

Reducing HIV/AIDS Vulnerability Among Students in the School Setting

A Teacher Training Manual

United Nations Educational,
Scientific and Cultural Organization
UNESCO Bangkok



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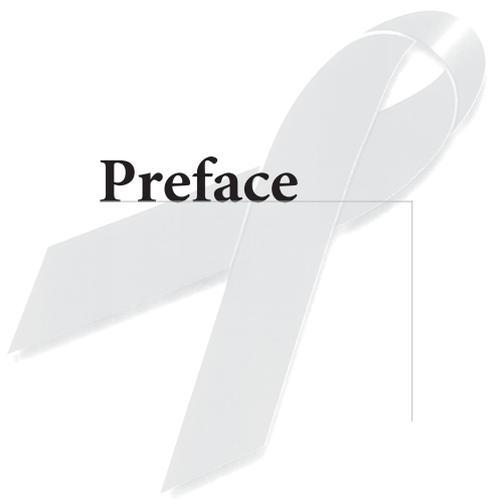
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Preface

While many teaching-learning materials on HIV/AIDS have been produced by government and non-government organizations over the past two decades, there is a need to develop strategies and methods for effective delivery of these materials and, towards that end, to train teachers, teacher educators, health educators, and curriculum developers to function as a team. Competence to use teaching-learning methods depends on one's own understanding of HIV/AIDS prevention.

The UNESCO Asia-Pacific Programme of Education for All (APPEAL) sought to develop this Training of Teachers (TOT) manual with the Southeast Asian Ministries of Education Organisation's Regional Network in Tropical Medicine and Public Health (SEAMEO-TROPMED) under the project, *Quality Improvement of the Curriculum and Teaching-Learning Materials on Prevention of HIV/AIDS and Drug Abuse in Asia and the Pacific*, funded by UNESCO and Japanese Fund-in-Trust (JFIT). The draft manual was presented at a regional experts' meeting in 1998. The manual was then pilot-tested and evaluated at a regional workshop in the Philippines in 1999. The result was a generic manual that could be adapted, translated and modified to suit the needs of individual countries, given their diversity in cultural and social environments.

During 2000-2002, the generic manual was adapted, translated and used in teacher training colleges in various countries, including Cambodia (Khmer), China (Mandarin), Indonesia (Bahasa Indonesia), India (Hindi and Maharathi), Lao PDR (Lao), Malaysia (Bahasa Malaysia), Mongolia (Mongolian), Pakistan (Urdu), Sri Lanka (Sinhala), Thailand (Thai), Viet Nam (Vietnamese), and Uzbekistan (Uzbek).

In 2003, the generic manual was evaluated and, based on the recommendations, follow-up action was taken to further improve it. Feedback from the field indicated that a stronger focus on sex education, life skills and more participatory learning-teaching methods was needed. Within the UN family, it was felt that a stronger integration of UNESCO's prevention education, UNICEF's life skills and UNFPA's sex and reproductive health approaches vis a vis the Ministry of Education would be essential for successful implementation. Therefore, a new project on *Strengthening and Expanding the Provision of HIV/AIDS Life Skills and Prevention Education in Pre-service Teacher Training Colleges in 12 Asian Countries* was begun, again funded by JFIT.

During 2004-2005, a full time HIV/AIDS prevention education and school health specialist provided regular technical assistance, advocacy and monitoring visits to targeted countries (Afghanistan, Bangladesh, Cambodia, Kazakhstan, Lao PDR, Malaysia, Nepal and Pakistan, China, Indonesia, Thailand and Viet Nam) in order to help improve and expand the use of the manual and complementary teaching-learning materials. The specialist worked in close collaboration with UNICEF and UNFPA. Technical assistance was also provided to officials dealing with teacher training and school curriculum in the Ministries of Education, the Ministries of Health and other UN agencies.

During the same period of time, the manual was updated and improved. Additional topics were added, such as the basics of growing up (understanding of adolescence); HIV/AIDS and drug abuse; HIV/AIDS and human rights; and care and support of people living with HIV/AIDS. In September 2004, the updated teacher training manual was reviewed at a regional expert meeting in Pattaya, Thailand. Many comments and suggestions were made that are incorporated in the latest version, *Reducing HIV/AIDS Vulnerability Among Students in the School Setting: A Teacher Training Manual*.

