of this guide are the responsibility of HC3, and reflect the views of neither USAID nor the United States Government.

WELCOME TO THE DISCUSSION GUIDE

Welcome to the ***Swazi Women4Health Discussion Guide for Interpersonal Communication with Women Aged 25 to 39.***

The goal of the extended National Multisectoral Strategic Framework for HIV and AIDS (eNSF, 2014–2018) is to halt the spread of HIV and reverse its impact on Swazi society. The first priority, in pursuit of that goal, is to prevent new HIV infections and reduce mortality among people living with HIV (PLHIV).

Political and community leaders in Swaziland, in concert with service providers and the support of development partners, are working tirelessly to combat the epidemic. But more work needs to be done to reach the right people in the right places with the right messages and services that address their unique vulnerabilities to HIV and AIDS. One of the strategic gaps among HIV prevention programming identified in the eNSF is inadequate targeting of interventions and services and a lack of intensity for reaching the most vulnerable.

This guide was developed to address this gap by focusing on the age group of women aged 25 to 39 that face the highest risk of HIV acquisition and/or transmission, and defining a communication package that addresses key behavioural determinants that influence desired behavioural outcomes in respect to uptake of key HIV prevention services. The basis for the guide is the eNSF and the *Core Package for HIV Prevention: Guidelines for Implementers*. The design was modelled after the *Tasankha Discussion Guide*, produced by the Malawi BRIDGE II project, also implemented by CCP.

We believe that the *Swazi Women4Health Discussion Guide* will spur the desperately needed action for a systematic approach to finding and reaching individuals, groups and communities that face the highest risk of HIV acquisition and/or transmission, thereby launching a cycle where the risk of HIV acquisition and/or transmission is minimised or otherwise eliminated through the uptake of key HIV prevention services.

Glory Mkandawire
Chief of Party, HC3 Swaziland

OVERVIEW

This guide has three modules – each to be completed in one day. Thus, the entire module can be implemented over a three-day period. It is recommended to tackle one session per day and stagger the sessions to allow space between them during which participants will reflect on what they have learnt, especially in the first two sessions, and attempt to practice the recommended behaviours.

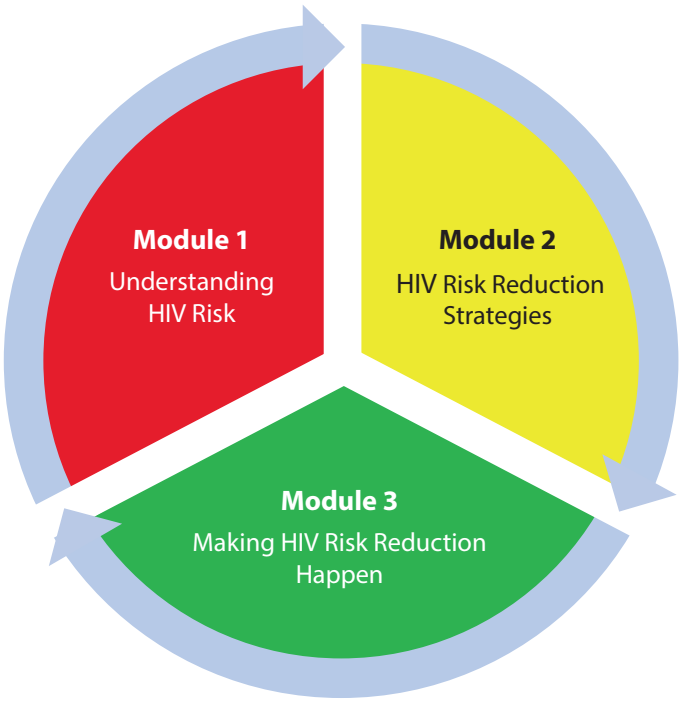
Module highlights:

Module 1 focuses on defining risk, and recognising what types of risk an individual may be taking. It also reviews comprehensive information about HIV and AIDS, and highlights key HIV reduction strategies, concluding with service mapping.

Module 2 explores the barriers and facilitators of HIV risk reduction strategies introduced in Module 1. The content is similar to Module 1, however, the intention of this session is to "stretch" participants to critically examine the practical barriers and enablers of positive behavioural outcomes that reduce the risk of HIV acquisition and/or transmission.

Module 3 guides participants through the exercise of developing individual risk reduction plans. This session helps participants to determine the actions that they will take at the personal, family, social – such as friends and co-workers – and community levels. This activity helps to bridge knowledge and action. The module concludes with a graduation ceremony where participants who have participated in all the three sessions are awarded a certificate, which is a reminder of what they have learnt and the promises they made to themselves.

Modules in This Tool



THE SWAZI WOMEN4HEALTH DISCUSSION GUIDE

The Swazi Women4Health Discussion Guide is an interactive tool designed for interpersonal communication (IPC) with women aged 25 to 39 in communities in Swaziland. The aim of the discussions is to provide comprehensive knowledge about HIV and AIDS and increase awareness of HIV risk, learn about strategies to reduce risk and ultimately take action to reduce one's own risk.

The guide comprises three modules, as follows:

- Understanding HIV Risk
- HIV Risk Reduction Strategies
- Making HIV Risk Reduction Happen

The delivery of these modules is designed as a three-day course whereby one module is delivered per day, and there is a certificate-awarding ceremony on the last day. The certificate is intended to be a memento that will remind the individual of their responsibility and personal commitment towards realising the vision of His Majesty the King of an HIV-free generation in Swazi society.

The women that participate in sessions using this tool will be able to:

- Increase their understanding about HIV transmission, prevention, antiretroviral treatment (ART) and the importance of adherence.
- Increase their awareness and understanding of the gender norms that impact HIV risk, prevention, ART adherence and service uptake.
- Examine and identify their risk for HIV and develop a personal plan and commitment to reduce their risk.
- Practice new skills to prevent HIV infection.
- Use condoms correctly and consistently.
- Increase their use of HIV-related services including HIV testing and counselling (HTC), prevention of mother-to-child transmission (PMTCT) and ART.
- Discuss what they have learned during the sessions with others – such as family, peer group and community – and inspire others to take action to reduce their HIV risk and access relevant services.

Target Group

As mentioned above, the information and activities in this guide are primarily tailored for discussions with women aged 25 to 39. The guide can be used for younger or older populations, but adjustments will need to be made to be responsive to the available evidence concerning a population's specific risks to HIV acquisition and/or transmission.

Desired Outcomes

As a result of the above actions, the following outcomes among women aged 25 to 39 are anticipated:

- Increased uptake of HTC
- Increased correct and consistent condom use
- Increased uptake and adherence to ART for those that test HIV positive
- Reduction of multiple concurrent partners
- Increased uptake of PMTCT
- Reduction in gender-based violence (GBV)

UNDERSTANDING YOUR AUDIENCE

As highlighted before, this tool is specifically designed for IPC with women aged 25–39. We recommend that the user of this manual takes time to thoroughly read this section and get acquainted with the audience, the reason why this target group has been prioritised and how the content relates to the key issues affecting this group. Although the content might be relevant to younger or older women outside this age group, it is crucial not to overgeneralise. Because of the social dynamics of HIV infection, priority should be given to women aged 25 to 35 for reasons outlined below.

Swaziland has a generalised HIV epidemic and about one in every four people (26 percent) aged 15-49 live with HIV. While projections show a steady decline in the number of new infections in all ages, women are more vulnerable. For instance, about 47 percent of women aged 25-29, 54 percent aged 30-34 and 49 percent 35-39 are HIV positive compared to 21 percent, 37 percent and 47 percent of men respectively (SHIMS). Overall, HIV incidence rate among adults aged 18-49 is estimated at 2.38 percent, with new HIV infection rates disproportionately higher among women (3.1 percent) than men (1.7 percent).

Women aged 25-39 are in the prime age for both marriage and child-bearing. A large proportion are either married or in a stable sexual relationship with a male partner. However, marriage rates are low and the prevalence of multiple and concurrent intimate relationships is high. Additionally, gender-based violence (GBV) is common and increases women's risk for contracting HIV. Combined, these form important HIV risk factors, as two critical peaks of HIV incidence occur in this age bracket, with HIV incidence peaking among women aged 35–39 at 4.09 percent and among men aged 30-34 at 3.12 percent.

While antenatal care (ANC) participation by pregnant women is high – 96.8 percent of women attend at least one ANC visit and 76.6 percent attend four or more visits – an analysis of ANC data reveals significant concerns: at least 38 percent of pregnant women test positive for HIV, 20 percent of pregnant women coming for ANC for the first time learn their HIV status for the first time, and only 26 percent have their first ANC visit by 16 weeks. Unmet family planning needs are also high, estimated at 63 percent unmet need for family planning (FP) among pregnant people living with HIV (PLHIV). In addition, the HIV seroconversion rate during the last trimester is 3-7 percent, and up to 15 percent of exposed children become infected between six weeks and two years of age. Only half (54 percent) of HIV-infected infants are on ART.

KEY ISSUES

1. Maintaining HIV- status among HIV- women – HTC, viral load suppression among intimate partners (men)
2. Elimination of risk of mother to child transmission of HIV
3. Informed choice (family planning) – FP/dual protection
4. Reduction of HIV risk among intimate partners, notably men with unknown HIV status and viral load suppression among HIV+ men
5. Reduce prevalence and tolerance of intimate partner violence – empowering women to say no to unwanted sex and enhancing access to/uptake of post violence services: post exposure prophylaxis (PEP and emergency contraception)

LEARNING PRINCIPLES USED IN THE GUIDE

This guide reinforces active learning, with a view to change ideas, beliefs and practices that are harmful or interfere with healthy behaviours, while expanding community members' capacities to learn new things.

Active learning goes beyond the ability to remember and recall. It is about questioning, examining and critiquing the material presented. This helps people to learn fully, providing them the opportunity to think critically about what they have learnt and how it applies to real-life situations at home or in their social circles.

The guide also applies principles of adult learning which emphasise concrete images, examples and experiences that promote learning in adults. Key principles include the following:[1]

- **Experience and Goal-Oriented:** Adults have accumulated invaluable experience and become stimulated when given an opportunity to share and apply their experiences to future actions. They are also interested in how new information can be applied to their own life.
- **Involvement:** Adults resent being "talked to." They are more stimulated when they are participants in the conversations and "co-learners" or "co-teachers" with the facilitator. Thus the most effective facilitator is the one that "learns to listen and listens to learn."
- **Relevance and Expectations:** Adults are usually practical. They have real-life pursuits and are motivated by learning experiences that have immediate relevance to their daily life struggles. Therefore, a key part of the facilitator's role is to highlight the benefit of the activities and sessions. In doing so, it is still vital to engage participants in sharing their expectations to ensure what is important is addressed where possible. The facilitator must "think-on-his/her-feet" and establish linkages between what participants see as important and beneficial to them, such as their expectations, and the purpose of this guide.
- **Self-motivation and Respect:** Regardless of the motives, adults participate in the learning process voluntarily and are self-motivated. A facilitator must try and understand why adults have come for the sessions and develop rapport with them by showing interest in them, appreciation for their coming and asking them their preference of how to perform some tasks. When they feel respected, their commitment to the learning process will also be strengthened.

[1] Knowles, M. (1984). The Adult Learner: A Neglected Species (3rd Ed.). Houston, TX: Gulf Publishing.

HOW TO USE THIS GUIDE

Key Assumptions

We have assumed that the facilitator who will use this guide already has:

- Well-developed facilitation skills
- Comprehensive knowledge about HIV and AIDS
- Basic knowledge about interpersonal communication

If a facilitator lacks any of the above-listed attributes, it is recommended those gaps be addressed prior to commencing any sessions. The objectives, content and structure of this guide can inform the development of a tailor-made capacity building curriculum for facilitators.

Before the Session

- Acquaint yourself with the contents of this guide
- Mobilise the target population:
  - » Identify the community link person, such as a community development assistant, rural health motivator and Gogo Center clerk.
  - » Share the expectations and duration of the sessions with the community link person, and agree on the place and start time.
  - » Estimate the possible number of participants and generate an initial list of participants. The group should be no more than 25 people to allow for good discussion, and for the facilitator to easily manage the group.

During the Session

- Be organised – keep time and follow the recommended sequence and time allocated.
- Be enthusiastic and motivate the participants to feel free and participate actively.
- Do not feel under pressure to know the answers to all questions from participants. Feel free to refer participants to the health facility or tell them that you will look for the answer and provide it another day. Be sure to follow up on any questions that you agreed to investigate. However, do not divert from the subject under discussion – do not stray to other topics on which you have neither the mandate nor training.

After Completing Each Module

- As part of quality improvement (QI), the facilitator using this guide should to take a few minutes to reflect on what worked well, what did not work well and provide concrete suggestions on how to improve the process in future sessions.
- Complete the activity participation form in **Appendix I** and ask a participant to endorse it. Before asking a participant to sign, it is important to explain the purpose of the data form and ensure they do not feel pressured to sign if they are not comfortable doing so.
- Write out referrals for any participants who want to go to a health facility.

GUIDELINES FOR THE FACILITATOR

The facilitator's aim is to guide community members through reflecting on what they have learned and how they can use it. The facilitator should summarise the main ideas and interpret them in a way in which community members can relate. The facilitator should also assess learning by asking community members what positive choices and actions they are going to take as a result of what they have discussed. Take special note of the following:

- **The People**: Know your target group. Before any session begins, ensure you have the basic knowledge of the group. Be aware of how many people will be in the session that you will conduct and the variety of backgrounds represented. Send clear and unequivocal invitations. If unintended target groups show up with the intended target group, be proactive and assertive – while maintaining sensitivity – thank them for coming but politely ask them to attend to other important business. An unintended audience could become a distraction and, more importantly, working with an unintended audience would affect the extent to which you achieve the intended objective.
- **The Place:** Ensure that the venue is conducive to learning and discussion of this nature. The venue should be protected from distraction, such as noise from passers-by. It should also have access to necessary facilities, such as water and toilets.
- **Resources:** Organise all needed resources well in advance and make sure that you know how to use them. It is advisable to have a field pack that has all the needed materials. Be creative and use locally available materials.
- **Facilitation Tips**
  - » Welcome participants and greet them all. Show that you are excited. This helps create anticipation among the participants.
  - » Introduce yourself.
  - » Ask participants if they want to start the day with a prayer. If they agree, ask a volunteer to pray.
  - » Give participants the chance to introduce themselves.
  - » Encourage all participants to be free and at ease. Ensure that they understand the importance of the discussions you will have.
  - » Agree on a few key rules of engagement.
  - » If it is at the beginning of a module, consider starting with an appropriate ice-breaker or energiser, suggestions can be found in **Appendix II**.
  - » If it is a follow-up session, recap the previous session by providing a summary focused only on key points.
  - » Explain the title and intention of the session clearly.
  - » Explain your expectations. Keep them short and to the point. Ask participants if they have any additional expectations.
  - » Explain how long the session will take and engage participants to agree on what time to start and when to end. Once this is done, keep to the recommended times for the sessions. During break times, set an example by being punctual yourself. Ask the group to appoint a timekeeper if helpful.
  - » Topics on HIV and GBV are sensitive, such as prevention with positives and post-exposure prophylaxis following an abusive event. As a facilitator, be mindful that some people might be affected directly and encourage the group to be sensitive to these potentially upsetting trigger points.
  - » Ensure that everybody participates actively by encouraging those that are shy or withdrawn, and tactfully controlling those that want to dominate the discussion.
  - » Encourage everyone to participate actively.
  - » It might be beneficial at times to separate participants according to narrower age groups.
  - » Use the "power-of-silence": when you pose a question and participants appear to be unresponsive, try to be silent for a moment and wait for someone to say something. This may have a more powerful effect than continuing to prod them to talk or respond.

» Remember that community members like to be shown respect. This can be done by use of their names when asking for people's comments on the discussion point or recognising their contributions, to name a few.

» Invite participants to share what they learnt and what actions they are contemplating as a result of the activity/session. Close each session by summarising the key messages from each activity/session.

Considerations

These discussions will be among women aged 25 to 39 only. However, this seemingly homogeneous group might have some attributes that will require you to be creative, as there are bound to be intra-group variances in sexual experiences and information needs, such as:

- Some of the women might already have motherhood experience
- Others might be HIV positive
- Others may have recent experiences of partner violence
- Some may be married, while others are single

It is important to keep all these aspects in mind while working with these women.

Dress Code

Facilitators must ensure that the way they are dressed does not interfere with their ability to command respect among the participating women and the community in general. It is thus important to know your community, and, while trying to maintain your individual preferences and lifestyle, be sensitive and considerate to the feelings of others.

Interactive Techniques

Facilitators have a diverse set of participatory techniques to choose from to use in a session. These include role plays, real-life stories, brainstorming, small group discussions and individual tasks. All these methods have been included in this guide.

Role play has been used more than the other methods. This is because role play gives more opportunities for everyone to participate. For example, the generally quiet personality can act out real-life situations in deeper ways than perhaps words can explain. The following are some of the advantages of using role play more:

- Role play provides information. Role play uses true-to-life drama. It helps people dramatise the myths that people spread and how to dispel the myths. Through role play, people might explore problems that they might otherwise feel uncomfortable discussing in real life.
- Role play creates motivation. Role play can effectively dramatise the external pressures that people face in real life and the difficult psychological situations that are sometimes the direct consequences of poor decision-making and risky behaviours.
- Role play builds skills. When done well, role play has the potential to shape behaviour. It can demonstrate various skills, such as negotiation, assertiveness and decision-making.
- Role play creates a linkage to services. Role play can create the opportunity to inform the audience about services that exist in the community. It can catalyse a critical analysis of the quality of services that are provided, such as whether providers respect the rights of clients, like confidentiality.

When using role play, provide a sufficient amount of time. After the role play, ask questions to find out what participants learnt from the role plays conducted. Instead of using the same people throughout, encourage every participant to take part in one of the role plays.

BASICS OF INTERPERSONAL COMMUNICATION

Principles[2]

- ***IPC is inescapable***: silence or not saying anything in itself communicates something.
- ***IPC is irreversible:*** what has been said cannot be fully retracted.
- ***IPC is complex:*** how the message is passed on and interpreted depends on who you think you are, who you think the other person is, who the other person thinks you are, who the other person thinks she or he is, where the conversation is taking place, when the conversation is taking place and who else is involved.
- ***IPC is contextual:*** contexts influencing how we communicate are psychological context, such as who you are and what you bring to the interaction (needs, desires, values and personality); relational context, such as your reactions to the other person; situational context, such as "where" (board meeting or bar discussion, party or funeral vigil); and environmental context, such as the physical "where" (under a tree, in a hotel, sitting on the ground, sitting on chairs, temperature and season); and cultural context, such as learnt behaviours and rules that affect the interaction, such as in some cultures long direct eye contact signals trustworthiness, while in others it is rude.

Best Practice

- Command the attention of the participants.
- Communicate a benefit. People are more likely to change their behaviour if they know what is in it for them.
- Appeal to their emotions.
- Communicate a clear message that is understandable, relevant, and delivered in a language that is familiar and appropriate. Prioritise what is most important to communicate.
- Provide a clear call to action. Participants should understand what they are supposed to do to achieve the desired result. Many times this will include promotion of service uptake.
- Create trust. Make sure that the messages take into account the cultural and social world view of the participants, are framed in the context of their day-to-day and overall priorities, and that are not offensive.
- Be consistent and ensure the messages are harmonised with what other partners are saying and, above all, are not contradictory.

[2] King, D. (2000). Four Principles of Interpersonal Communication. Accessed from: http://www.pstcc.edu/facstaff/dking/interpr.htm

SESSION PLANNING

"Give me six hours to chop down a tree and I will spend the first four sharpening the axe."

– Abraham Lincoln

This tool has ensured that the content is right for the group for which it is intended. Module 1 meets the minimum standard. However, a certificate of completion would only be issued to participants if they go through all three modules.

Before you decide to conduct these sessions in a community, it is important to talk with the leadership or community link person about what your plans are and explain how your work can benefit their community. Explain that for this workshop you plan to only target women aged 25 to 39 as this population has a high rate of new HIV infections.

It is important to be familiar with the content you will be presenting and all methods to be used before going into the community. Be sure to practice before and make sure that you have all materials needed before beginning the session.

Facilitator's Note

- The discipline of planning is vital for both success and quality.
- The guide should be used in groups of 25 participants or less.

There is a field readiness checklist located in **Appendix III** that can be used to assess if you are ready to present in the field.

REFERENCES AND SOURCE MATERIALS

Materials in this guide include elements from and/or have been adapted from or otherwise inspired by and the following sources:

1. EngenderHealth & Planned Parenthood Association of South Africa. (2001). Men As partners: A program for supplementing the training of life skills educators. Second Edition. New York, New York.

2. Johns Hopkins Center for Communication Programs. (2005). People like us: An HIV participatory assessment discussion guide. Windhoek, Namibia: Johns Hopkins University Health Communication Partnership (JHU/HCP).

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14. UNICEF. (2007). National Study on Violence against Children and Young Women in Swaziland. Mbabane, Swaziland: Government of Swaziland.

15. University of Michigan. (2010). Pedagogy of action: The module on HIV prevention through education. Accessed from: http://sites.lsa.umich.edu/nzh/the-module-on-hiv-prevention-through-education/

16. World Health Organization (WHO). (2014). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO.

MODULE 1:
UNDERSTANDING HIV RISK

MODULE OVERVIEW

Objectives:

After participating in this module, participants will be:

- Acquainted with the basic HIV facts
- Aware of their individual levels of risk to HIV acquisition and/or transmission
- Familiar with the key HIV risk reduction strategies relevant to them as women aged 25 to 39
- Aware of core HIV services within their locality

Activities:

1. Exploring the Concept of Risk
2. The Story of Make Vilakati
3. Individual HIV Risk Assessment
4. Basic Facts about HIV
5. HIV Risk Reduction Strategies
6. Service Mapping

Materials:

- Copies of the Story of Make Vilakati (**Appendix IV**)
- Copies of the HIV risk assessment tool (**Appendix V**)
- Newsprint/flip chart paper
- Markers
- Wooden penis model
- Male condoms
- Female condoms

Module Introduction:

In this module, we begin to explore the idea of risk, what it is and what it means when we talk about HIV. We also will review the basic HIV facts and discuss seven risk reduction strategies to prevent the transmission and acquisition of HIV.

This is the first of three sessions that we will be conducting here and we hope that you will be able to attend all three. Each session will build upon the previous one to form a comprehensive program.

Questions and comments are welcome at any time. If you do not feel comfortable asking questions in front of the group, please feel free to come up to me after the session and we can have a private discussion.

EXPLORING THE CONCEPT OF RISK

Aim:

After going through this session, participants will have a basic understanding of risk, how and why people take risks, and the range of risks from low to high risk, in relation to HIV.

Materials:

- Flip charts
- Markers

Directions:

Step 1: Briefly introduce the topic

Inform participants that you will have a discussion on:

- What is risk? How do you define a risk?
- Why do people take risks?
- Susceptibility and severity of risks related to health.
- Applying the concept of risk to health, especially individual health.

Step 2: Lead an open discussion with the larger group

Ask for volunteers to share their understanding of risk.

- What comes to your mind when you hear the work "risk"?
- How would you define risk?
- What is a risk you or someone you know has taken in the past? Why was it a risk?

Summarise the discussion by emphasising key words and phrases used by participants. Share the definition of risk (from Merriam-Webster) below:

- Risk is the possibility that something bad or unpleasant, such as injury or loss, will happen, or that someone or something may cause something bad to happen.
- Risk can either be low or high.
- When risk is LOW, it means that either the likelihood of it happening, impact to the person's life or both are low.
- When risk is HIGH, it means that either the likelihood of it happening, impact to the person's life or both are high.

Step 3: Group work

Divide participants into groups of six to eight people.

Ask participants in each group to:

- Select a group leader who should moderate the discussion and a reporter who should take notes for the group discussion.
- Share personal experiences of risk, any risk.
- Rank the risks as LOW or HIGH.
- Select two risks they want to share in plenary.
- For each of the two risks, they should explain the criteria that they used to rate it as either LOW or HIGH.

Step 4: Plenary

Let each group report back in plenary.

In plenary, after group presentations, ask volunteers to explain some of the reasons why people take risks. Ask volunteers to give a few examples of health risks and how likelihood and severity can be reduced

Step 5: Summary:

Conclude group work with a succinct summary.

Risk is exposure to the chance of injury or loss.

- Risk can either be LOW or HIGH.
- When risk is LOW, it means that either the likelihood of it happening, impact to the person's life or both are low.
- When risk is HIGH, it means that either the likelihood of it happening, impact to the person's life or both are high.

People take risks because their perception of the value of the benefit from an action is considered greater at that point in time than the potential for injury or loss.

To avoid or reduce risk an individual has to:

- Avoid or reduce the likelihood of loss or harm, such as cars are fitted with car tracking devices, homes are fitted with locks and burglar bars, dogs are put on leash, banks require IDs or password for you to draw the money that you have saved.
- Reduce the severity of the loss or harm when it happens, such as cash that is not needed immediately is put in the bank so that if thieves break into your house, they will not find money, so your loss is minimised.

Step 6: Wrap Up

In this session, we have learnt what risk is and why people take risks. In our next session, we will explore some of the ways women take risks related to HIV acquisition and transmission. We will do this with the help of a story of a woman named Make.

THE STORY OF MAKE VILAKATI

Aims:

After discussing the story of Make Vilakati, participants will be able to:

- Critically analyse the health risks that women may take and the consequences of such behaviours to themselves and their families.
- Identify the key determinants of risky health behaviours.

Materials:

Copies of the story of Make (**Appendix IV**)

Directions:

Step 1: Briefly introduce the session

Inform participants that you are going to read the story Make and you would like them to actively listen.

Distribute copies of the story of Make. If you do not have copies of the story, that is fine, but you will need to read the story to the group then. The story is in **Appendix IV** for ease of printing.

- If you have copies of the story, ask participants to volunteer to read a section of the story in turn, pausing at points as indicated in the story.

Step 2: Lead discussion at certain points in the story

When the story reaches a point of pausing. Ask the participants the discussion questions listed below and lead them through the exercise of discussing each issue raised.

Step 3: Conclude the story and final questions

Wrap up with the final discussion questions. Ask participants if they have any further questions or clarifications.

THE STORY OF MAKE VILAKATI

Make Vilakati is 34 years old. She is married, according to the Swazi law and custom. Her husband, Ntokozo Vilakati, is 42 years old. They have been married for four years and they have two children together, a girl aged five and a boy aged three. In keeping with tradition, they own a house at Hlaleni, Ntokozo's parental home.

However, Ntokozo is a mine worker in South Africa. Consequently, he is away most of the year. Although he is away from home, he makes efforts to ensure that Make and the children are provided for. He regularly calls to check on them and sends money for upkeep. Occasionally, he also sends gifts, either when friends and relations living in South Africa visit Swaziland or when friends and relations living in Swaziland visit South Africa. Despite the support that she receives, Make still finds that she must work and earn additional income to support the children. She currently has job as a factory worker at Malkerns, where she also rents a flat. Her mother-in-law takes care of the children. This compels her to visit her matrimonial home almost every weekend, to check on the children.

Pause to ask discussion questions.

- What do you like about this story?
- Does it sound familiar? Explain what sounds familiar and why?
- Does something strike you as strange? Explain what it is and why you consider it strange.
- Why is it possible that Make and Ntokozo have been married for four years, but their first child is five years old?
- Is it common to have "absent husbands"?

- Is it common for amakoti to be allowed to work while their maketala look after children?

One warm Thursday, in the third week of November, when Make was just about to take her lunch break, her mobile phone beeped and vibrated. She was not allowed to take private calls while on duty, so she rushed to the bathroom. The buzzing stopped just as she managed to fish the phone out from her bra, but not soon enough before registering a missed call. It was an unfamiliar South African number. She stood there aimlessly and hoped the caller would persist. Before long, the screen lit and the phone beeped and vibrated again. She quickly accepted the call. The voice on the other end was rather weary, but unmistakable. Finally, Ntokozo had called her. He apologised repeatedly for not calling for a long time. He explained that he had been taken ill and that he did not inform her in order not to alarm her and his parents. He assured her of his undying love for her and, after enquiring about everyone, he announced his vacation plans to visit Swaziland. After lunch that day, before resuming work, Make went straight to negotiate her leave plans with her supervisor, to make sure that she would by free from the demands of work when her love and father of her children, returned home.

One warm Saturday afternoon, in the second week of December, there was ululation and fanfare at the Vilakati homestead. Ntokozo had finally arrived home for his annual vacation. Soon the homestead was abuzz with neighbours, friends and extended family relations who came to see their son. The amount of cooking and cleaning to serve all the visitors that came made it appear like Make had merely changed her employers instead of taking leave from her paid job. By evening she was very tired.

Finally, on their own in their house that evening, with children deep asleep on Ntokozo's lap, Make and Ntokozo had time to themselves. She stood up and picked the children one by one and laid them side by side on a sleeper couch after which she deposited herself next to Ntokozo.

"It is a great joy to have you back home again." Make broke the silence, throwing her hands around him. "I missed you so", she choked with emotion and buried her head on his shoulders.

"I am happy to be home as well", Ntokozo muttered through his teeth. "Alive", he added. Then he narrated how severe the illness was and how grateful he felt to be alive and well.

"I feel ashamed to say that after how much I ate during the day, I feel hungry again", Ntokozo changed the subject.

"I am hungry too", replied Make. "Would you like a hot beverage or juice?" She asked.

"Tea please", he replied. "With milk, rather, a tea bag in a hot cup of milk, if you like", he added.

As they talked some more, updating each other, while sipping their tea, Make kept fighting back the urge to ask Ntokozo to explain a bit more about his illness, especially to know if he had bothered to check his HIV status. However, she could not take the risk this time around, because her questioning had landed her in trouble in the past. During one of his annual visits, in the year preceding the birth of her second child, Ntokozo was taking a bath and Make busied herself with his phone as she waited for him. When she found some photos in which Ntokozo was captured in compromising positions with a woman, her instincts told her she was sharing her husband with someone. To her, this was merely confirmation of her fears. She had put back the phone and slipped into bed, armed with a pack of condoms under her pillow. That night, when Ntokozo tried to touch her, she introduced the condoms, a subject that earned her pinching in the thighs and a blinding slap in the face. She did not cry or retaliate, but, in protest, she went to sleep on the couch that night. She told him, she would not return to the matrimonial bed and make love without a condom with him, unless they go for HIV testing. This had upset Ntokozo a lot.

"I cannot waste my time and money to return to a wife that disrespects me." He charged. "OK. You have a choice to make, my mother's daughter", he said mockingly, before declaring: "either you-are-my-wife-and-you-will-do-it-as-I-please or you are out of here."

Make felt defenceless and overcome with fear of the shame she would face in the community for being chased away from marriage. Denying her husband his conjugal rights was sufficient reason for divorce. She followed him to bed and had sex with him, but in the evening of the following day a group of elderly women were organised to "sit her down."

Pause to ask discussion questions.

- From the story we just read, we have seen that Make already had reasons to suspect her husband was seeing other women in South Africa. The photos she saw in his phone were just a confirmation.
- Can someone explain why she could be right?
- Does it apply to all men?
- Is it true for men only or for both men and women?
- If Ntokozo was your brother, what would you advise him in relation to his sickness?
- Make is afraid to learn more about her husband's health because of a previous experience that was not pleasant. What is the unpleasant experience?
- When Make introduced condoms, Ntokozo felt disrespected.
- Can someone explain exactly how making this suggestion was disrespectful?
- If you were Make, how would you have introduced the subject of using condoms?
- In what way was using a condom going to be beneficial to Ntokozo as well?
- Did Ntokozo have a right to force Make to have sex with him on his terms? Please explain.

Ntokozo had been gone for three weeks before daily routines really came back to normal in the Vilakani household. Although Make had returned to work as well, she had decided to commute to work during the past three weeks following Ntokozo's departure. It was now time to clean up, pack and put away some things in her house. The weekend before her departure to Malkerns, she selected clothes that required washing, from stuff that did not ,and returned her prized cutlery into storage boxes. She dusted cushions, changed pillowcase covers and beddings, and cleaned every corner of the house.

Once back at Malkerns, she had a lot of time to herself in the evenings. She relived every moment she had spent with Ntokozo. She was grateful to have such a caring and loving husband.

One morning she woke up feeling sick. As she brushed her teeth, she vomited. It was like a light bulb had been switched on in her mind. She straightened up, looked herself up in the mirror and mischievously muttered: "Silly girl, you are pregnant again." She went through that day with a mixture of emotions. This is something she did not want to happen. In her reflection, the two children she gave to Ntokozo were enough. After all, both of them have two children each from their previous relationships. That makes six children. She agonised about having to feed all those mouths, keep them in school and give them a good education.

She fought back the thoughts of any possibility that Ntokozo was HIV positive. However, the more she did, the greater her fears grew. Ntokozo had said he had been ill, and he looked sickly when he visited. What if he was HIV positive? What if she had been infected?

Pause to ask discussion questions.

- Make said to herself: "Silly girl, you are pregnant again."
- How did she know that she was pregnant?
- Suggest a few personal health issues that she ought to be concerned about as well and why?
- Make had concerns about how her husband looked and the illness he had before visiting. She also has evidence that strengthens her suspicion that her husband was seeing other women. Do you think it was justified for her to accept to have sex with him without a condom?

Facilitator's Note:

- Ask the participants that say "yes" to put their hands up. Then do the same with those that say "no." Try to insist that no one should be undecided.
- Place those that said "yes" in one group; and those that said "no" into another group. Ask the groups to stand facing each other, then ask each group to explain why they say either "yes" or "no."
- While still standing and facing each other, ask them to suggest what actions Make should take.

Wrap Up

Make, and her husband live apart. Although circumstances will always create situations that result into long-distance relationships, such relationships create their own pressures. Some people manage the pressures better than others do.

We have heard that Ntokozo was seeing other women while away from his wife. We have also heard that some women are so traumatised by intimate partner violence that their fear of violence is greater than their capability to make and implement the necessary choices that reduce their health risks. Further, we have seen how some women are more worried about pregnancy than by HIV. Why do you think this may be?

Take-home Messages:

1. ***Make should go for a pregnancy test at a health facility.*** She should also ***explain her fears*** to the health-care provider and ***ask for an HIV test***.
2. If it turns out that she is both pregnant and HIV positive, she should ***enrol in PMTCT*** and f***ollow all the advice provided by the care provider***. If her HIV status is HIV negative, she should ***go for a re-test*** based on her health-care provider's recommendation.
3. She should ***choose someone that she can trust and confide in*** and ask her to stand with her – assisting her to cope with the situation, as a confidante. This could be any person that she trusts and feels free to confide to, such as a close friend, counsellor, her mother, her sister-in-law or a church pastor.
4. She should ***call her husband and inform her him about her fears*** (of pregnancy and HIV), ***inform him of the actions she is taking*** and ***encourage him to go for HIV test as well***.

In the next activity, we will practice how to assess one's HIV risk. Among other benefits, doing this will help us increase self-awareness and learn more about the behavioural choices that can reduce one's susceptibility to the risk of HIV acquisition.

INDIVIDUAL HIV RISK ASSESSMENT

Aim:

After going through this session, participants will understand their own susceptibility to health risks, with emphasis on HIV acquisition and/or transmission.

Materials:

- Copies of the HIV Risk Assessment Tool (**Appendix V**)
- Pens

Directions:

Step 1: Introduce the HIV risk self-assessment tool.

Step 2: Share the definition of "acquisition" and "transmission" as used in this tool, and why both need to be prevented.

Mention the following, and indicate that these will be discussed in greater detail in subsequent sessions:

- Transmission primarily refers to the situation whereby HIV is passed from an HIV-positive person to an HIV-negative person. However, a person that is HIV positive also can be re-infected. Both situations must be prevented. Correct and consistent use of a condom is effective at preventing this from happening. ART compliance among HIV-positive individuals also reduces the viral load and prevents the likelihood of passing on HIV, especially if there is correct and consistent use of condoms as well.
- Acquisition refers to the situation whereby a person that is HIV negative is exposed to HIV and, ultimately, gets infected, such as the person sero-converts from HIV-negative status to HIV-positive status. Every HIV-negative person has the right and responsibility to make the behavioural choices that will prevent this from happening. Correct and consistent use of condoms is effective at preventing this from happening.

Step 3: Hand out a copy of the tool to all participants.

Step 4: Explain the process for using the tool.

- Working by yourself, answer all the questions by either checking "yes" or "no."
- Mark only one answer for each question.
- Do not consult your friend. Your answers are confidential.

Step 5: Provide the participants with about five minutes to complete the tool.

Step 6: Walk through the questions with the group and explain what a "yes" or "no" answer means for each question based on the table below.

Step 7: Answer any questions and lead a discussion around the assessment.

- Without asking the women to disclose anything too personal that they do not want to share, ask if any of them were surprised by the results. What surprised them most?

FACTS	KEY MESSAGES
Have you ever had sex without a condom?	
• If one sexual partner is HIV positive, the HIV negative partner can be infected with HIV. • If both sexual partners are HIV positive they can re-infect each other	• Using a condom during sex helps prevent STI and HIV transmission. • Condoms also help prevent STIs and pregnancy, use one every time you have sex if you do not know your status or your partner's status or suspect they have other partners. • Get an HIV test.
Have you ever had anal sex?	
• Some women engage in anal sex to preserve their virginity or simply enjoy it. • The rectum does not produce lubricating fluids like the vagina does. For that reason, anal penetration can cause lacerations and bruises to both partners. This increases the risk of contracting and/or transmitting HIV.	• If you have anal sex, always use lubricants together with a condom. This will reduce the risk of HIV to both you and your partner, and make anal sex more pleasurable.
Have you ever had or do you currently have sex with more than one partner at the same time?	
Having multiple and concurrent sexual relationships increases your risk of being infected with HIV, because you are one part of a sexual network which makes protecting yourself more difficult if condom use is not practiced consistently. • Ask participants to share what makes it difficult to protect oneself in a multiple and concurrent sexual partnership. In a polygamous union, the desire to have children can affect condom use.	• Reduce your sexual partners. If possible, choose and keep only one sexual partner. • If not possible, in the case of an official polygamous union or other reasons, take the following actions: » Go for an HIV test (you have responsibility over your own health). » Insist on consistent condom use until your partner also tests for HIV (go to test together with him, if possible). » Use a condom correctly and consistently if either or both of you are HIV positive or you do not know your sexual partner's status. » In a polygamous union, talk with your husband and ask him to also communicate with your co-wives about HIV, and encourage them to test for HIV as well.
Have you ever had an STI?	
STIs increase your chances of getting infected with HIV. STIs can cause tears and openings in the vagina that allow HIV to enter the body.	• STIs can be treated. Seek medical help at a health facility whenever you think you may have an STI. Symptoms may include pain while urinating, discharge from the vagina that smells or is a strange color, or lumps or bumps around the vagina. • Using a condom correctly and consistently during sex prevents HIV, STIs and pregnancy

FACTS	KEY MESSAGES
Have you ever received money, goods or favours in exchange for sex?	
• The practice that "one good turn deserves another" has the tendency to make people feel indebtedness, which in turn can make you vulnerable to sexual exploitation, among others, because your power to negotiate is weakened by the feeling that you owe somebody sexual favours if gifts/money/favours are given. • It is tempting to think that "I will pay back with what I have", because you may think that is what everyone like you is doing. This has led to some women to have sex in exchange for money or gifts or other favours with men, even those they really like or are in love with.	• Always be on your guard and use your best judgement when faced with free money, gifts or favours. Free gifts can make you feel like you owe something in return and that can make you vulnerable to their requests. » Society trains us to be kind and generous. Sometimes kindness and generosity is genuine, such as generosity from family and close friends or acquaintances. » It is not impolite to say "no, thank you." If such offers are from people that you do not know well, appreciate the gesture, but decline politely. This will earn you respect. If you do it more, your confidence and self-reliance will also grow. » It helps to think about what might be expected in turn from you as a result of the gifts that you are being offered. It is advisable to ask. Remember, it is not wrong to say "no, thank you." • If it is your intention or choice to engage in a transactional sexual relationship, negotiate for condom use. You have the right and responsibility to protect yourself from HIV, STIs and unintended pregnancy by using a condom. Remember that you have the right to say "no."
Do you know your HIV status?	
It is important to know your HIV status to remain healthy and protect yourself.	• Going for a test is a simple procedure and will help you to make decisions about your future. • If you have ever had sex without a condom with somebody whose HIV status you do not know, you should go for a test. • Being open to your partner about your HIV status can motivate him to know and/or disclose his. • Testing together with your partner can facilitate mutual disclosure
Do you know the HIV status of your past and current sexual partners?	
When you do not know your partner's HIV status, it is difficult to take appropriate measures to protect yourself.	• If you do not know your sexual partner's HIV status, insist on using a condom whenever you have sex. • Use condoms correctly all the time. • Encourage your partner to get tested and offer to go together.

FACTS	KEY MESSAGES
Have you ever been forced to have sex or had sex against your will?	
• Studies have shown that perpetrators of sex-by-coercion are usually people that someone is familiar or otherwise close to – people that one would otherwise trust and whom it is difficult to report on account of preserving the relationships and/or reputation. • Sex is meant for pleasure between consenting adults. • You have the right to say "no" to sex. • It is a violation of your rights if someone uses force to have sex with you against your will. • It is difficult to effectively protect yourself from STIs, HIV and pregnancy when somebody forces you to have sex against your will	• Be assertive. This means to be clear and firm when you do not want to have sex. Your words and body language matters, such as your posture and the tone of your voice • You have the right to defend yourself, but keep calm under threat. When faced with danger, it is normal to become afraid. These emotions affect good judgment and the ability to protect yourself. Also, the risk for you becomes greater, if the offender gets provoked by what you say or do, such as do not insult them. • Seek post-violence services, such as psychosocial support and post-exposure prophylaxis. • Remember, it is not your fault. Therefore, shame and guilt should not make you to suffer in silence. Reach out to a trusted friend to get support for what you have been through. • Report offenders. Reporting facilitates access to appropriate services

FACTS	KEY MESSAGES
FOR PREGNANT OR LACTATING WOMEN – Risk to Your Infant	
Did you ever deliver at a health facility?	
Delivering at a health facility ensures that every pregnant woman is assisted by a trained service provider. This increases safety for both the baby and the mother.	• Every pregnant woman must deliver at a health facility. Enrolling in ANC facilitates this.
Did you attend ANC within the first trimester?	
Although it may be contrary to common practice among women, early enrolment into ANC is beneficial to both the mother and unborn child. A mother is taught on how to care for her pregnancy, she is assessed for any risk related to childbearing, and has access to other services.	• Every woman that misses her period for more than six weeks since the previous one should go to health facility for check-up to rule out that it she is not pregnant. If pregnant, she must enrol into ANC immediately. This is beneficial for your health as well as that of the unborn baby.
Did you bring your child back for HIV testing/re-testing?	
Re-testing is a way of monitoring your child. Early infant diagnosis of HIV facilitates their enrolment in ART which helps them to survive and thrive	• Every HIV exposed baby must be brought back to a health facility for re-testing based on your provider's recommendation.
Have you fed your baby any other food apart from breast milk?	
Exclusive breastfeeding during the first six months of a baby life prevents malnutrition and other infections like diarrhoea. Breast milk has adequate nutrients to meet all the food needs of a young child. Hard food stuff bruises the intestinal walls of young children, and exposes them to infections.	• Exclusively breastfeed your young child until six months. Talk to a health-care worker if you are facing challenges with it.
If you are HIV positive and pregnant or lactating, are you on ART?	
Early start and compliance with ART helps suppresses viral load, which in turn reduces the risk of transmitting HIV.	• All HIV-positive women that are pregnant or lactating should enrol in ART. Talk to a health-care worker if you are facing challenges with it.
Are you confident that you can ensure all caretakers of your baby give only breast milk?	
It is difficult for a caretaker to always or even ever give breast milk to your child. This is because expressing breast milk may be considered taboo and ensuring hygiene can be difficult. And when the breast milk runs out, the baby will cry, which tempts caregivers to give the baby food in order to quiet it. Some caregivers will breastfeed your baby (on their breasts).	• As far as possible, a mother with a breastfeeding baby should not travel far or for too long from their baby. If such becomes necessary, they should take the baby with them or express enough milk. If another person gives their breast to your baby, they may infect your baby, if they are HIV positive. The caregiver of your baby should be given thorough information on how you want them to care for your baby.
Have you had sex without a condom with someone whose status you did not know while pregnant or lactating?	
There is a chance that someone whose HIV status you do not know could be HIV positive. Thus, having unprotected sex with someone whose HIV sex you do not know can expose both you and your baby to HIV infection.	• Always use a condom during sex if your partner is HIV positive or if you do not know his HIV status. This is imperative when a woman is either pregnant or breastfeeding.

Conclusion

After walking through the answer table and answering any questions the women may have, provide the following summary:

- The leading cause of HIV infection in Swaziland is sex without correct use of a condom, when one of the two is HIV positive, whether he or she know his or her status or not.
- Some women who fear they are already HIV positive, are in actual fact HIV negative. The only way to know for sure is to get an HIV test.
- Forced sex is a crime and can expose you to the risk of HIV, STIs and cause you emotional trauma. A woman has the right to say no to unwanted sex. If you are survivor of sexual violence, seek clinical care including post-exposure prophylaxis and emergency contraception.
- Sexual relationships with older and more experienced men increase the risk of being exposed to HIV and STIs, according to national statistics of HIV prevalence. Having more than one sexual partner and not using condoms is another significant risk factor. It is equally important to find out your HIV status and that of your partner(s).
- Exchanging sex for money, gifts or other favours weakens your ability to make healthy choices.
- A person who is HIV positive should reduce the risk of being re-infected with HIV or transmitting the virus to others by using a condom during sex.
- A person that is HIV positive has a responsibility not to expose a sexual partner to the risk of HIV infection. Using a condom during sex reduces this risk.
- Women who are HIV positive and know their status should regularly go to health facility for review/monitoring.
- Early access to ART has great health benefits. At the health facility, your care provider will determine whether you need to start treatment on ART. They do this by assessing your CD4 count and/or viral load.
- Adherence to ART reduces the risk of treatment failure. The person who is HIV positive and already on ART has the responsibility to adhere to treatment by following the advice provided by the care provider. By adhering to treatment (taking it every day), an HIV-positive person can reduce their viral load and in doing so, reduce his or her chances of transmitting the virus to their partner(s), while also remaining healthier.

In the next session, we will refresh our knowledge on the basic facts of HIV and discuss HIV risk reduction strategies that you can implement in your life to lower your risk of getting infected and/or infecting your sexual partners.

BASIC FACTS ABOUT HIV

Aims:

After participating in this session, participants will:

- Become acquainted with the key facts about HIV.
- Become familiar with key terms in HIV and AIDS.

Directions:

Step 1: Go through and define the key terms listed below.

Acknowledge the fact that many of the women may already know these terms, but you just want to refresh them quickly so that everyone in the room is on the same page.

Step 2: Ask for and allow questions at any point while reviewing key terms.

Step 3: Once everyone is comfortable with the terms, walk through how HIV is transmitted and acquired, linking back to the risk discussion you had previously.

KEY TERMS

HIV: This is the virus that infects the body and takes over cells in your body, breaking down your immune system that works to fight off other diseases.

AIDS: A result of having HIV in your body for a period of time, breaking down the immune system. It is a syndrome that usually results in a person contracting opportunistic infections and becoming very sick if they are not put on treatment.

Immune system: What keeps you healthy. It consists of different cells in your body that fight off infection, such as flu, and works to keep bacteria and viruses out of your body.

CD4: A type of cell in your body that is part of your immune system. It is the cell the HIV is attracted to and will enter in order to replicate itself and create more of the virus to enter more CD4 cells in the body.

Antibodies: Part of the body's immune system that work to keep a person healthy. The body makes them in reaction to a virus or bacteria to help fight them off. The HIV test looks for HIV antibodies, showing that the body is trying to fight off the virus.

HTC: The process used for a person to find out his or her HIV status. In most cases, a drop of blood is taken from a prick on the finger and tested to see if there are HIV antibodies in the blood.

Window period: The time between when a person gets infected with HIV and when it will show up on a test. Right after a person gets infected, the body has not had a chance to react to the virus yet and make antibodies, so the test may come out negative, even though the person is HIV positive. This is why it is important to get retested again after three months.

ARVs: The medication that HIV-positive people take to reduce the viral load in their body. These medications must be taken for the rest of a person's life to help control the virus and keep a person healthy.

ART: The combination of ARVs that HIV-positive individuals take in order to slow down HIV in the body.

Viral load: How much HIV you have in your body. A test is done to measure the amount of the virus in your blood. The higher a person's viral load is, the more likely they are to infect other people and become sick themselves.

Undetectable viral load: When someone is HIV positive, but the test can no longer measure how much virus is in the blood because it is so little. When someone has an undetectable viral load, it makes it more difficult for them to transmit the virus to others.

Opportunistic infection: Other illnesses that are known to be associated with HIV because they take advantage of a person's weakened immune system. Some opportunistic infections include TB; Kaposi's Sarcoma, a cancer; bacterial pneumonia; and others.

WHAT IS HIV?

HIV stands for human immunodeficiency virus. This is a microscopic organism that, when it enters the body, destroys the natural protection to diseases.

How is HIV Acquired or Transmitted?

HIV can be passed from one person to another when the body fluids (blood, vaginal secretions, semen, breast milk) of an infected person come into contact with another person, through openings in the body or cuts and scrapes.

What Are the Modes of HIV Transmission?

Evidence indicates that the leading cause of HIV transmission in Swaziland is unprotected sexual contact between two people, when one of the two is HIV positive.

Some sexual practices broaden one's exposure to HIV. Secrecy as a result of denial and shame and even punishment associated with sex and some sexual practices can create higher risk.

- Anal sex carries the highest risk, then vaginal sex, then oral sex, but all carry risk.
- Vaginal sex is practiced between a man and woman.
- Anal sex is practiced between same sex partners (man-to-man) as well as heterosexual partners (man-to-woman).
- Oral sex is practiced between heterosexual partners (man and woman) and same-sex partners (man-to-man and woman-to-woman).
- Risk is highest if an HIV-positive partner has a high viral load, which is a measure of the amount of virus in a person's body.
- The amount of virus in the blood spikes immediately following infection and in the later stages of HIV as the body's immune system begins to weaken, making it the easiest time to transmit HIV.

HIV can also be passed on from a mother who is HIV positive to her baby. The following are the high-risk moments when HIV can be passed from mother to child:

- While the baby is still in the womb. Without intervention, the chances of mother-to-child HIV infection during pregnancy is one in 10 cases (5–10 percent).
- During labour and delivery. Without intervention, the chances of mother-to-child HIV infection during labour and delivery up to two in every 10 cases (15–20 percent).
- During breastfeeding. About two in every 10 children born HIV free to HIV-positive mothers are infected with HIV positive (sero-convert) by the age 24 months.

What Are Some Danger or Warning Signs of HIV Infection?

- Many people infected with HIV do not show any sign at all for up to 10 years or more.
- You cannot recognise a person that is infected with HIV by the way they look or ascertain that they are indeed infected by signs and symptoms.
- An HIV test is the only way to ascertain one's HIV status. A person that is HIV negative and has reason to believe that she has been exposed to HIV, such as through unprotected sex with an HIV-positive partner or a person whose HIV status they do not know, should seek HTC.

What Is the Treatment for HIV?

- Once a person has been diagnosed with HIV, he or she should get their CD4 cell levels tested immediately at a health centre. Depending on the number of CD4 cells a person has he or she may or may not be eligible to be

enrolled in treatment immediately.

- Even if a person is not eligible, he or she should continue to attend regular appointments at the health centre to monitor their health.
- If someone is eligible for treatment, he or she will be enrolled on ART immediately, to lower the amount of virus in their body and increase their CD4 count.
- When on treatment, it is very important to take the medication every day.

AIDS

- A person whose immune system is weakened by HIV becomes susceptible to many diseases, including TB. Treating these diseases also becomes harder than it is in an HIV-negative person.
- If nothing is done to contain the reproduction of HIV in an infected person, the person develops a condition called AIDS. A person with AIDS suffers from multiple and concurrent conditions that are otherwise reversible. But, because the immune system is too weak, it struggles to fight off illness.

Additional Notes

- To achieve the King's Vision 2022 of an HIV-free generation, new HIV infections must be brought to a halt.
- Women who are unaware of their partner's HIV status face a higher risk of HIV acquisition.
- HTC is the only sure way to know one's HIV status. It is not possible to ascertain a person's HIV status merely by the way they look.
- Ignorance of one's HIV status before getting pregnant can put both the mother and the baby at health risk.
- A woman who is already HIV positive can get pregnant and have healthy HIV-negative children if enrolled in care.
- About one in every five pregnant women learn their HIV-positive status for the first time when they are already pregnant and enrol in ANC.
- An HIV-negative woman who is pregnant can also be infected with HIV if she has unprotected sex with an HIV-positive partner. This puts both the mother and the baby at risk.
- About one in every 13 women (8 percent) who are pregnant and HIV negative acquire HIV (sero-convert) by the time they deliver or before their baby is one year old.
- Fear of learning your status is understandable, but do not let it keep you from finding out how you can protect yourself and those you care about.

Take-home Messages

- ***Prevention is better than cure.*** HIV can be prevented. Use a condom correctly and consistently during sex.
- ***Enjoy responsibly.*** Sex is nature's gift to humanity for pleasure and reproduction. But, engaging in unprotected sex exposes you to the risk of not only HIV infection, but also to pregnancy and STIs. Use a condom correctly and consistently.
- ***Be fully aware of where the risk is.*** Some women choose to engage in anal and/or oral sex in order to preserve their virginity or because they enjoy it. Both sexual behaviours expose you to the risk of HIV as well as other infections, with anal sex carrying higher risk. Insist on a condom, and use lubricants as well when having anal sex.
- ***Gender-based violence.*** Denounce and develop skills to protect yourself from sexual violence. Reporting violence facilitates your access to post-violence services, such as psychosocial counselling and post-exposure prophylaxis (PEP). These services reduce your vulnerability to HIV infection and help get you the support you need.

HIV RISK REDUCTION STRATEGIES

Aim:

By the end of this session, participants will have acquired basic knowledge about HIV and skills to reduce the risk of HIV acquisition and/or transmission.

Materials:

- Flip chart
- Markers
- Wooden penis model
- Male condoms
- Female condoms

Directions:

Step 1: Introduce the topic on HIV risk reduction strategies.

- Following the discussion of the main ways HIV is transmitted, transition into the key HIV risk reduction strategies by explaining there are ways for women like us to take control of our health and reduce our risk of HIV acquisition and/or transmission.
- We should do everything within our control to prevent both acquisition, as well as transmission of HIV.

Step 2: In plenary, ask volunteers to share their knowledge of, or experiences with, HIV risk reduction strategies.

Ask them to list some risk reduction strategies they have heard of, writing them on a flip chart.

Step 3: Explain that in line with the key modes of HIV transmission, we will discuss the following key strategies for reducing the risk of HIV acquisition and/or transmission:

- HTC
- Condoms
- ART
- PMTCT
- Partner reduction
- Reducing GBV
- Voluntary Medical Male Circumcision (VMMC)

HIV TESTING AND COUNSELLING

What Is It?

- HTC is a voluntary and confidential counselling session and blood test that involves the screening of one's blood to determine one's HIV status. Blood is taken from a small prick on the person's finger and then placed on the test strip to create the results.
- When HIV infects a person, it provokes the "soldiers" or antibodies in the body to fight the virus and provide us with protection from diseases. There is technology that can detect whether these "soldiers" have reacted to HIV in the body, and if this reaction is seen in the test result, a person is considered to be HIV positive. This technology is available for free in every public health facility and it is reliable. The test and screening process take only a short time before the results are known, and a health-care professional will share the result with you and explain what it means.
- You can also go for couples counselling at the health facility where you and your partner are counselled and tested together. This is a way for both you and your partner to learn your own status, as well as your partners, so you can make a plan to stay healthy together.

How Does HTC Reduce HIV Risk?

Part of HTC is counselling that allows you to assess your risk with a professional and talk through ways to reduce it. Ideally, counselling should take place both before and after taking an HIV test. The counselling provides you with basic knowledge about HIV and AIDS, and enables you to have sufficient information to make healthy choices. HTC also helps to reduce risk because, by knowing your status, you can take the appropriate steps to protect yourself and your partner. If you are positive, for example, you can monitor your HIV viral load and be sure to take ARVs, while using condoms to protect your partner(s). If you are negative, you can confidently take steps to remain that way by using a condom and learning your partner's status, as well.

Benefits of HTC

- An HIV test provides you with the "freedom of knowing" your HIV status. Not knowing one's HIV status can cause people to worry and have anxiety about their past, current and future sexual relationships.
- By knowing your HIV status, you can make plans to continue to lead a healthy life, whether positive or negative.
- HTC is a gateway to a diverse range of health information and services, such as condoms and other HIV prevention strategies. Depending on the result of your HIV test, a health-care provider will discuss with you strategies for protecting yourself and possibly refer you to other services such as ART and PMTCT.

Discordancy

- It is important to be aware that two people in a sexual relationship can have different HIV statuses from one another – one can be HIV positive, while the other is HIV negative. This is called a discordant couple.
- It is possible for either a man or woman to be the HIV-positive partner. This holds true even in a polygamous union where one or two partners can be HIV positive, while the others can be HIV negative.
- Discordant couples can protect each other by using a condom correctly and consistently and, if the HIV-positive partner is on treatment, adhering to that treatment to reduce their viral load and, in the process, reduce the chances of transmitting HIV.

Disclosure

- The outcome of your HIV test is confidential. However, you can choose to disclose your HIV status to your family and friends. In turn, family and friends can provide you with psychological support and also support you in making healthy choices.
- Disclosure to your partner is particularly important. An open and honest relationship can strengthen trust between you and your partner, and provide an opportunity for support from your partner. Your partner may also

find it easier to disclose their status to you because you trust them with yours.

Role Play/Demonstration

Ask for two sets of volunteers (at least two per scenario) to prepare and perform role plays demonstrating:

Pair 1: The HTC process

Roles:

- Woman
- Outpatient nurse
- HTC provider

Plot: Assume that the woman does not know her HIV status. She is married but does not know her husband's status. She just found out she is pregnant and has decided to be tested.

Focuses of the role play:

- What is trigger that motivates the woman to go for an HIV test?
- What other services does she has access to as a result of HIV test?
- What are her feelings about getting an HIV test?
- What circumstances/factors that work to her advantage?
- What challenges does she face, and what enables her to overcome potential challenges.

Discussion Questions Following Role Play by Pair 1

1. Did the role play look real to you? Explain.
2. What did you like about the role play? Explain what you liked and why.
3. What other services did she have access to as a result of her decision to go for an HIV test?
4. What decisions did she make as a result of going for an HIV test?
5. What are the specific the circumstances or factors that worked to her advantage?
6. What challenges did she face and how did she overcome the challenges?
7. How did she handle her fears before and after the HIV test?
8. Overall, what have we learnt from this role play?

Pair 2: Partner Disclosure

Roles:

- Woman aged 25-39
- Woman's partner

Plot: Assume the woman just recently found out she was HIV positive, she wants to tell her partner but is worried about his reaction and the reaction of the community.

Discussion Questions Following Role Play by Pair 2

1. Did the role play look real to you? Explain.
2. What did you like about the role play? Explain what you liked and why.
3. What triggered the woman to disclose her HIV status?
4. What did she struggle with in making the decision to tell her partner?

5. How did her partner react to the disclosure? How would you expect those you know to react if you were in that situation?
6. What are the specific the circumstances or factors that worked to her advantage?
7. Overall, what have we learnt from this role play?

Take Home Message

The only way to be certain about one's HIV status is to go for HTC. Partners can have discordant HIV results, and this is okay, but it is important to know. Disclosing your HIV status to your partner can strengthen trust and partner support.

CONDOMS

What Is It?

A condom is a thin latex or polyurethane form of contraceptive and/or protection from STIs during sex. There are two types of condoms:

- The male condom is in the form of a latex sheath that is worn over a man's penis. It is put on when the penis is erect and partners are ready to have sex.
- The female condom is inserted in the vagina. It can be put on hours before a couple intends to have sex.

In this session, we will discuss how condoms work and how to use condoms correctly.

How Do Condoms Reduce HIV Risk?

Condom protects either partner from direct contact with their partner's bodily fluids during and after sexual intercourse.

Benefits of Condoms

If used correctly and consistently, condoms prevent pregnancy, as well as most STIs, including HIV.

Demonstrations

Using a condom correctly: Explain steps for correct and consistent condom use. Ask for a volunteer to demonstrate on a wooden penis model. Include information on proper care of a condom and disposal of used condom.

How to Use a Male Condom

Remember: A male condom is to be worn on the penis. This gives more power and control to the male partner. Therefore, you need to negotiate skilfully. Being ready with one puts you in a stronger position to negotiate. If you are not winning the argument to use a condom, remember that you have the right to say no to unprotected sex.

1. Check the expiration date on the outside packaging of the condom. If it is expired, discard and get another condom. Expired condoms are more likely to break.
2. Slide the condom to one side inside the package and carefully tear open the package. Do not use scissors, your teeth, finger nails or anything sharp that could tear the condom.
3. Slide the condom out of the package and check to ensure that is will roll down the right way. The seam of the circle should be on the outside.
4. Pinch the tip of the condom so there is no air. Air bubbles can lead a condom to break.
5. Place on the head of the penis (with the tip still pinched) and roll down the erect penis.
6. Once finished, carefully pull the condom off the penis while it is still erect, away from your partner.
7. Discard in a dustbin. Do not throw it in the toilet as it can cause damage.
8. Be sure to use a condom every time you have sex to protect yourself and your partner. If you are having multiple rounds of sex, use a new condom for each round.

Female Condoms

A female condom is designed based on the same concept as the male condom. The key differences are that it is made of non-latex (polyurethane) material and that it is in form of a pouch that is inserted in the vagina (while a male condom is a sheath that is worn over a penis and is made of thin latex). Like a male condom, a female condom can also be used for either vaginal or anal sex.

The female condom covers the vaginal walls to prevent direct contact with the penis, as well as the fluids from it and vice versa. It has two rings. The inner ring, at the closed end, is inserted into the vagina while the outer ring on the open end is left to hang just outside the vagina. The close end collects the pre-cum fluids and semen after ejaculation.

Some of the reasons why you should consider using a female condom:

- It puts a woman in a position where she shares responsibility for preventing infection.
- It can be inserted by a partner as part of foreplay thereby making it fun to use.
- The outer ring can rub on the clitoris during sexual intercourse thereby enhancing pleasure.
- The female condom can stay in place, whether or not a man sustains an erection.
- It can be inserted in advance – as much as eight hours in advance during which a woman can still use the bathroom to urinate.

How to Use a Female Condom

Remember: When using a female condom, the man should not have a condom on his penis, as doing so will create friction between the two condoms. The friction can make irritating noise and also cause the condoms to break.

1. Check the cover and ascertain that the expiry date has not passed.
2. Gently squeeze the packet to evenly distribute the fluid inside.
3. Check for the mark where to open and tear it open carefully, removing the condom from the packaging.
4. Find a comfortable position to insert it. You can put one foot on a chair, squat or lie down, whichever position works for you.
5. Squeeze together the sides of the inner ring of the condom at the closed end and insert it into the vagina (like a tampon). Push with a finger as far it can go (until it reaches the cervix).
6. Pull out your finger and let the outer ring hang just about 2-3 cm or 1 inch outside/above the vagina. (One inch is almost the same in length with a third part of the length of your index finger.)
7. When a man's penis is erect, help him to insert by guiding it into the ring at the open end. Helping him will make it more fun while you ensure it does not slip between the condom and the vaginal wall.
8. Once the man has ejaculated, let him withdraw gently. Thereafter, squeeze and twist the outer ring to keep the fluids in and gently pull it out
9. Wrap it in tissue and dispose safely where no one can accidentally touch it. Do not flush it down the toilet, but you can throw it in a pit latrine.
10. Do not re-use the female condom. If you decide to have another round, use a fresh condom.

Role Play

Condom negotiation: Ask for four pairs of volunteers to role play successful condom negotiation, using one of the scenarios listed below. Each pair should agree on who will play the man and who will play the woman. After each pair has performed their role play, facilitate a discussion by asking the discussion questions below.

Scenarios for Role Play

1. A woman aged 25 who is studying at university and has a steady boyfriend. She has one child from a previous relationship.
2. A woman aged 30 with an acquaintance that she has met for the first time and is attracted to, but the likelihood of a long-term relationship or ever meeting again is random/uncertain and she does not know his HIV status.
3. A woman aged 35 who is in a polygamous marriage. She does not know the HIV status of her husband or the other wives.
4. A woman aged 32 and married. She has three children.

Discussion Questions after Each Role Play

1. Did the role play reflect what happens in real life? Why or why not?
2. What did the pair do well? (checklist):
   - **When:** Did she seize the correct moment to discuss condom use – was timing for the discussion appropriate? Did she seem sufficiently prepared for this discussion, for example, did she have a condom with her?
   - **Why:** Was she persuasive or give an understandable and convincing explanation of why it was necessary to use a condom? Did she put forward strong arguments, to counter any skepticism from her partner? Did she explain the benefits of using a condom?
   - **How:** Did she make it fun? Did she seem comfortable and confident?
   - **Where:** Where did the discussion take place? Was it in a private, quiet place?
   - **Resilience:** How did she deal with a negative reaction from her partner, if there was one? Was she persuasive and determined?
   - **Respect:** Overall, did she conduct herself with confidence, dignity and self respect? Did she treat her partner with respect? Did she avoid using force, threats or manipulation?
   - In real life, what practical challenges would you face? How would you address such challenges?

Take-home Messages

- Condoms can prevent pregnancy as well as STIs, including HIV.
- Condoms are most effective when used correctly and consistently.
- The health risks that come with not using a condom are higher than the cost of any embarrassment or shame that may be associated with buying, talking about or using a condom.
- If a partner uses force or violence to have sex without a condom, against your will, report the incident to police immediately and talk with a trusted friend for support.
- Police will provide you with a referral letter to a health facility where the following services are offered: counselling, health assessment and PEP.
- If physical violence results in injury that requires immediate attention the person can go directly to a health facility who will facilitate a referral to police.
- It is a legal requirement to involve police if you go to the health centre. The main reason for their involvement in such cases is to gather and preserve evidence in the event that the matter goes to court.

ANTIRETROVIRAL TREATMENT/THERAPY

What Is ART?

ART is a combination of drugs given to people who have been diagnosed with HIV and whose test results and evaluation by a health-care provider indicate they are ready to begin treatment. ART suppresses multiplication of the virus in a person's body.

How Does ART Reduce HIV Risk?

- ART does not kill HIV, however, it significantly slows down the multiplication of HIV in the body, which boosts a person's ability to fight off disease.
- ART makes a person with HIV less likely to pass on HIV to other people by lowering the amount of HIV in a person's body. The amount of virus detected in a person's blood is known as viral load. Having a low viral load reduces the chances of an HIV-positive person passing HIV to her partner(s). With correct and consistent use of a condom, the risk becomes even lower.
- **Important!** The viral load of an HIV-positive person on ART can reach undetectable levels. This does not suggest that they have been cured of HIV, but rather, that ART has limited HIV to a very low level beyond measure. If the person does not adhere to treatment, the viral load will increase again over time.

Benefits of ART

- ART strengthens the body's defence system, thereby reducing one's vulnerability to opportunistic infections such as pneumonia. ART does this by slowing down the multiplication of HIV and is highly effective.
- ART helps to suppress viral load. This makes it less likely for you to transmit HIV to your sexual partner. If your partner is HIV positive and on ART, the risk of him infecting you is also reduced. It is always advisable to use a condom, even if you, your partner or both of you are on ART.

Eligibility for ART

- To begin taking ART, you need to be HIV positive and meet other criteria that your health-care provider will assess. The only way to determine your HIV status is to go for HTC.
- You must get your own prescription for ART from an authorised health-care provider. Never share your ART with other people. Do not buy ART from unauthorised outlets.

Adherence to ART

For ART to be most effective, you must take it correctly and consistently. If you do not, it is possible you might develop resistance. Resistance is a condition whereby the virus is no longer affected by the ART or, in other words, the ART stops working. When this happens, you will need another prescription of drugs that are rare and more expensive. The availability of such drugs is lower.

Take-home Messages

ART lowers viral load in HIV-positive individuals. This improves the body's defence against diseases and also reduces the risk of transmitting HIV to a partner. Adherence is crucial for ART to be effective. Even when one is adhering to ART, using a condom further reduces the risk of transmission. To be eligible for ART one must be HIV positive and meet other criteria to be explained by your health-care provider. The only sure way to know your HIV status, is to go for HTC.

PARTNER REDUCTION

What Is Partner Reduction?

Partner reduction means decreasing one's number of sexual relationships, ideally limiting it to one person at a time.

How Does Partner Reduction Reduce HIV Risk?

When you or your partner has sexual relations with more than one person at the same time, you become part of a sexual network, resembling a cobweb. The size and complexity of the web depends on how many partners each person has and the connections between partners. If one person in the sexual network has HIV and condoms are not used correctly and consistently, HIV can be passed from one person to another very fast. Reducing the number of sexual partners also reduces the size of the sexual network, thereby reducing the risk of HIV.

Sexual Network Activity

This activity can be used to show how fast HIV can spread in a sexual network.

1. Cut strips of paper so there is one for each participant; write HIV positive with on two or three of them and write HIV negative on the rest.
2. Fold all the strips tightly and place them in a bowl or box. You can also just place them into your cupped hands held together. Then ask all the women to stand up and collect one piece. They should not open it.
3. After steps 1 and 2 are done, ask the women to place the piece (while still not opened) in their left hand, walk around and, with their right hand, shake hands with two other participants. Tell them to be sure to remember who they shook hands with.
4. Have them all sit back down and then ask everyone to open their pieces of paper, and ask those whose pieces are written HIV positive to step forward.
5. Tell the group that these women represent someone who is HIV positive.
6. Ask everyone who shook hands with that person to now also stand up. They have all been exposed to HIV.
7. Point to one of the women now standing and tell her to sit back down, she is safe because she used a condom to prevent infection.
8. Have the women look around the room at all those who are standing. Have anybody who shook hands with any of the women standing to now also stand up as they have been exposed to HIV. Again, have one woman sit back down because she used a condom to protect herself.
9. Continue like this until all women are standing, except those protected by condom use.

Explain to the women that this is how a sexual network works. Just one exposure can be enough to become infected with HIV. By reducing your number of partners and using a condom, you can reduce your risk.

Benefits of Partner Reduction

- Reduced exposure to HIV
- Peace of mind
- More time and energy to strengthen your relationship with your one partner

Take-home Messages

- Partner reduction is a choice that every woman can make. It helps you to reduce the size of or exit a sexual network where risk of HIV infection is high.
- Women that do not feel they can reduce their number of partners, such as a polygamous union, should make sure that they and their partners go for an HIV test regularly, and remain faithful within the existing network. In addition, correct and consistent use of condoms will further reduce one's risk of HIV infection.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

What Is PMTCT?

PMTCT is an intervention that involves HIV testing for all women who are pregnant and breastfeeding. HIV-positive pregnant women are enrolled on ART right away. This service can be accessed from antenatal clinics (ANC), through a referral from HTC or other points of service at a health facility.

How Does PMTCT Reduce HIV Risk?

- HIV can be passed from an HIV-positive mother to the baby while still in the womb, during labour and delivery or during breastfeeding.
- A woman that is HIV negative but gets infected with HIV while pregnant or during the breastfeeding period can also pass the HIV to her baby.
- ART reduces the chances of HIV-positive pregnant and breastfeeding women passing the HIV virus to their babies.
- Among children born to HIV-positive women enrolled in PMTCT, 98 out of 100 do not get the virus from their mother.
- This risk for both mother and child is reduced even more if the HIV-positive woman starts ART early (within six weeks of becoming pregnant) and continues on ART after delivery and through breastfeeding – like any other HIV-positive person that is on ART.

Benefits of PMTCT

- PMTCT protects the health of both the mother and child. Both mother and child are monitored through periodic HIV tests until the child is 24 months old and/or stops breastfeeding.
- Children born HIV positive or otherwise get infected during breastfeeding are enrolled on ART, thereby increasing their chances of survival.
- PMTCT enables all couples to enjoy their reproductive health rights by providing access to customised health care for the mother and child, appropriate family planning methods after the child is born, and counselling for prevention of STIs, including HIV transmission.
- PMTCT is an entry point for health information and services to the entire family.

Take-home Messages

Through PMTCT, the HIV risks for the mother and child are reduced. The partner/spouse also has access to core health-care services. Thus, PMTCT is beneficial for the whole family. PMTCT holds the key to an HIV-free generation.

REDUCTION OF GENDER-BASED VIOLENCE

What Is GBV?

GBV is violence involving men and women, where the woman is usually the victim; and usually stems from gender norms and roles and unequal power relations between women and men.

Violence is specifically targeted against a person because of his or her gender, and it affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family or within the general community).

Included in this is rape or unwanted sexual contact. A person should never be pressured to have sex and its important to always recognize when your advances may be wanted.

How Does Reducing GBV Reduce HIV Risk?

Unequal power in relationships can result in forced situations where people may not feel in control or comfortable in a situation. These types of scenarios can lead to an increased risk for HIV as people may not feel they are able to speak up and protect themselves or say not to unwanted sexual intercourse.

Gender Norms Activity

Explain to the group that justifications for violence are frequently based on gender norms:

- Gender norms are the socially assigned roles and responsibilities of women and men.
- Cultural and social norms often socialise men to be aggressive, powerful, unemotional and controlling. This contributes to a social expectation (by both men and women) that accepts men as dominant.
- Similarly, expectations of women are that they be passive, nurturing, submissive and emotional. This reinforces women's roles as weak, powerless and dependent on men.
- The socialisation of both men and women has resulted in an unequal balance of power and unequal power relationships between women and men.
- In many societies, children learn that men are dominant and that violence is an acceptable means of asserting power and resolving conflict. It is not.
- Women as mothers and mothers-in-law unwittingly perpetuate violence by socialising boys and girls to accept the dominance of men and by being tolerant or giving in throughout life to men's demands.
- It is important to recognise the gender roles in your community and how they may perpetuate GBV.
- Ask participants to give a few examples of gender roles in their community and how they may perpetuate GBV.
- Lead a discussion around what are some of the more common gender norms, such as women doing the cooking and cleaning.
- Ask the women how they feel about these norms.
- How do these gender norms impact risk for HIV as a woman?
- What are some ways you think you can begin to change gender norms that may help reduce GBV?
- Make a list of these so that everyone can see and reflect on them.

Benefits of Reducing GBV

Reducing GBV can lead to a more positive and productive society. By recognising that not all social norms may benefit the community and that by harming others you are perpetuating the cycle. Reducing GBV can also lead to a reduced risk for HIV for you, your partner and the community.

Take-home Messages

Violence against others is never acceptable. It is important to be aware of your surroundings and know when you are in a situation that could become violent. It takes work to change gender roles and norms in a society, but it is important to recognise that some should be changed for the better of everyone.

VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

What Is VMMC?

Although this prevention strategy is only for males, it is important for you as a female, to be aware of it and support your partner if they decide to be circumcised. You may also one day need to decide if this is something you want for your son. Male circumcision is a voluntary procedure involving the removal of the foreskin from the penis. The VMMC procedure can be performed on infants, adolescent boys as well as adult men. The procedure is simple, relatively painless and heals quickly.

How Does VMMC Reduce HIV Risk?

The foreskin of the penis contains a type of cell that is very susceptible to HIV. By removing this skin, the chance of HIV entering the body is reduced by 60 percent. If a man is circumcised and also uses a condom correctly and consistently, the chance is lowered even further. To be safe from pain and infection, the newly circumcised man must wait six weeks for the wound to completely heal before having sex again. If your partner gets circumcised, it is important for you to support him to adhere to this six-week time-line to protect both yourself and him.

Benefits of VMMC

- VMMC reduces the chances of getting infected with HIV during sex by 60 percent. If a man is circumcised and also uses a condom correctly and consistently, this chance is lowered even further.
- VMMC is an entry point to important health information and services, such as HTC, ART and other health services. Before the procedure is performed, a man has the option of being tested for HIV, but it is not required for the surgery. If a man tests positive, he can still have the surgery done if he chooses to and will also be referred for ART.

Strategic Opportunities for VMMC

- If you and your partner have a baby boy, you can decide to circumcise your son while he is still young. This makes VMMC easier, compared to the anxiety and stress that adult men can go through.
- You can encourage your partner to be circumcised around the time you are giving birth. This will allow you both the time needed to heal and make abstinence from sex during the six weeks easier/more natural.

Take-home Messages

VMMC is a simple and relatively painless procedure. Circumcised men must also use condoms correctly and consistently to reduce the risk of HIV infection. Women should support their partner when making a decision about circumcision.

CONCLUSION

We have discussed seven different risk reduction strategies here for those who are both HIV positive and HIV negative to reduce the risk of transmission. We hope that at least a few of these strategies will be of use and can be adapted into your lifestyle to help protect you and those you care about.

SERVICE MAPPING

Aim:

To ensure all women are aware of all the different service points available to them in the area and what is available at each.

Materials:

- Flip chart paper
- Markers

Directions:

Step 1: Divide participants into groups of six to seven people, hand out flip chart paper and markers to them, then ask them to draw a map of their community. The following is a recommended process:

1. Mark a central point that all of them relate to, which can be a combination of the following: road, river, school and inkhundla centre.
2. Identify where each one of the members of the group lives, relative to the central point(s), have them draw their houses on the map, as well as the roads and paths that connect the places.
3. Have them fill in any other locations that they feel are important to have on the map of their village.
4. Mark all points where they access various health services, including where they can access condoms, such as small shops.

Step 2: Each group then hangs up their map on the wall, next to one another.

Step 3: Have all the participants work together to combine the different elements from group maps and develop one joint map.

Step 4: Engage participants in a discussion and ask if the places marked on the map offer any or all of the services that are core to HIV risk reduction. Mark the map to show which services are provided where. In addition, engage participants further on where else they feel able to go to access such services. Mark/add these on the map.

Step 5: Make sure that all participants have a chance to participate and be heard. Ask to confirm that all participants agree with what is being put on the larger map.

Step 6: Conclude the session by letting participants know that this map will be used again in Module 2 and be sure to hang on to it and bring it back for the next session.

Facilitator's Note

Participants may raise specific concerns about the quality of services offered at the service points that are mapped. If this happens:

- Do not be defensive. Allow them to express their concerns. Ask them to be specific about the issues, without being personal. Note the issues in your field notebook, and devise a strategy for verifying the concerns and helping the community and service providers to find solutions. Remember that:
- You cannot speak on behalf of the service providers.
- The service providers may not be aware of these concerns.
- The service providers also have their own perspective. In fact, they might also have concerns about the community.
- Do not rush into what appear to be solutions to their concerns. Engage participants on how they will overcome their concerns. Your role is not to fix things but to help them find solutions to their concerns. Remember they are part of and central to the solution.
- Ask them if it is okay if you share these concerns with the facilities they are naming. Make sure they know that individuals will not be named in giving them the information. Explain that for services to improve, they need to know what needs to be worked on and get better.
- If they do not want the information taken back to the facilities, respect that choice. The sessions need to be a safe space where women feel they are respected and listened to.

WRAP UP OF MODULE 1

In this module, we learnt about what risk is. We also conducted individual HIV risk assessments and discussed the key HIV risk reduction strategies for women. We concluded with service mapping. We now are fully aware of where to access the relevant services. Utilise these services, they are intended for us. Our utilising them is what will draw the nation closer to an HIV-free generation by 2022.

As we call it a day, each individual is also encouraged to keep their risk assessment safe. It is confidential to you. Continue to reflect on it.

Agree on the date and time for **Module 2** and encourage them to return.

Session Evaluation/Feedback

Before dismissing the participants, the facilitator or any other person that led this session should take the following actions focusing on both participants and him/herself as follows:

WITH PARTICIPANTS:

Conduct an evaluation process, to solicit feedback from participants on which information they found:

- Most useful
- Least useful
- That they desire to have, but feel was missing

The facilitator shall use buzz groups or fully fledged group sessions where all groups shall respond to all questions, and, as they present in plenary, he/she shall take notes. These notes shall form part of the activity report.

Forms for this evaluation can be found in **Appendix VI: Session Evaluation Guide**.

THE FACILITATOR ON HIS/HER OWN:

Complete a feedback form, summarising:

- Which topics/sessions he/she enjoyed facilitating and why
- Which topics he/she found difficult to facilitate on and why
- What specific topics he/she feels that he/she has adequate information on
- What specific topics or sessions she/he feels are redundant and need to be removed
- What specific new topics or sessions or information she/he feels need to be added and why
- What specific skills he/she feels that he/she lacks or needs strengthening and why

Forms for this evaluation can be found in **Appendix VII: Facilitator Feedback Form**.

MODULE 2:
BARRIERS AND FACILITATORS OF HIV RISK REDUCTION STRATEGIES

MODULE OVERVIEW

Aims:

After participating in this module, participants will be able to:

- Devise strategies to effectively reduce their risk of HIV acquisition and/or transmission.
- Identify solutions to factors that hinder their ability to effectively reduce their risk of HIV acquisition and/or transmission.
- Develop a sense of both individual and collective responsibility to reduce their risk of HIV acquisition and/or transmission.

Activities:

1. Discussion of Risk Reduction Strategies
2. Gender's Role in HIV
3. Overcoming Stigma
4. Service Mapping

Materials:

- Newsprint/flip chart paper
- Markers

Module Introduction

In Module 1, we learnt about the meaning of risk and reviewed the basic terms and facts around HIV. You were able to conduct individual HIV risk assessments to see where your level of risk sits and discussed the key HIV risk reduction strategies that you can use in your life to reduce your risk. I hope that you saved your risk assessment so that you were able to reflect further on it, as well as maybe use it again in the future after you have made some changes to see where your risk falls at a future date. Module 1 concluded with the service mapping and a discussion on where to access HIV prevention and care services in your community.

In Module 2, we will have a deeper discussion on each of the HIV risk reduction strategies, assessing how you can best make positive changes to your life. In particular, we will explore what helps or hinders uptake of the relevant services to prevent HIV acquisition and/or transmission.

DISCUSSION OF RISK REDUCTION STRATEGIES

Aim:

To allow women to dive deeper into risk reduction strategies and explore what may assist them in taking up the behaviour or make it more difficult.

Materials:

- Copies of risk reduction strategy discussion questions for each group. (**Appendix VIII**)

Directions:

Step 1: Divide participants into six groups of four to five members each. Assign one HIV risk reduction strategy to each group.

Risk Reduction Strategies:

- Go for HIV testing
- Use a condom correctly and consistently
- Adhere to treatment
- Reduce your number of partners
- Be involved in PMTCT
- Reduction of GBV

Step 2: Give the groups 60 minutes to discuss the facilitators and barriers associated with their risk reduction strategy, as well as actions they recommend to take advantage of the facilitators and overcome the barriers.

- Below is a list of questions for each group to consider. **Appendix VIII** has questions divided up by reduction strategy that can be handed out to each group.
- Encourage the groups to explore and agree on a creative and entertaining way of presenting their discussion back to plenary, such as role play or pictures.

Questions for group discussion

1. Discuss the factors that make it easier to help women to participate in the risk reduction strategy. What can be done to promote these factors?
2. Discuss the factors that make it difficult for women to participate in risk reduction strategies. What can be done to address these difficulties?
3. Specify one or two things that you think make it easier for women to participate in the risk reduction strategy. Be sure to consider:
   - Internal forces, such as how women may feel, think or act.
   - External forces, such as service providers, family, friends or culture.
4. Specify one or two things that you think make it extremely difficult for women to participate in the risk reduction strategy. Be sure to consider:
   - Internal forces, such as fear, shame, guilt or pride.
   - External forces, such as access and quality of services (cost, distance, confidentiality).
5. If there was one thing (or two) that would help women to engage in the risk reduction strategy, what would you recommend?

Step 3: Instruct the groups that after discussing their risk reduction strategy groups should prepare to present back to plenary at the end. Groups should:

- Choose two members that will present: one for helping factors, another for hindering factors.

- Develop a short skit to demonstrate the factors that help, as well as those that hinder engaging in the risk reduction.

Step 4: Bring everyone back together in the large group.

- Ask groups to perform their skits and then have the two members present their discussions in plenary. After a group presents, acknowledge them and ask the other participants to give feedback to the group or add any thoughts.
- As a facilitator, ask the group specific questions (skip the questions that other participants may have already asked). Be sure to summarise the key facts about the risk reduction strategy (listed in the boxes on the following pages) and once feedback has been provided, conclude with any key messages that were left out or you want to emphasise more.

Facilitator's Note:

The sections below have a group work guide and prototypes of the key facilitators and barriers for each HIV risk reduction strategy that the facilitator can use during plenary.

Suggested questions for plenary

1. When we reflect on it, do we as women feel that we are at risk of being infected with HIV? Please explain your answer.
2. Which of the risk reduction strategies do you feel confident to use? Please explain your answer.
3. Which risk reduction strategies do you feel less confident to use? Please explain your answer.
4. How do you think you can become more confident in using these strategies?

Step 5:

- After all the groups have presented, encourage the participants to identify "small, but doable" actions that they will take to reduce the risk of acquiring or transmitting HIV to their partners. For this purpose, ask each participant to take time to reflect and write the top three actions that they will take. Let them know that these are just for themselves, unless they choose to share.
- Inform the participants that the next module will pick up from there. Encourage them to come back, as this is also the graduation day.

HIV TESTING AND COUNSELLING SUGGESTED SUMMARIES

It is important to get tested and to know your status. By knowing your status you can better plan for the future, whether negative or positive, and take steps to live a healthy productive life.

Helping Factors	Key Message
Peer Support: Speaking to a friend that has already tested for HIV can increase confidence. You can also attend the clinic or test site with a friend to both get tested and support each other with the process.	We can learn a lot from others that have already gone for HTC and gain support from friends who also want to test.
Couple Communication: Discussion with one's partner helps overcome fears. Going to couples counselling and testing is also an option and can provide a lot of support for the process.	Couple communication deepens mutual trust, respect and support. Couples counselling and testing is available at most health facilities.
Attitude: A positive attitude and "fighting spirit."	A person trips and falls, but rises up again. Do not allow regret, grudges or anger to blind you. You are in charge of your life.
Responsibility: A deep sense of responsibility for one's health and one's family's health can give a person courage.	The choices we make are important for our health. We can make those choices as individuals because we are responsible for our health.

Hindering Factors	Key Message
Fear: Some women are afraid of how to explain where they got HIV because they do not want to be blamed for bringing HIV to the family.	Talk to a friend or the counsellor about your fears related to getting an HIV test. Reflect on how it feels to live in fear. Disclosure builds a trusting relationship. It also enables family and friends to support you to make and stick to healthy choices.
GBV: Fear of violence and abuse makes it difficult to disclose one's HIV status, especially if the result is HIV positive. This also affects the decision of whether to go for HTC at all.	Sexual partners can have different HIV test results. Surround yourself with people who are supportive. Be the first to denounce violence. Report GBV to police or nearest service organisation, such as the Swaziland Action Association Against Abuse (SWAGAA). If any of these are far, report to community police or any relevant community structure.
Discordancy: Some women may believe that because their partner is negative, they are also negative. Or if their partner is positive, they are automatically positive.	Sexual partners can have different HIV test results. It is important for both members of a relationship to test in order to take steps to stay healthy.

CONDOMS SUGGESTED SUMMARIES

You should always use a condom to protect yourself and your partner. It is even more important if you do not know your partner's HIV status, or are in a multiple and concurrent sexual relationships.

Helping Factors	Key Message
Knowledge: Comprehensive knowledge and awareness of HIV risk and how to correctly use condoms.	If you fully understand HIV and the risk involved in sex without a condom, you are more likely to make the right choices and understand how a condom can protect you.
Responsibility: A deep sense of responsibility for one's health can motivate a person to use a condom.	To protect yourself, you also need to protect your partner.
Preparedness: Having condoms within reach or easily accessible increases the likelihood that you will use them.	Have condoms available for when you need them. Keep them in convenient locations so you are more likely to use them with the moment comes. It will make it easier to negotiate if you have them nearby.
Attitude and Beliefs: Sex can still be pleasurable with a condom. Condom use shows you care about your and your partner's health.	Acceptance of condom as a tool for risk reduction reduces the shame, guilt and judgemental feelings about using it. Have a conversation with your partner before having sex and explain why you want to use a condom, to protect both you and your partner because you care about him.
Determination: Deciding what you will do ahead of time before emotions get involved.	Having a clear stand makes it easier to reject risky behaviour and stay true to using condoms consistently.

Hindering Factor	Key Message
Capacity: Some women lack skills and confidence to negotiate with a partner.	Prepare to negotiate condom use before sex starts. Practicing negotiation skills with friends can prepare you.
Acceptability: Some women have negative attitudes towards condoms and people that use them.	A condom in itself does not make a woman promiscuous. Promiscuity is a behaviour.
Access: Sometimes condoms are not available in the community. When they are available, the cost is prohibitive or the dispenser/ distributor is inappropriate.	Condoms are available at every health facility. If you are embarrassed to be seen getting condoms, you could ask a friend to get some for you. It is important to protect yourself.
Responsibility: Putting pleasure ahead of health and safety.	Let your partner(s) know that you care about your health as well as theirs. To protect yourself, you must protect others.
Alcohol and/or Drug Abuse: Substance abuse can impair the ability to make healthy choices.	When going out to a social event, carry a condom on you in case that moment comes and do not let your desire or the affect of alcohol keep you from using it.
GBV: Force or coercion is sometimes used in order to have sex without a condom.	Every person has the right to say no to sex. You should never be threatened or forced to have sex without a condom. You should report GBV to the police or the nearest service organisation, such as SWASAA, if this happens to you.

ANTIRETROVIRAL TREATMENT/THERAPY SUGGESTED SUMMARIES

If you are HIV positive it is important to enrol in care and maintain regular appointments with a health-care provider. Once you qualify for ART you should begin taking medication immediately and continue as directed by your health-care provider. Taking your ARVs will lower your viral load, allowing you to stay healthy and lower the chances of transmitting HIV to your partner.

Helping Factors	Key Message
Knowledge: Awareness of one's HIV status and the benefits of being on treatment.	Knowledge of one's HIV status is the gateway to health services and support for HIV-positive individuals that are in need of treatment.
Disclosure: Informing partner(s), close family and friends about one's HIV status.	Informing partner(s), close family and friends about one's HIV status helps to unlock their support. Community health workers are a huge resource as well and can link people who are HIV positive to other services.
Example/Role Model: Knowing someone that is HIV positive and also on treatment.	We draw strength when we know someone that has a similar condition as ourselves. We are even stronger if we share our experiences together.
Confidante/Counselling: Talking to someone about the challenges we face. Community health workers are a huge resource.	When we face challenges and we talk to someone about them, we become stronger as our hope is renewed. If we keep to ourselves, the burden can become unbearable and crush us until we give up.

Hindering Factors	Key Message
Fear of Positive HIV Test Result: Some women are HIV positive, but do not know their HIV status. Thus, they cannot be enrolled into the ART program.	Knowing ones status is the first step to leading a healthy life. Learning your status is a useful trigger for you to take appropriate steps. Ignorance of your HIV status does not change your HIV status if you are already HIV positive.
Acceptability: Some women find ARVs intimidating and frightening because they are taken every day, for life.	Combined ARVs have made it easier because only a tablet a day must be taken. Although it is a long time to have to take medication, by taking it is will allow you to live a long and healthy life. Without medication this becomes more difficult.
Adherence: For various reasons, some women fail to take ART according to advice given by their health-care provider. Forgetting is a common reason (especially on weekends). The need to do it every day can be a burden. Women that have not disclosed their HIV status find it even harder to adhere.	The client has a responsibility to try to make taking ART part of a daily routine, such as at home in the morning, so it will become automatic and be less likely to forget. If disclosed to family and friends, they can help with reminders. Join a support group. Seek support if facing challenges.
Traditional Medicine: Some women seek modern medicine as a last resort. By the time they finally do so, they may be very sick or have caused serious damage to their health.	Traditional medicine and modern medicine can co-exist. However, entirely substituting modern medicine with traditional medicine can increase the risk of your HIV becoming worse. The only proven and effective treatment for HIV is ART.
Stigma: Some women feel guilty and ashamed that they are HIV positive and are taking ART.	As an individual, learn to forgive yourself. Value yourself and believe that your HIV status does not define your worth as a human being.

PARTNER REDUCTION SUGGESTED SUMMARIES

Having multiple partners puts you in a sexual network that increases your risk for HIV. By reducing your number of sexual partners you can not only reduce your risk but also strengthen your relationships.

Helping Factors	Key Message
Couple Communication: By talking with your partner and being open about your relationship, you can come up with ways to be safe together.	It is easier for partners to find ways to satisfy their partners when they are open to each other. This can create a more rewarding relationship, not to mention better sex life.
Hobbies: Some women may have multiple partners because they say they are "bored." By finding hobbies outside of relationships or with your main partner, it may help reduce partners.	Sex should never be the answer to boredom. It is an emotional commitment that along with great pleasure comes risks and consequences. Before beginning a sexual relationship with anyone be sure you are ready to protect yourself from an unintended pregnancy or HIV.
Friends: Surround yourself with friends who are in monogamous relationships.	Hang out with the right friends who can have a positive influence on you and who also choose to have only one partner.
Children: Thinking about your children and setting a good example for them.	Set a good example for your children and have more time and energy to invest in their development.

Hindering Factors	Key Message
Dissatisfaction: Some women do not feel fulfilled with their regular or stable sexual partners.	Couple communication can address this by being open to each other so that, together, you can explore how to fulfil one another.
Gifts/Money: Some women are in relationships with more than one man in order to get gifts and financial or other forms of livelihood support.	It is important to be in a relationship for the right reasons. Men may be able provide items you may be unable to purchase on your own, but it is important to think about the risks in putting yourself in this position. They may ask for more of you than you are ready to give, but if they have given you items, you may feel like you owe them and have to say yes to sexual activity. If you are in this type of relationship, it is also important to think about other partners you may have and the risk you are exposing them to. It is important you protect yourself and insist on condom use.
Previous Sexual Partners: Past sexual partners resurface for different reasons, such as children.	Leave past relationships in the past. If you are unable to do this, use condoms correctly and consistently. Or if you realise that is the person you want to be with, end your other relationships.
Boredom: Some women may have multiple boyfriends in order to occupy their time or get attention.	Having many partners is risky. Spending time with friends or finding new activities is a better way to spend time.
Long-term Commitments: Some women are already in a polygamous marriage union. This is both legal and culturally acceptable.	If in a polygamous union, keep faithful to each other within this circle. In addition, the man and all his wives should test for HIV. If one is HIV positive, seek treatment early, disclose to your partners and always use condoms.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV SUGGESTED SUMMARIES

If you are HIV positive, your baby does not have to be. Entering into PMTCT as soon as you find out you are pregnant is important for both your health and your unborn child. By going through the program, keeping your appointments and adhering to ART, your baby will be born HIV negative.

Helping Factors	Key Message
Fulfilment: Many women desire to have a healthy family. This desire is a driving force for their involvement in PMTCT.	A couple who is HIV positive or discordant can still have an HIV-free baby if they plan their pregnancy, enrol in PMTCT early and adhere to the guidance provided by their health-care provider, including taking ART and using condoms.
Knowledge: Having comprehensive knowledge about HIV helps individuals understand the importance of PMTCT.	Learning starts with interest. By knowing the steps that you can take to protect your baby, you will be more likely to stay with the program and follow all recommendations.

Hindering Factors	Key Message
HIV Test: Some women may not want to get an HIV test because they fear that if their partners find out, they might lose them or be subject to violence.	Although it can be stressful and difficult to get a test after you just found out you are pregnant, it is important for you and your baby's health. By testing immediately for HIV your health-care provider can give you the best treatment to ensure your baby remains HIV negative, whether you are positive or negative.

REDUCING GENDER-BASED VIOLENCE SUGGESTED SUMMARIES

GBV is a serious problem that can affect the lives of anyone. It is important to recognise and make an effort to reduce GBV. Violence is never an acceptable action and no one should ever feel fearful, guilty or ashamed of who they are.

Helping Factors	Key Message
Communication: Having open and honest communication with those in your life can help. If you are being abused, tell someone.	If you are being abused, tell someone. Although this might be difficult, you should not feel ashamed, guilty or embarrassed. IT IS NOT YOUR FAULT. By telling someone you know you can get support and access to services that can help you. Tell a friend or family member, or you can talk to someone at the health centre or community police station.
Knowledge: Having knowledge and understanding can reduce violence.	Educating yourself on gender norms and roles, and how they may impact you and those around you, can help to reduce violence. Know what services are available to you and what is a healthy relationship.
Peers: Surrounding yourself with those who condemn violence and abuse can help you stay strong.	Having supportive friends around you can help you to avoid situations that may be abusive, or escape ones you may already be in. Draw strength from their support and realise that is it not your fault, and is unacceptable.
Community: A community that is supportive, aware and speaks out when they see abuse, can help protect women.	When people see something that does not seem quite right, or abuse happens in public, it is important to speak up and condemn it. Let the abuser know that it unacceptable behaviour. In some places this may be difficult, as it is the accepted norm or past but this makes it even more important to say something.
Children: By wanting to set a good example for your children it can help you recognise dangerous situations.	By focusing on your children, and how you want them to behave and live, you can take the steps necessary to protect yourself and them. Think about the society that you want them to grow up in.

Hindering Factors	Key Message
Violence and Abuse: Sometimes force or coercion is used to make partners submit to sex without condoms. Fear of violence and abuse also make it difficult to disclose one's HIV status, especially if results are HIV positive. This also affects adherence to treatment.	Every person has the right to say no to sex. Nobody should ever be threatened or physically forced to have sex. You should feel safe with your partner at all times and allow trusting a relationship to develop. If you are ever physically or verbally abused, made to feel unsafe or forced to have sex against your will, leave immediately and seek guidance and support.
Social Norms: Gender roles and responsibilities are often ingrained into a culture.	Sometimes ingrained gender roles and social norms may contribute to GBV. It is important to recognise what triggers may exist and realise that just because something may have been done in the past does not mean that it is acceptable now. Be open to change and really consider what is best for yourself and your partners' happiness.
Acceptability: In many places it is acceptable to beat women, especially if they are your wife.	It is never acceptable to be hit or to hit another person. Verbal abuse or being forced to do things that you are not comfortable with, is also unacceptable. You should never feel forced to do anything.

OVERCOMING STIGMA

Aim:

To identify some of the root causes of stigma, different forms of stigma and how stigma affects people.

Materials:

- Flip chart
- Markers

Directions:

Step 1: Prior to the session beginning, draw a tree on a flip chart that includes the roots, trunk, branches and leaves. Next to the roots write "Causes," next to the trunk write "Forms" and next to the branches write "Effects."

Step 2: Form five groups. Ask them to draw a tree similar to what you have prepared on the flip chart.

Step 3: Define stigma and self-stigma. Make sure everyone clearly understands.

- Stigma – Stigma is something that comes from others or your surroundings. It aims to make people feel bad about themselves and powerless in a situation. It is usually associated with a certain condition, such as HIV, or standing in the community.
- Self-stigma – Self-stigma comes from within. It is when someone judges themselves and makes themselves feel powerless because of a certain condition or standing.

Step 4: Ask them to consider the following in their groups:

- Why do people stigmatise others, such as lack of knowledge? List their responses as the roots (or causes).
- What do people do when they stigmatise people, such as name-calling? List their responses as the trunk (or forms).
- How do these actions affect the person being stigmatised, such as isolation? List their responses as the branches/leaves.

Step 5: Once they have completed the activity, have each group share their trees. Check the facilitator's notes for any additional causes, forms or effects that were not mentioned.

Step 6: Conclude with the following questions:

- Do you think we focus more of our stigma reduction efforts on fixing the causes, forms or effects? Why?
- What can be done to address the causes of HIV-related stigma, and therefore reduce them?
- What will you do to reduce HIV-related stigma after considering the harm it causes to our communities?

Step 7: Closing: HIV-related stigma is a major factor stopping people from learning their HIV status. Stigma is caused by various factors, including lack of knowledge, fear of death, shame/guilt associated with an STI and the moral judgment of others. Stigma has serious effects that can compromise an HIV-infected person's life. However, stigma can be reduced.

Facilitator's Notes

Below is a list of potential causes, forms, and effects of stigma to keep in mind and prompt participants with if they get stuck:

Effects or Consequences (leaves/branches)

Shame. Denial. Isolation. Loneliness. Loss of hope. Self-blame. Self-pity. Self-hatred. Depression. Alcoholism. Anger. Violence. Suicide. Dying alone without love. Feeling useless/not contributing. Family conflict. Quarrels within the family over who is responsible and who will take care of the PLHIV. Divorce. Getting kicked out of family. Fired from work. Dropping out from school. Orphans and street kids. Abuse or poor treatment by relatives. Deprived of medical care (health staff arguing that it is a "waste of resources"). Ceasing to make use of clinics, HTC, and home-based care and support programs. Reluctance to take medication. Lack of treatment. Spread of infection.

Forms of Stigma (trunk)

Name-calling. Finger-pointing. Labeling. Blaming. Shaming. Judging. Spreading rumors. Gossiping. Neglecting. Rejecting. Isolating. Separating. Not sharing utensils. Hiding. Staying at a distance. Physical violence. Abuse. Self-stigma (blaming and isolating oneself). Stigma by association (family or friends also affected by stigma). Stigma due to looks/appearance.

Causes (roots)

Morality (the view that PLHIV are sinners and promiscuous). Religious beliefs. Fear of infection, the unknown, of death. Ignorance that makes people fear physical contact with PLHIV. Gender (as women are more stigmatised than men). Peer pressure. Media exaggerations.

SERVICE MAPPING

Aim:

To explore deeper why some services may be used by women and others not as well as explore ways to increase service utilization.

Materials:

- Map from Module 1
- Flip chart paper
- Markers

Directions:

(Note that it is critical to have the physical map that was created in Module 1.)

Step 1: Remind the women that this map was created by them during Module 1. Go back to that map. Hang it up on the wall so all are able to see it. Review what services are found where, including those for GBV, which were discussed in Module 1.

Step 2: Ask the women if there are any they may have missed the first time. Make any updates as needed.

- If, for some reason, the physical map is not available, engage all participants to draw another one on a flip chart. Alternatively, list the services in a matrix showing the available health service deliver points beginning with the list of high impact services (list both government and private health facilities, as well as outreach/mobile service points).

Step 3: Explain that now we are going to identify the key factors that can facilitate (helping factors) and inhibit (hindering factors) utilisation of the identified points of services.

Step 4: Divide participants into groups of five to six people, ideally four groups but make sure there are an even number of groups.

- Assign half of the groups the task of identifying the key factors that can facilitate utilisation of the identified points of services (helping factors). Assign the remaining groups the task of identifying the key factors that can inhibit utilisation of the identified points of services (hindering factors).
- Ask the groups to work together to come up with a list for each service point.

Step 5: Ask everyone who worked on helping factors to make their presentations together. Do likewise for those who worked on hindering factors. Remember to take notes of what the groups present as key helping factors and hindering factors.

Step 6: Role play (this is an optional activity, if there is time for it, and if the participants agree to it):

- Ask the groups who presented on the helping factors to combine into one big group and develop a skit or role play to act out the helping factors. Ask the remaining two groups who presented on hindering factors to join into one group and also develop a skit or role play. They should portray this

Facilitator's Note:

- You cannot speak on behalf of service providers, the government, Ministry, or Department.
- Communities have concerns about the quality of services, but service providers may not be aware of those concerns. Service providers might, in fact, also have concerns about the community's attitude or participation in the available services.
- Your role is not to fix things, but to help the participants and other community members find solutions to their concerns. Therefore, engage the participants to identify a few key actions that they intend to take in order to overcome their concerns, such as the community can arrange a meeting with the clinic committee and/or sister-in-charge to give them feedback on the quality of services, and what they recommend (within their power to do so).

from both the point of view of women, as well as from the point of view of service providers at the service point. Remember to take photos and brief video clips, if possible and the men are okay with it.

Step 7: Conclusion.

- End by having a discussion around what action steps women may take to decrease the factors that may prevent them from utilising services and how they can take advantage of the facilitators to ensure more women in their community utilise what is available.

WRAP UP OF MODULE 2

In Module 2, we examined in detail the factors that help as well as those that hinder women to use the key HIV risk reduction strategies. Based on these, we identified solutions to increase utilisation of these services. We concluded the module with service mapping. In the next and final module, we will learn the skills of risk reduction planning and you will receive an award for your commitment to these sessions.

Session Evaluation/Feedback

Before dismissing the participants, the IPC Facilitator or any other person that led this session should take the following actions focusing on both participants and him/herself as follows:

WITH PARTICIPANTS:

Conduct an evaluation process, to solicit feedback from participants on: Which information they found:

- Most useful
- Least useful
- That they desire, but feel was missing

The facilitator shall use buzz groups or fully fledged group sessions where all groups shall respond to all questions, and, as they present in plenary, he/she shall take notes. These notes shall form part of the activity report.

Forms for this evaluation can be found in **Appendix VI: Session Evaluation Guide**.

THE FACILITATOR ON HIS/HER OWN:

Complete a feedback form, summarising:

- Which topics/sessions he/she enjoyed facilitating and why
- Which topics he/she found difficult to facilitate on and why
- What specific topics he/she feels that he/she has adequate information on
- What specific topics or sessions she/he feels are redundant and need to be removed
- What specific new topics or sessions or information she/he feels need to be added and why
- What specific skills he/she feels that he/she lacks or needs strengthening and why

Forms for this evaluation can be found in **Appendix VII: Facilitator Feedback Form**.

MODULE 3:
MAKING HIV PREVENTION HAPPEN: DEVELOP A PERSONAL RISK REDUCTION PLAN, BE AN ADVOCATE

MAKING HIV PREVENTION HAPPEN

Objectives:

After participating in this module, participants will:

- Demonstrate knowledge and skills in developing action plans
- Identify concrete actions that they will, individually, carry out to reduce the risk of HIV acquisition and/or transmission
- Commit to becoming an advocate in their own social networks and the wider communities

Activities:

1. Quiz
2. Summary of Core Services
3. Making a Plan
4. Individual Risk Reduction Planning
5. Becoming an Advocate
6. Celebration of Completion

Materials:

- Newsprint/flip chart paper
- Markers and pens
- Pre-printed action planning forms
- Certificates for participants who completed all three modules

Module Introduction

In Module 1, we explored the concept of risk, conducted individual risk assessments and discussed key HIV risk reduction strategies. In Module 2, we examined in detail the factors that help, as well as those that hinder women to use the key HIV risk reduction strategies. Based on these, we identified solutions to increase utilisation of these services among women. We concluded Module 2 by revisiting the service mapping exercise conducted in Module 1.

Today is the last day. We will continue to build on the foundations laid down in Modules 1 and 2. Specifically, in Module 3, we will learn the skill of developing Individual HIV Risk Reduction Plans. We will conclude the entire process by awarding participants with a "Certificate of Completion."

QUIZ

Aim:

To serve as a recap of what has been discussed so far. This can also serve as an assessment tool that gives insights into how much knowledge gain has occurred as a result of these sessions.

Materials:

- Score sheet for quiz (**Appendix IX**)
- Quiz questions
- Pens

Directions:

Step 1: Divide the participants into two teams by asking them to count 1, 2, 1, 2, …. Assign the 1s to Team 1 and the 2s to Team 2.

- Ask each team to choose whether they prefer to have their team name be a type of bird or animal. Once they make this choice, further ask them to choose the type of bird or animal that they prefer.
- To further motivate them, you can make it fun, such as ask them to explain their choices – why they chose to be birds and why a specific bird was chosen, such as an eagle, or why they chose to identify with animals and why a specific animal, such as a giraffe.

Step 2: Explain the rules of the quiz. Each team will have only one chance to give the right answer to a question posed to them. Only the team whose turn it is can answer the question, the other team should wait and listen until it is their turn.

- The group has a maximum of 60 seconds to discuss the answer and should then appoint a spokesperson to provide the answer. A different spokesperson should be chosen for each question.
- Explain that by getting a correct answer each team benefits, just like good health, and that by knowing how to take steps to decrease your risk, you can gain more. Getting an answer wrong represents a loss and a sacrifice, just as making poor choices cost you.
- A correct response is worth 100 points. If a team gives a wrong response, they lose 150 points. The group will gain or lose points depending on whether the answer is wrong or right.
- If a team gives only a partially right response, they will not earn 100 points; instead they will lose 100, as opposed to the full 150, which is the maximum loss for a completely incorrect response.
- If a team gives an incorrect response, questions will be given to the other group for an opportunity to answer and gain points. If the other team gets it correct within 60 seconds, it is a steal and they will earn 50 points. If both teams get it incorrect, the facilitator should use it to form the basis of discussion by the entire group, after which the facilitator concludes with an emphasis on the key facts.

Step 3: Conduct the quiz, alternating which team answers and sticking to the rules laid out above. Be sure to be keeping accurate score after each question.

Step 4: Summarise the results. Suggested questions and an accompanying tally table are on the next page.

SUGGESTED QUESTIONS FOR QUIZ

No.	Question	Answer
	HTC	
1.	What is the window period?	The time between when you become infected with HIV and when it will show up on the test.
2.	What is discordancy?	When one partner is HIV positive and the other is HIV negative.
	Condoms	
3.	A condom can be used for two important purposes. What are those two purposes?	Prevent pregnancy and STIs, such as HIV.
4.	Complete the following statement: "For condoms to be effective, one must use them c….. and c…..".	Consistently Correctly
	VMMC	
5.	Does circumcision provide complete protection from HIV?	No, it only reduces the risk by 60 percent for the male, it is important to still always use a condom. It does not reduce any risk for the partners of a circumcised male.
	ART	
6.	Mention one way by which ART reduces the risk of HIV transmission.	Reduces viral load.
7.	What does it mean to have an undetectable viral load?	That you have so little virus in your blood that the test cannot detect it. You are still HIV positive, though.
8.	Once you begin taking ART, how long will you need to continue to take it?	For life.
	PMTCT	
9.	HIV can be passed from an HIV-positive mother to her baby in three ways. Mention all the three ways.	During pregnancy, labour/child birth and breastfeeding.
10.	A pregnant woman that is HIV negative can become HIV positive. Mention one main method that can prevent this if their partner is positive.	Use a condom. Adhere to ART medication.
11.	PMTCT makes it possible for a child born to an HIV-positive mother to be born HIV negative. However, the baby can still acquire HIV from her mother. Explain the child care practice that carries the highest risk for the baby.	Breastfeeding
	GBV	
12.	Give two examples of sexual violence.	Touching a female's body part without her approval. Forcing someone to have sex against their will.
13.	Give two interventions that you could use to address sexual violence.	Report abuse to the police Encourage respect in the community.
	Partner Reduction	
14.	How does having multiple partners increase the risk of HIV acquisition and/or transmission?	You are part of a sexual network and exposed to more risk of getting HIV.

QUIZ WRAP UP: DISCUSSION QUESTIONS

1. **Question: What did you learn from this quiz?**

Suggested Summary by Facilitator

The decisions that we make have a cost to them. Wrong decisions make us lose. Wise decisions make us gain. Likewise, poor choices of health behaviours by an individual have a cost on her and her partner(s) overall health. It is also not unusual for immediate family and friends to also be affected.

2. **Question: How did you feel after the group agreed on an answer that was inaccurate thereby sustaining a loss, yet you had the right answer (that they rejected or you otherwise did not get a chance to put forward for the group to consider)?**

Suggested Summary by Facilitator

Sometimes the wider community is wrong when individuals in the same community are right. It takes courage and persistence for the concerned individuals to make the choice to be different and change their own destiny. This might ultimately benefit their family and community, as well.

3. **Question: On the whole, do you feel like your individual mark would have been better if you acted alone?**

Suggested Summary by Facilitator

When we act in solidarity, everyone wins. Remember that to protect yourself, you must also protect your partner.

SUMMARY OF CORE SERVICES

Aim:

To give an overview and recap of the information provided on the key HIV services available for HIV prevention, care and treatment.

Directions:

Step 1: Review each of the sections below highlighting the information given previously. Be sure to pause and ask if anyone has any further questions since this is the last time you will all meet together.

HTC

HTC is for everyone. HTC services are provided at all health facilities. In addition, there are stand-alone HTC centres, as well as mobile clinics. Services offered at include the following:

- Counselling
- HIV blood test
- Based on need identified during HTC, one is referred to other clinical services, such as TB screening, ART or PMTCT.

When you get your HIV-negative test result, it is important to go for a re-test after six weeks, to confirm your status. This is because of the window period. The window period is when HIV has just entered your body and antibodies against HIV are just starting to multiply, but are in such small quantities they do not show up on the test. If you have sex without a condom and do not know your partners' status after HTC, you must go again for HTC.

HTC is private and results are confidential, but an individual can make a choice to disclose her results to anyone she chooses. Disclosure unlocks support from family and friends. It also helps reduce self-stigma.

Pre-ART

People who test HIV positive are then assessed to see if they should start treatment at a health facility. Services offered are the following:

- Your blood is tested to assess CD4 count. Results are provided the same day (within 30 or more minutes).
- You may get medication, depending on the CD4 assessment and your symptoms. Follow the instructions you are given. Do not share medicines. If you are not yet ready to begin treatment, you will need to return to the facility for further testing until it is time to begin ART.
- Be sure to return for all appointments scheduled.

ART Initiation

This service is offered only at health facilities. Individuals who test HIV positive and meet the eligibility criteria can be initiated on ART. The services offered are the following:

- ART initiation – initial ARV supply for 2 weeks
- You should return to the health facility so that your health-care provider can review how you are responding to treatment:
- If newly initiated, come back on day 15 for a check-up.
- You will then come every month for one year.
- Thereafter, you will come every three months for a check-up and to receive a refill on your medication.

It is helpful if you speak with someone you know is also on ART in your community or workplace. This can help you remember to take your medicine on time, get reminders about your appointment days for refill and/or review, and

have the support of others who are also on treatment.

ANC and PMTCT

A sexually active woman that misses her monthly period should immediately go for check-up within six weeks from when she misses her period. At the health facility, she will be tested for pregnancy, as well as HIV. If pregnancy is confirmed, the woman is provided with information of how to care for her pregnancy and prepare for birth. If the woman is both pregnant and HIV positive, she is enrolled in PMTCT. In Swaziland, it is sometimes called Life-long ART for HIV+ Pregnant and Lactating Women (LLAPLa). It is more beneficial to go for such check-up as soon as a woman misses her monthly period. This helps address other health risks, even when the woman is not pregnant.

ANC is available to pregnant women at health facilities. Services provided are the following:

- Check vitals of the woman and the baby
- Advice on pregnancy care
- Family planning counselling and services
- HTC, including partner testing for men

Take-home Messages

There are a variety of HIV-related services to help you either prevent HIV or live positively. Every service delivery point in the health-care system is an entry point. For example, if your primary reason for going to a health facility was to seek medication for a cough or headache, you can also ask your health-care provider for HTC, condoms and other services.

Wrap Up

Thus far, we have gained comprehensive knowledge about HIV and how to reduce the risk of HIV acquisition and/or transmission. We have also become acquainted with the core HIV prevention services available to us. We learnt that to protect ourselves, we have to protect others as well. Among other things, this places responsibility on you regarding the decisions you make and how you treat and support yourself and your partners. In the next activity, we will develop individual tools that can help us make this happen.

MAKING A PLAN

Aim:

To gain an understanding of what it means to make a plan in life, follow through on it and discuss what the benefits of having a plan in place are.

Materials:

- Flip chart
- Markers

Directions:

Step 1: In plenary, ask participants to explain what they understand a plan to be. Write the responses down on the flip chart.

Step 2: Provide the following summary:

- A plan is a roadmap that shows how we will get to where we desire to go. It is comprised of decisions and actions or tasks that will be undertaken to get us where we want to go. A plan can exist as a mental process, and also can be written down. For example, a farmer's plan can include tasks like deciding what crop to grow in a particular season, buying seed, deciding when to till, hiring a tractor to till the fields, deciding when to plan, harvesting and more.
- In the context of HIV, the questions each one should ask herself are: "How can I reduce my risks of acquiring HIV?" or "How can I reduce the risk of transmitting HIV to my partner?" or "How can I reduce the risk of HIV re-infection"?
- A plan is not the same as a wish, a dream. A wish can be translated into a plan. Successful plans start with wishes and dreams.

Step 3: Read the story of Nomfuneko, which illustrates plans and wishes:

Nomfuneko is a single mother. She lives in Mbuluzi. She is a hawker in Mbabane and sells fruits-in-season. On a good day she makes anything between E500 and E1000 in a day. Nomfuneko lives in a stick-and-mud house and she desires to upgrade it one day

She has adopted a frugal lifestyle in order to save money for the initial deposit in a rural housing scheme. Early this year, she joined a self-help group that operates a group savings and loan scheme. To date, her total savings are E5, 000. Her business is also growing, with capital having doubled over the past eight months. At the end of the year, when the group gives out dividends, she hopes to use her money as deposit for housing loan from the Rural Housing Project.

One morning, it was raining and her house was leaking in several places. She busied herself moving her belongings and placed basins on the spots where water from the roof landed. As she sat by her charcoal burner, sipping tea while waiting for the rains to cease, she watched the small rivulets that had formed on the ground.

Believing that she was only thinking to herself, she said out loud: "my children will not live in this kind of poverty, not my children". Her daughter, who sat there silently all the while, replied: "may God hear your prayer". Unperturbed, Nomfuneko replied: "amen, you will finish your schooling, receive a scholarship to university and get a big fancy job".

Step 4: Lead a discussion with the group, identifying plans and wishes from the story of Nomfuneko.

- Plans: Nomfuneko want to upgrade her house. She hopes to get a loan from the Rural Housing scheme, but the rural housing scheme wants a deposit. Therefore, she has joined a self-help group where she has saved up E5000. By the end of the year, she hoped to use her dividends as deposit for her new house.
- Wishes: Nomfuneko wishes that her children did not live in poverty. Although she has taken a concrete step to improve her home, it is not sufficient to guarantee that her children will not live in poverty. Her hope is that her

daughter will receive a scholarship to a university and get a good job, but currently she does not know if that will happen. Both of these are wishes.

Step 5: Lead a discussion around the importance of having a plan.

- In plenary, ask participants to explain what they see as the key benefits of having a plan. Participants who feel comfortable can even share the plans that they have.
- Provide the following summary. A plan has the following benefits:
- An individual can refer to it, to be reminded of her decisions. This increases commitment to the decisions made.
- An individual is reminded of the goals they have set for themselves. This increases the levels of motivation to achieve the goals.
- A plan helps an individual to focus their time, energy and other resources on their priorities. This further helps an individual to take more control over their life.
- A plan helps an individual to be more aware of their achievements. Awareness of success helps in building self-confidence. Self-confidence further helps an individual to be more motivated and committed.

Step 6: Highlight the key elements of an effective/successful plan. An effective and successful plan should have the following attributes:

- It must be specific about what the goals/desired results are.
- It must be ambitious, stretching the individual to attain a better condition than the present one.
- It must set targets that are realistic, especially taking into account the resources and decisions that are within one's control. In other words, a successful plan has tasks/activities that one can implement. Support from others is supplementary.
- A plan should be reviewed/updated regularly, to get a sense of the progress being made and the changes that need to be made to the strategies for implementing the plan.
- It must define a timeframe within which the results must be realised.
- A big goal/desired result can have multiple actions that achieve subsidiary results that, in turn, act as key milestones towards the ultimate result. Big problems get sorted when they are dealt with in stages.

INDIVIDUAL RISK REDUCTION PLANNING SESSION

Aim:

For each participant to create their own individual risk reduction plan.

Materials:

- Action plan template (**Appendix X**)
- Pens

Directions:

Step 1: Distribute the planning template to each participant. Explain how to use it. Illustrate an example in plenary.

Step 2: Give the participants 30 minutes to work individually. Check to assure yourself that everyone has understood the task and provide support to those who need it. Encourage those that want to work in pairs or trios to do so, but prevent it from becoming a group activity, as the plans are really individual.

Step 3: In plenary, ask a few volunteers who feel comfortable to share their plans to do so. Ask the rest of the participants to give positive input/feedback, with the understanding that the plan is meant for that individual and is confidential.

Step 4: Inform the participants that each should keep their action plans, reflect on them while at home, refine the actions where need arises and implement their plans.

Step 5: In a brainstorm session, identify support mechanisms to help individuals stick to their plans. In addition to what participants put forward, suggest the following:

- Talk to a health-care worker
- Know when and where to get services
- Get a buddy to help you
- Join a support group
- Encourage a friend to make a plan

EXAMPLE OF A COMPLETED INDIVIDUAL ACTION PLAN

Plan Owner	Nomfuneko Masuku
Plan Title	HIV Reduction Strategies
Goal	Examples 1. If already HIV positive, achieve undetectable viral load. 2. If HIV negative, remain HIV negative and avoid getting HIV. 3. If unaware of my status, get tested and know my HIV status. 4. Remain in school until graduation.
Desired Outcome	

Action	Timeframe	Risks & Assumptions	Risk Mitigation Measures
1. Go for an HIV test	By end of next week	If I wait for too long, I might change my mind.	I will inform my close friend who has already tested that I plan to test.
2. Disclose my HIV-positive status to my family.	By end of the week	They might be disappointed in me and shun me.	I will join a support group to learn skills on disclosure.
3. Start a long term family-planning (FP) method.	This month	If people see me they might think I have many partners and am leading an immoral life.	I will educate them about the benefits of FP.
4. Talk to my partner about the benefits of VMMC.	By next month	He may become angry that I am discussing so personal with him and say it is not a woman's business.	Talk to friends who have talked to their partner previously. Speak to a health worker for strategies about how to approach it.
5. Reduce my sex partners	By next month	I will be all alone and will not have any fun.	Understand that by reducing my partners I am protecting myself and them.
6. Adhere to treatment	Ongoing	People will see me taking medication who I do not want to know my status.	Join a support group for help in adherence and ask a family member to be my treatment buddy and help me remember.

BE AN ADVOCATE

Aim:

To encourage women to become advocates in their communities and among peers to prevent HIV.

Time:

60 minutes

Materials:

- Flip chart
- Markers

Directions:

Step 1: Explain to participants: Every day we interact with many people. With all these people we could be encouraging change through our words and actions. Often we do not think about it this way, though, and feel that activism can only be some large or well-planned activity. Our attitudes and actions affect others. The choices we make can inspire others to also create positive change in their own lives. We may think that we have little power to make a difference, but in reality, we can be a spark that lights a fire. Many times the most effective activism happens in the course of normal life.

Step 2: Explain: I am going to read you a simple story. Please make yourself comfortable and listen carefully.

Once you have everyone's attention, begin reading: Faith is married and lives with her husband and four children. Her family lives in a small village 30 minutes from the city. Faith and her family get up at 7:00 a.m., bathe and have breakfast. From 8:00 a.m. until 10:00 a.m. they go to church, after which they talk for a while with some of their fellow church members. On the way home, they stop at the market to buy some vegetables and food for cooking. They come home and prepare food, with everyone helping in the food preparations, and at 1:00 p.m. they enjoy a nice meal together. At 2:00 p.m. Faith goes to visit the next village to visit friends, chatting with people as she walks and sitting outside with her friends enjoying the day once she arrives. From 4:00 p.m. until 5:30 p.m. the whole family goes to visit a relative with a sick child. When they arrive back home, there are neighbours sitting outside enjoying a rest. Faith works with her daughter to cook a special supper. Some neighbours come by and they all share food. The whole family takes supper at 9:00 p.m. and goes to bed at 10:00 p.m.

Step 3: Debrief the story:

Explain: The story, about a day in the life of Faith, is a simple one. It focuses on the social interactions Faith had during her Sunday. This could have been the story about any woman living in your community. Let us review Faith's day and the social interactions that she had.

- Write on the flip chart: 7:00 a.m.
- Ask participants: What social interaction did Faith have first thing in the morning? (Answer: She had breakfast with her family.)
- Write the answer on the flip chart next to the corresponding time. In this case, you could just write "breakfast with family".
- Review Faith's whole day like this, writing down the time and the corresponding social interaction. Reread parts of the story if needed to help participants remember.

Step 4: Summarise as follows:

- • Every day you interact with multiple people. Every social interaction is an opportunity for activism and to talk

about what you have learnt during these three days we have spent together. Remember that activism can be personal or public.

- • Ask participants: Please choose a day from the past week. Write out your day and its social interactions like we have done for Faith. Write down both formal and informal interactions, personal (with family) or public (with community members, school friends and others). For each social interaction, write down a way you could have used that social interaction for activism and to spread the information you have learnt. Take five minutes to do this independently.

Call "time is up, please stop" after five minutes have passed.

- Ask participants: Please turn to your neighbour to discuss your work. Explain your day and its opportunities for personal or public activism. Be specific. Work together to ensure you have named specific ways to take action for each social interaction. You will have 10 minutes for this discussion. After five minutes, I will tell you to switch roles and begin working on the other person's opportunities for everyday activism.
- Ask participants to begin. After five minutes ask participants to switch roles. When five minutes have passed call "stop"!

Step 5: Debrief the exercise, using the following questions as a guide:

- What did you learn from this exercise?
- What are some things you identified that you can do to teach other women what you have learnt?
- Did the exercise help you think differently about your day and your role as an activist? If so, how? If not, why not?
- What times of day or types of social interaction were the most challenging for identifying how to take action?

Step 6: Wrap up the session.

- Everyone can take action.
- Action comes in many forms. Activism does not have to always be a large or organised event. We can be activists in our everyday interactions and relationships. Every choice we make throughout a day allows us to live and demonstrate our beliefs.
- It is actually when our activism becomes part of our everyday life that we will begin to see social change.
- Everyone has the power to reach many people. The more people we reach out to, the more we will be able to effect social change.
- If each of you reach 10 people, and those people reach 10 people and those people reach 10 more, we will soon create a critical mass of people with knowledge and skills to prevent HIV.

WRAP UP

Thus far, we have learnt what a plan is, benefits of having a plan and features of a successful plan. We have used this knowledge to develop individual HIV risk reduction plans. Now is the time to make HIV risk reduction happen.

- Implement your plans.
- You may slip back, but do not abandon your plan.
- Be an advocate.
- Identify someone that you care about that you feel should have the same information.
- It is important to share what you have learnt and experienced. Doing so will help you to maintain your commitment.
- Identify people that you can inspire and motivate.
- Also, identify opportunities in community groups, churches and more to share what you have learnt.

Session Evaluation/Feedback

Before dismissing the participants, the IPC facilitator or any other person that led this session should take the following actions focusing on both participants and him/herself as follows:

WITH PARTICIPANTS:

Conduct an evaluation process, to solicit feedback from participants on which information they found:

- Most useful
- Least useful
- That they desire to have, but feel was missing

The facilitator shall use buzz groups or fully fledged group sessions where all groups shall respond to all questions and, as they present in plenary, he/she shall take notes. These notes shall form part of the activity report.

Forms for this evaluation can be found in **Appendix VI: Session Evaluation Guide**.

THE FACILITATOR ON HIS/HER OWN:

Complete a feedback form, summarising:

- Which topics/sessions he/she enjoyed facilitating and why
- Which topics he/she found difficult to facilitate on and why
- What specific topics he/she feels that he/she has adequate information on
- What specific topics or sessions she/he feels are redundant and need to be removed
- What specific new topics or sessions or information she/he feels need to be added and why
- What specific skills he/she feels that he/she lacks or needs strengthening and why

Forms for this evaluation can be found in **Appendix VII: Facilitator Feedback Form**.

CELEBRATION OF THE COMPLETION OF THE ENTIRE PROGRAM

Aim:

To celebrate the work the participants did.

Materials:

Certificates for each participant who attended all three modules.

Option 1:

This can be done fairly quickly as part of the third day – the day on which people develop individual action plans. In addition to the facilitator, key program staff, as well as community leaders and government officials, can be invited. Selected participants can give testimonies about how the training has changed them and what the commit to doing going forward.

Option 2:

Considering that the participants have been in the session for long enough already, it might be more convenient and have even greater impact to award the certificates during a community-wide event at chiefdom level. In that way, you would have graduates from among all the priority populations. Such an event might be in the form of or closely to a World AIDS Campaign event to which key program staff as well as community leaders and government officials are invited; and services (such as HTC) are offered on site. Selected participants can give testimonies about how the training has changed them and what they commit to doing going forward. There can also be cultural performances to underline the celebration.

Remember:

Each participant should be given the resources to keep their risk assessment form, individual risk reduction plan and the certificate together. Doing so will go a long way in helping them value the process that they went through and serve as a reminder to them of the commitments they had made in their individual risk reduction plans.

QUALITY IMPROVEMENT AND ACCOUNTABILITY

QUALITY IMPROVEMENT AND ACCOUNTABILITY

Introduction

For this tool to result in the intended impact, it is important to put in place a system for checking if the process and modules are implemented as designed and if the desired outcomes are being achieved in the quantity and quality expected. That system should embrace a culture of quality improvement (QI) and accountability. This section contains recommendations on the specific actions and processes, relevant to IPC sessions using this tool that can be taken to ensure QI and program accountability.

Definitions

Quality Improvement: A systematic process that involves collection of process data and using it to decide what to focus on more (and/or what to reduce focus on) to complete the process and get "the most of the best" of the desired results or outcomes; and how to achieve that with less time and other resources. It must be noted that QI is not an event. Rather, it is a continuous process. To emphasise this fact, some people prefer to refer to it as continuous quality improvement (CQI).

Accountability: Refers to the act(s) or processes aimed at demonstrating progress being made towards delivering on set commitments, in a transparent way that makes sure information is timely, available and accessible to all relevant stakeholders; and that information is collected systematically and used, beyond reporting obligations, to inform changes in implementation and design of similar projects in future. The key attributes of accountable program implementation include the following:

- Regular, timely and accessible information, including standardised tools, systematic process of collection and user-tailored packaging of the information.
- Monitoring, reporting and learning: regularly reviewing monitoring data to inform changes in implementation, and ensuring evaluation data informs future project design, thus building a culture of learning and continual improvement.
- Building staff and partner competencies for accountable programming, by ensuring that our staff have the technical and behavioural competencies to deliver our commitments to communities.

THE QI PROCESS

QI is an aspect of organisational culture. In relation to the use of this tool, the QI process shall involve the following activities/tasks:

- Periodically conduct a "process-audit" to ascertain the level of compliance by facilitators in the field, such as to ensure that the implementation process follows the sequence and time allocated.
- Periodically collect and analyse feedback from facilitators and participants in order to identifying redundant content, as well as opportunities for integrating new insights.

Tasks

1. **IPC Facilitators:** The IPC Facilitator shall, at the end of each module, take the following actions:
   - Conduct an evaluation process, to solicit feedback from participants on which information they found a) most useful, b) least useful and c) that they desire to have, but feel was missing. The facilitator shall use buzz groups or fully fledged group sessions where all groups shall respond to all questions and, as they present in plenary, he/she shall take notes. These notes shall form part of the activity report. Forms for this evaluation can be found in **Appendix VI: Session Evaluation Guide**.
   - Complete a feedback form, summarising: a) which topics/sessions he/she enjoyed facilitating and why, b) which topics he/she found difficult to facilitate on and why, c) what specific topics he/she feels that he/she has adequate information on, d) what specific topics or sessions she/he feels are redundant and need to be removed, e) what specific new topics or sessions or information she/he feels need to be added and why, and f) what specific skills he/she feels that he/she lacks or needs strengthening and why. Forms for this evaluation can be found in **Appendix VII: Facilitator Feedback Form**.
2. **Program Team Leader:** The officer responsible for defining and delivering program content, whatever the designation or title is, shall ensure the following:
   - Define a training curriculum and implement a capacity building session for IPC facilitators to ensure they understand the basis for targeting women, relevance of the core package and understanding on how to implement it, basics of social and behaviour change communication, facilitation skills and the key outcomes/ deliverables, such as how performance/success shall be measured.
   - Develop a clear plan for supportive supervision, complete with specific dates and locations. During the supportive supervision, conduct mentoring to IPCs and, thereafter, compile a specific report for each or all supportive supervisions conducted, highlighting strengths, weaknesses and corrective actions implemented or to be implemented, with clear timelines.
   - Compile a report, with clear findings and concrete recommendations, and, using the findings and recommendations, facilitate a discussion during a program review meeting where concrete actions, timelines and responsibilities are defined as to how to implement them.
3. **Central Office:** Shall set up a QI Team that will carry out the following tasks:
   - Periodically visit a sample of IPC sessions that, at that time, shall be using this tool to:
     - Assess if the facilitator follows the sequence and recommended time.
     - Observe the facilitator in action to ascertain his/her level of skills in a) facilitation skills and b) level of organisation, confidence and accuracy in presenting content
     - Interview the facilitator on topics that he/she considers a) redundant, b) inadequate or c) totally missing. For each, clear reasons/justification should be solicited.
     - Take a sample of participants to individually share the topics/information that they find/found a) more helpful, b) least helpful and c) missing. For each, clear reasons/justification should be solicited.
   - An on-site observation form to be used can be found in **Appendix X**.

ACCOUNTABILITY PROCESS

Like QI, program accountability is an aspect of organisational culture. More information on how to strengthen program accountability can be found here: http://usaidprojectstarter.org/content/monitoring-evaluating-and-learning-toolkit-pathways

In relation to the use of this discussion guide, accountability shall be ensured by undertaking the following actions:

- **Ensure Transparency:** Attendance information shall be collected using standard tools that show the age and sex/gender of participants and further include means for re-tracing the participants in case that need arises in future.
- **Maintain an up-to-date database:** All attendance information shall be submitted within five working days of conducting a session on each module. A copy of the attendance information for the first two sessions shall be submitted as a copy. The original shall be submitted after conducting the final session. (To the extent possible, the same people that started Module 1 should complete Modules 2 and 3. Interested participants that missed Module 1 should not be admitted to Modules 2 or 3. Instead a new group should be formed.) Such information shall be signed off by the person submitting it, signed off by the program staff assigned to review and certify records and stored by the monitoring and evaluation (M&E) team in hard copy, as well as in retrievable form electronically.
- **Using data for program improvement**: Participation in IPC session is a means to an end; it is not an end in itself. To assure yourself that you are "doing the right thing", participation in IPC sessions should lead to or correlate with the number of individuals linked or referred for services, especially HTC, ART, VMMC and PMTCT. Therefore, a special reporting form should be used to capture this information. An analysis of this information shall feed into program progress reviews, and strategies shall be revisited to strengthen this level of program outcomes.
- **Monitoring, evaluating and learning**: Every month, the M&E team shall analyse the data, summarise specific findings and make specific recommendations that shall be discussed at both management and program meetings, as well as make specific recommendations for program improvement. Management shall take concrete steps to ensure that implementation is adjusted accordingly.
- **Data Quality Assessment (DQA):** For USAID activities, adapt the DQA guidance. This shall be defined as a separate process, as part of routine monitoring. However, the DQA guidance, as defined by USAID, may be useful to the M&E process as a function, regardless of source of funding for the activity. Resources and guidance on DQA can be found here: http://usaidprojectstarter.org/content/conducting-data-quality-assessments
- **Develop staff capacity:** The M&E team should ensure that all program staff understand the basics of QI and program accountability. Additional effort shall be made to provide mentoring support to primary data collectors and reviewers at program level and, generally, cultivate interest in them for M&E (or QI and program accountability).

APPENDICES

ACTIVITY PARTICIPATION FORM

APPENDIX I

Name of person completing form:_____ Signature:_____ Title:_____ Cell:_____ Inkhundla:_____ Chiefdom:_____Priority Group:_____ Date:_____Session ____ of_____					**HIV Prevention Package Offered**						
No.	Name	Sex	DOB/Age	Cell #	Education on HIV	Condom Promotion/ Skills Training	Information on HTC	Service Uptake	Social & Gender Norms	Referral to Service	Participant Signature
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

ICE BREAKERS

APPENDIX II

Get to know your neighbour

1. Divide participants into pairs.
2. Ask each participant to introduce themselves to their partner and share three things about themselves. Give them about three minutes to do this.
3. Bring everyone back together to larger group and ask the participants to introduce their partner to everyone else and share one thing they learned about the person.

A Cold Wind Blows to…

1. Have all the participants arrange their chairs in a circle and sit down.
2. Stand in the middle of the circle and begin the game by saying, "A cold wind blows to whomever_____" (fill in whatever you want, such as is wearing a green shirt, has a son, plays soccer and so on).
3. Anyone who fits that description should then get up and change seats with another person who also stood up, including the person in the middle. One person will be left standing since the person in the middle did not have a chair.
4. The person left standing should make the next statement.

FIELD READINESS CHECKLIST

APPENDIX III

	Key Question *If there are more than one question, a "no" answer to any one question equals to a "no" in the box where you are required to "Tick Your Answer"; and a "no" means that you are not ready.*	Tick Your Answer	
		Yes	No
1	Do you understand your audience? Do you fully understand the key risks they face and the drivers of their behavioural choices? Have you read and do you understand the section in this tool entitled "Understanding Your Audience"?		
2	Do you agree with what has been recommended in this tool as "high impact" interventions to reduce the risk of HIV acquisition and/or transmission? For example, do you agree that the following are effective at reducing one's risk to HIV: condoma, HTC, ART, VMMC, PMTCT and partner reduction?		
3	Have you been trained on how to use this tool?		
4	Do you feel confident to facilitate a discussion, using this guide, without having to read every word and every sentence?		
5	Have you mobilised the right people of the required age? Do you know how many are likely to show up for your session?		
6	Did you involve the recognised coordination structures at community level such as community engagement group (CEG). Did the CEG meet and develop a plan that includes this activity? If yes, do you have a record/minutes of their meeting? If the mobilisation was done by the Interpersonal Communication Facilitator (IPCF), was he/she mandated by the CEG? For example, is there a community action plan on which his/her actions are based?		
7	Have you arranged an appropriate venue for the discussions? Have you visited and seen the space so you know it is adequate and suitable?		
8	Do you have the required materials, such as stationery, copies of the risk assessment tool, stories and others?		
9	Some participants might need referral to appropriate services. Do you have the MOH referral book? Have you been trained on how to do referrals? Have you built a relationship with the local health facility so that you can refer people there?		

THE STORY OF MAKE VILAKATI

APPENDIX IV

Make Vilakati is 34 years old. She is married according to the Swazi law and custom. Her husband, Ntokozo Vilakati, is 42 years old. They have been married for four years and they have two children together, a girl aged five and a boy aged three. In keeping with tradition, they own a house at Hlaleni, Ntokozo's parental home.

However, Ntokozo is a mine worker in South Africa. Consequently, he is away most of the year. Although he is away from home, he makes efforts to ensure that Make and the children are provided for. He regularly calls to check on them and sends money for upkeep. Occasionally, he also sends gifts either when friends and relations living in South Africa visit Swaziland or when friends and relations living in Swaziland visit South Africa. Despite the support that she receives, Make still finds that she must work and earn additional income to support the children. She currently has job as a factory worker at Malkerns, where she also rents a flat. Her mother-in-law takes care of the children. This compels her to visit her matrimonial home almost every weekend, to check on the children.

Pause. Go to Discussion Question Set 1.

One warm Thursday, in the third week of November, when Make was just about to take her lunch break, her mobile phone beeped and vibrated. She was not allowed to take private calls while on duty, so she rushed to the bathroom. The buzzing stopped just as she managed to fish the phone out from her bra, but not soon enough before registering a missed call. It was an unfamiliar South African number. She stood there aimlessly and hoped the caller would persist. Before long, the screen lit and the phone beeped and vibrated again. She quickly accepted the call. The voice on the other end was rather weary, but unmistakable. Finally, Ntokozo had called her. He apologised repeatedly for not calling for a long time. He explained that he had been taken ill and that he did not inform her in order not to alarm her and his parents. He assured her of his undying love for her and, after enquiring about everyone, he announced his vacation plans to visit Swaziland. After lunch that day, before resuming work, Make went straight to negotiate her leave plans with her supervisor, to make sure that she would be free from the demands of work when her love and father of her children, returned home.

One warm Saturday afternoon, in the second week of December, there was ululation and fanfare at the Vilakati homestead. Ntokozo had finally arrived home for his annual vacation. Soon the homestead was abuzz with neighbours, friends and extended family relations who came to see their son. The amount of cooking and cleaning to serve all the visitors that came made it appear like Make had merely changed her employers instead of taking leave from her paid job. By evening she was very tired.

Finally, on their own in their house that evening, with children deep asleep on Ntokozo's lap, Make and Ntokozo had time to themselves. She stood up and picked the children one by one and laid them side by side on a sleeper couch after which she deposited herself next to Ntokozo.

"It is a great joy to have you back home again". Make broke the silence, throwing her hands around him. "I missed you so", she choked with emotion and buried her head on his shoulders.

"I am happy to be home as well", Ntokozo muttered through his teeth. "Alive", he added. Then he told her how severe the illness was and how grateful he felt to be alive and well.

"I feel ashamed to say that after how much I ate during the day, I feel hungry again." Ntokozo changed the subject.

"I am hungry too", replied Make. "Would you like a hot beverage or juice?" She asked.

"Tea please", he replied. "With milk, rather, a tea bag in a hot cup of milk, if you like", he added

As they talked some more, updating each other, while sipping their tea, Make kept fighting back the urge to ask Ntokozo to explain a bit more about his illness, especially to know if he had bothered to check his HIV status. However, she could not take the risk this time around, because her questioning had landed her in trouble in the past. During one of his annual visits, in the year preceding the birth of her second child, Ntokozo was taking a bath and Make

busied herself with his phone as she waited for him. When she found some photos in which Ntokozo was captured in compromising positions with a woman, her instincts told her she was sharing her husband with someone. To her, this was merely confirmation of her fears. She had put back the phone and slipped into bed, armed with a pack of condoms under her pillow. That night, when Ntokozo tried to touch her, she introduced the condoms, a subject that earned her pinching in the thighs and a blinding slap in the face. She did not cry or retaliate, but, in protest, she went to sleep on the couch that night. She told him, she would not return to the matrimonial bed and make love without a condom with him, unless they go for HIV testing. This had upset Ntokozo a lot.

"I cannot waste my time and money to return to a wife that disrespects me", he charged. "OK. You have a choice to make, my mother's daughter", he said mockingly, before declaring: "either you-are-my-wife-and-you-will-do-it-as-I-please or you are out of here".

Make felt defenceless and overcome with fear of the shame she would face in the community for being chased away from marriage. Denying her husband his conjugal rights was sufficient reason for divorce. She followed him to bed and had sex with him, but in the evening of the following day a group of elderly women were organised to "sit her down".

Pause. Go to Discussion Question Set 2.

Ntokozo had been gone for three weeks before daily routines really came back to normal in the Vilakani household. Although Make had returned to work as well, she had decided to commute to work during the past three weeks following Ntokozo's departure. It was now time to clean up, pack and put away some things in her house. The weekend before her departure to Malkerns, she selected clothes that required washing, from stuff that did not, and returned her prized cutlery into storage boxes. She dusted cushions, changed pillow case covers and beddings, and cleaned every corner of the house.

Once back at Malkerns, she had a lot of time to herself in the evenings. She relived every moment she had spent with Ntokozo. She was grateful to have such a caring and loving husband.

One morning she woke up feeling sick. As she brushed her teeth, she vomited. It was like a light bulb had been switched on in her mind. She straightened up, looked herself up in the mirror and mischievously muttered: "Silly girl, you are pregnant again". She went through that day with a mixture of emotions. This is something she did not want to happen. In her reflection, the two children she gave to Ntokozo were enough. After all, both of them have two children each from their previous relationships. That makes six children. She agonised about having to feed all those mouths, keep them in school and give them a good education.

She fought back the thoughts of any possibility that Ntokozo was HIV positive. However, the more she did so, the greater her fears grew. Ntokozo had said he had been ill, and he looked sickly when he visited. What if he was HIV positive? What if she had been infected?

Pause. Go to Discussion Question Set 3.

Wrap Up

Make, and her husband live apart. Although circumstances will always create situations that result into long-distance relationships, such relationships create their own pressures. Some people manage the pressures better than others do. We have heard that Ntokozo was seeing other women while away from his wife. We have also heard that some women are so traumatised by intimate partner violence that their fear of violence is greater than their capability to make and implement the necessary choices that reduce their health risks. Further, we have seen how some women are more worried about pregnancy than by HIV. Why do you think this may be?

RISK ASSESSMENT TOOL FOR WOMEN

APPENDIX V

Complete this tool by putting a check or x in either the yes or no box for each question.

This is a private exercise for you to assess yourself, no one else will see your answers unless you want them to. Once you have completed this, turn it over and wait for the facilitator to explain what each answer means.

Question	Yes	No
Risk to all women of reproductive age		
1. Have you ever had sex without a condom?		
2. Have you ever had or do you currently have sex with more than one partner at the same time?		
3. Have you ever had anal sex?		
4. Have you ever had a sexually transmitted infection?		
5. Have you exchanged money, goods or favors for sex?		
6. Do you know your HIV status?		
7. Do you know the status of your past and current partners?		
8. Have you ever been forced to have sex or had sex against your will?		
For women who are pregnant or lactating – risk to your infant		
1. Did you deliver at the health facility?		
2. Did you attend ANC within the first trimester?		
3. Did you bring your child back for HIV testing/re-testing?		
4. Did you feed your child any other food apart from breast milk during its first six months of life?		
5. If you are HIV positive and pregnant or lactating, are you currently on ART?		
6. Have you had sex without a condom with someone whose status you did not know while pregnant or lactating?		

SESSION EVALUATION GUIDE

APPENDIX VI

This evaluation form should be completed by the facilitator each time she leads a session using this tool. The completed form should be handed in together with the Activity Participation Form.

The purpose of this evaluation process is to solicit information from participants so that we are better able to address their information needs to allow them make healthy choices. Therefore, ask the same question in different ways. This has already been integrated into the way the questions in the table below have been framed. Therefore do not be surprised if, in some cases, you get the same response for different questions.

Directions:

1. Form six groups. Use existing groups, if they exist. Do not let them disperse
2. Assign one question to each group.
3. Give the groups five minutes to agree on a maximum of three responses to the questions. Ask them to write down their responses.
4. In plenary, ask each group to share just their number one response to the question. Record their responses on the form, then collect their completed forms.
5. Pin all the forms together, with the summary that you compiled on top of the six forms from the group discussion
6. Submit the forms together with the Activity Participation Form and the Facilitator Feedback Form.

Participant Session Evaluation Form

Facilitator Name: _____

Location of Session: _____

Date: _____

Module Presented: _____

Question	Topics/Sessions	Reason, explain your answer
1. Which topics/sessions did you enjoy the most and why?		
2. Which information do you find most useful and why?		
3. Which topics did you find least enjoyable and why?		
4. Which topics did you find least useful and why?		
5. Which topics do you desire more information on and why?		
6. What other topics do you wish you had learned about in this session and, why?		

FACILITATOR FEEDBACK FORM

APPENDIX VII

Session 1: Understanding HIV Risk			
Checklist	**Yes/No**	**If No, Why**	**Additional Comments**
Were there any topics that you felt you did not have enough information or skills on to lead?			*If yes, please explain:*
Did you feel confident leading discussion on each topic in this session?			*If no, list the topics that you found hard to lead discussion on:*
Were you able to deliver the content in the suggested time?			*If no, briefly list the main constraints:*
Did you complete this session?			*If no, list the topic not covered here:*
Do you have specific suggestions on how to improve the content of this session?			*If yes, provide details here:*
Are they any specific sections your feel are redundant and could be removed?			*If yes, which sections:*
Are there any specific topics that you feel should be added to the session or that more time should be spent on?			*If yes, which sections:*
Your Name:	Sex:	Age:	Contact Phone No:

Session 2: Exploring Barriers to HIV Risk Reduction Strategies			
Checklist	**Yes/No**	**If No, Why**	**Additional Comments**
Were there any topics that you felt you did not have enough information or skills on to lead?			*If yes, please explain:*
Did you feel confident leading discussion on each topic in this session?			*If no, list the topics that you found hard to lead discussion on:*
Were you able to deliver the content in the suggested time?			*If no, briefly list the main constraints:*
Did you complete this session?			*If no, list the topic not covered here:*
Do you have specific suggestions on how to improve the content of this session?			*If yes, provide details here:*
Are they any specific sections your feel are redundant and could be removed?			*If yes, which sections:*
Are there any specific topics that you feel should be added to the session or that more time should be spent on?			*If yes, which sections:*
Your Name:	Sex:	Age:	Contact Phone No:

Session 3: Making HIV Risk Reduction Happen			
Checklist	**Yes/No**	**If No, Why**	**Additional Comments**
Were there any topics that you felt you did not have enough information or skills on to lead?			*If yes, please explain:*
Did you feel confident leading discussion on each topic in this session?			*If no, list the topics that you found hard to lead discussion on:*
Were you able to deliver the content in the suggested time?			*If no, briefly list the main constraints:*
Did you complete this session?			*If no, list the topic not covered here:*
Do you have specific suggestions on how to improve the content of this session?			*If yes, provide details here:*
Are they any specific sections your feel are redundant and could be removed?			*If yes, which sections:*
Are there any specific topics that you feel should be added to the session or that more time should be spent on?			*If yes, which sections:*
Your Name:	Sex:	Age:	Contact Phone No:

MODULE 2 DISCUSSION GROUP QUESTIONS

APPENDIX VII

HIV Testing and Counselling (HTC)

In Module 1, we learnt that HTC informs healthy decisions and also provides a gateway to core HIV prevention services. In your group, discuss the following questions and prepare to present back to the plenary.

- Choose two members to present, one on the factors that help women go for HTC and one to present on the factors that may prevent women from going.
- Develop a short skit to demonstrate the factors that help, as well as those that impede going for HTC.

1. Discuss the factors that make it easier for women to go for HTC. What can be done to promote these factors?
2. Discuss the factors that make it difficult for women to go for HTC? What can be done to address these difficulties?
3. Specify one or two things that you think make it easier for women to voluntarily go for HTC. Be sure to consider:
   - Internal forces, such as feeling vulnerable, reflection on some event or circumstance.
   - External forces, such as service providers, family or friends.
4. Specify one or two things that you think make it extremely difficult for women to voluntarily go for HTC. Be sure to consider:
   - Internal forces, such as fear, shame, guilt, pride or a sense of safety.
   - External forces, such as access and quality of services (cost, distance, confidentiality, long queues/waiting).
5. With the exception of compulsory HTC, if there was one thing (or two) that would help get all women to go for HTC, what would you recommend?

Condoms

In Module 1, we learnt that condoms provide protection from pregnancy, STIs and HIV, and that condoms are most effective when used correctly and consistently. In your group, discuss the following questions and prepare to present back to the plenary.

- Choose two members to present, one on the factors that help and encourage women to use condoms and one to present on the factors that may prevent women from using condoms.
- Develop a short skit to demonstrate the factors that help, as well as those that impede condom use.

1. What factors make it easier for women to use a condom correctly and consistently?
2. What factors make it difficult for women to use a condom correctly and consistently?
3. Specify one or two things that you think make it easier for women to use condoms correctly and consistently. Be sure to consider:
   - Internal forces, such as feeling vulnerable or fearing to infect a partner.
   - External forces, such as friends, service providers or family.
4. Specify one or two things that you think make it extremely difficult for women to use condoms correctly and consistently. Be sure to consider:
   - Internal forces, such as trust/sense of safety, fear of being accused of infidelity, ashamed to suggest condom use or religious beliefs.
   - External forces, such as friends/peers, access (like availability and cost).

5. If there was one thing (or two) that would help get women to use condoms correctly and consistently, what would you recommend?

Anti-Retroviral Treatment/Therapy (ART)

In Module 1, we learnt that, if a person is HIV positive, ART slows down the multiplication of HIV in their body and keeps it at a low level, allowing them to stay healthy. We also learnt that people who adhere to ART become less vulnerable to opportunistic infections, thereby reducing the likelihood of HIV progressing to AIDS. A person with a low viral load is less likely to pass HIV to their sexual partner than someone with a high viral load. In your group, discuss the following questions and prepare to present back to the plenary.

- Choose two members to present, one on the factors that help women adhere to ART and one to present on the factors that may prevent women from adhering.
- Develop a short skit to demonstrate the factors that help, as well as those that impede ART adherence.

1. What factors make it easier for women to accept, enrol and adhere to ART?
2. What factors make it difficult for women to accept, enrol and adhere to ART?
3. Specify one or two things that you think make it easier for women to accept, enrol and adhere to ART. Be sure to consider:
   - Internal forces, such as knowledge about HIV.
   - External forces, such as volunteers, friends or family.
4. Specify one or two things that you think make it extremely difficult for women to accept, enrol and adhere to ART. Be sure to consider:
   - Internal forces, such as fear, shame or guilt.
   - External forces, such as traditional and religious beliefs. Be specific which ones.
5. If there was one thing (or two) that would help get more HIV-positive women to accept, enrol and adhere to ART, what would you recommend?

Partner Reduction

In Module 1, we learnt that having multiple sexual partners connects you to a sexual network that increases your risk of HIV acquisition, compared to if you have only one sexual partner. Women that are in multiple and concurrent sexual partnerships can reduce their risk of HIV by reducing the number of partners they have, testing for HIV and supporting those in their immediate sexual network to do the same, and using a condom. In your group, discuss the following questions and prepare to present back to the plenary.

- Choose two members to present, one on the factors that help women in reducing their number of partners or only having one partner, and one to present on the factors that may prevent a woman from reducing her partners.
- Develop a short skit to demonstrate the factors that help as well as those that impede partner reduction.

1. What factors make it easier for women to reduce their number of sexual partners?
2. What factors make it difficult for women to reduce their number of sexual partners?
3. Specify one or two things that you think make it easier for women to reduce their number of sexual partners. Be sure to consider:
   - Internal forces, such as desire to be faithful.
   - External forces, such as peers.
4. Specify one or two things that you think make it extremely difficult for women to reduce their number of

sexual partners. Be sure to consider:

- Internal forces, such as feel as though partner is cheating too or revenge.
- External forces, such as peers or social norms.

5. If there was one thing (or two) that would help get women to reduce their number of sexual partners, what would you recommend?

Prevention of Mother-to-Child Transmission of HIV (PMTCT)

In Module 1, we learnt that PMTCT reduces the risk of HIV-positive pregnant and lactating women passing HIV to their babies. Condoms should also be used correctly and consistently during pregnancy and breastfeeding. Babies and young children should be brought to a health facility according to schedule so that their health and growth are monitored and they receive the appropriate services. In your group, discuss the following questions and prepare to present back to the plenary.

- Choose two members to present, one on the factors that help pregnant women to participate in PMTCT and one to present on the factors that may prevent a woman from being part of PMTCT.
- Develop a short skit to demonstrate the factors that help as well as those that impede being a part of and supporting PMTCT.

1. What factors make it easier for women to accept and participate in PMTCT?
2. What factors make it difficult for women to accept, support and participate in PMTCT?
3. Specify one or two things that you think make it easier for women to accept and participate in PMTCT. Probe:
   - Internal forces, such as they want to ensure baby is healthy.
   - External forces, such as family members or community acceptance.
4. Specify one or two things that you think make it difficult for women to accept and participate in PMTCT. Probe:
   - Internal forces, such as afraid to test for HIV or are not aware of the importance.
   - External forces, such as family members or stigma.
5. If there was one thing (or two) that would help get women to accept and participate in PMTCT, what would you recommend?

Reduction of Gender-Based Violence

In Module 1, we learnt that reduction of GBV can help to reduce a woman's risk for HIV. In your group, discuss the following questions and prepare to present back to the plenary.

- Choose two members to present, one on the factors that help women avoid and identify situations that may lead to violence and one to present on the factors that may hinder reduction in GBV, or possibly even increase it.
- Develop a short skit to demonstrate the factors that help as well as those that impede avoidance and reduction of GBV.

1. Discuss the factors that play a role in avoiding and reducing GBV. What can be done to promote these factors?

2. Discuss the factors that make it difficult to avoid and decrease GBV. What can be done to address these difficulties?
3. Specify one or two things that you think make it easier for women to speak up and report GBV. Be sure to consider:
   - Internal forces, such as feeling vulnerable or learnt behaviours.
   - External forces, such as cultural and social norms.
4. Specify one or two things that you think make it extremely difficult for women to work to reduce or remove themselves from violent relationships GBV. Be sure to consider:
   - Internal forces, such as fear, shame, guilt, pride or a sense of safety
   - External forces, such as cultural and social norms
5. If there was one thing (or two) that women could do today to reduce GBV and protect themselves, what would you recommend?

QUIZ SCORE SHEET

APPENDIX IX

Question	Team 1		Team 2	
	Gain	Loss	Gain	Loss
HTC				
1				
2				
Condom				
3				
4				
VMMC				
5				
ART				
6				
7				
8				
PMTCT				
9				
10				
11				
GBV				
12				
13				
Partner Reduction				
14				
Totals (Gain/ Loss)				
Net (Gain/ Loss				
TOTAL SCORE				

ACTION PLANNING TOOL

APPENDIX X

Plan Owner			
Plan Title			
Goal			
Desired Outcome			
Action	**Timeframe**	**Risks & Assumptions**	**Risk Mitigation Measures**

SITE OBSERVATION FORM

APPENDIX XI

This form should be completed both during supportive supervision and QI missions to the field.

Directions:

- Be orderly: if the supervision or QI team is comprised of more than one person, agree who is the team lead for the visit. Each member of the supervisory team should fill a separate form.
- Talk less, listen more: observe and make an opinion based on what you see and hear. Remember that you are only a visitor. It is important not to interrupt the facilitator while in the process of leading a discussion. Interrupting can demoralise the facilitator and also undermine the confidence of participants in her/him.
- If you are a team, act as a team: share and discuss your individual observations before providing feedback to the facilitator. During the feedback session with the facilitator, only one person should engage with the facilitator at a time. Other members of the team should speak only if it is absolutely necessary. Alternatively, agree as a team who shall give feedback on what topic, and take turns.
- Provide encouragement: negative feedback has to be given tactfully lest it be perceived as criticism or a lack of appreciation. Therefore:
  - » Always appreciate the facilitator for her/his time and commitment. This shall sound genuine only if the feedback session is conducted in an orderly and respectful manner, as recommended above.
  - » Do not overload the facilitator with negative feedback. If you observe too many gaps, just pick out a few key ones and take up the matter as more of a management issue and try to intervene at that level.

1. People (Participants): the sessions involved the right target group, such as age and sex/gender. **YES/NO**

If no, explain exactly what the mismatch is: _____
_____

2. Facilitator: the facilitator is effective

- The facilitator follows the sequence and recommended time. **YES/NO**
- The facilitator is knowledgeable in the topic he/she is facilitating. **YES/NO**
- The facilitator is organised, for example, readily finds the page where he/she is facilitating, has printed storylines, all necessary materials (such as demo-penis and condoms) handy, and HTC/other services available onsite. **YES/NO**
- Facilitator manages time, arrives on time and spends the right amount of time on the session. **YES/NO**
- Spends the appropriate amount of time on important topics, does not give too much time to less important discussions and releases participants on time. **YES/NO**

Overall rating out of 5 = _____/5

Give a brief statement for the overall rating awarded: _____
_____
_____

3. Location: Is the session being conducted in a conducive environment?

- The place is away from distractions, such as noise from passers-by or noisy traffic.
- Participants are in a comfortable seating arrangement.

- There are appropriate, clean bathroom facilities on-site.
- There is enough space for everyone to comfortably move around.
- There is a sense of privacy so that participants can feel comfortable in sharing personal stories.

Overall rating out of 5 = _____/5

Give a brief statement for the overall rating awarded _____ _____
_____

4. Interview the facilitator on topics that he/she considers a) redundant, b) inadequate or c) totally missing. For each, clear reasons/justification should be solicited. Be sure to record the answers.

5. Take a sample of participants, talk to them individually and record their responses. Please note that the information required is about "participant perception" and in "comparative mood". Therefore, do not leave blank spaces, make sure to press for an answer. If that cannot be done, this cannot be done, it is as good as not doing this process altogether. Example questions are below.

- Did you feel comfortable speaking with the facilitator about concerns you may have or asking for further explanation if you did not understand something?
- Was the facilitator available for questions and to speak with participants one on one if they wanted?
- Do you feel like you learned from the facilitator?
- What did the facilitator do well?
- What could the facilitator improve on?

Provide overall feedback to the facilitator:

- Positive feedback.
- Areas requiring improvement. DO NOT REPRIMAND.
- Ask the facilitator what specific support he/she requires from other team members.

Ask the facilitator specific questions as listed in the table below. Record the answers in the table.

Question	Topics/Sessions	Reason, explain your answer
Which topics/sessions did you enjoy facilitating and why?		
Which topics did you find difficult to facilitate on and why?		
What specific topics did you feel that you have adequate information on?		
What specific topics or sessions do you feel are redundant and need to be removed and why?		
What specific new topics or sessions or information do you feel need to be added and why?		
What specific skills do you feel that you lack or need strengthening and why?		