I would like to thank all those who were associated in improving and revising the manual.

I sincerely wish that, with the support of UNAIDS, UNICEF and UNFPA, this teacher training manual will make a difference in our continued attempts to provide high-quality HIV prevention education to all young people in the Asia-Pacific region.



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Reducing HIV/AIDS Vulnerability Among Students in the School Setting: A Teacher Training Manual was produced through a process of consultations, meetings with Ministries of Education and other related Ministries in the East and South-East Asia region, and a peer review workshop organized by UNESCO Bangkok.

Key contributors to review, update and finalize the manual were Arun K. Mallik and Jan W. de Lind van Wijngaarden of the HIV/AIDS Coordination and School Health Unit, UNESCO Asia and Pacific Regional Bureau for Education.

Other contributors were Bharat Pant, a free-lance life skills expert, Shankar Chowdhury of UNESCO New Delhi; Sandra B. Tempongko of the SEAMEO-TROPED Network, Bangkok; Amitava Mukherjee of UNESCAP Bangkok; Greg Carl of UNICEF East Asia and the Pacific Regional Office; Chaiyos Kunanusont, UNFPA/CST for East and South-East Asia; Swarup Sarkar, UNAIDS Regional Support Team, Asia and the Pacific; and Caroline Haddad of UNESCO Bangkok, who edited the manual. I would like to thank each one of them for their contribution.

Thanks go to the HIV/AIDS and school health focal points in the Ministries of Education, Ministries of Health, National Commissions for UNESCO, and UNESCO cluster/country offices in the Asia-Pacific region, especially those delegates from 13 countries (Afghanistan, Bangladesh, Cambodia, Kazakhstan, Lao PDR, Malaysia, Nepal and Pakistan, China, Indonesia, Iran, Thailand and Viet Nam) who participated in and contributed to the peer review workshop that was held in Pattaya during September 2004.

UNAIDS (Regional Support and Country Offices), UNICEF (Regional and Country Offices), and UNFPA (Regional and Country Offices) also deserve recognition for their collaboration and support in identifying the country-specific needs for HIV/AIDS prevention education teacher training.

Thanks are due to the Japanese-Funds-in-Trust, Government of Japan, for its ongoing support of UNESCO's teacher training projects.

Finally, thanks goes to the HIV/AIDS Coordination and School Health Unit team and other sector staff (Education, Culture, Social and Human Sciences and Publication Services) within the UNESCO Bangkok office for helping to finalize this document.

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community-based organization
DOTS	Directly Observed Therapy Short Course
ESAR	Eastern and Southern Africa Region
EFA	Education for All
FAWE	Forum for African Women Educationalists
FGM	Female genital mutilation
FRESH	Focusing Resources on Effective School Health
FSW	Female sex worker
HIV	Human immunodeficiency virus
IDU	Injecting drug users
INGO	International Non-governmental Organization
KAVSP	Knowledge and development of attitudes, values, skills and practices
LSD	Lysergic acid diethyl amide
LSE	Life Skills Education
PID	Pelvic Inflammatory Disease
PLWHA	Person living with HIV infection or AIDS
RTI	Reproductive tract infection
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TOT	Training of Teachers/Trainers
MSM	Men who have sex with men
MMT	Methadone maintenance treatment
MTCT	Mother to child transmission
NGO	Non-government organization
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA:	United Nations Population Fund
UNICEF	United Nations Children's Fund
UTI	Urinary tract infection
WHO	World Health Organization

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Introduction to the Manual

Introduction

The success of any HIV/AIDS Prevention Education programme depends largely on the knowledge, attitudes, values, skills and commitment of its major implementers – classroom teachers. Resource materials and activities may be omitted or modified to make them relevant to social norms and contexts, cultural practices or religious convictions in particular countries, areas or groups of people. As needed, alternative relevant materials/activities should be used.

Point of View

This manual is developed recognizing the principle of learning and teaching by doing. This is embodied in the Active Learning Credo stated by Silberman (1996):

What I hear, I forget.

What I hear and see, I remember a little.

What I hear, see and discuss, I begin to understand.

What I hear, see, discuss and do, I acquire knowledge and skill.

What I teach to another, I master.

Goal & Objectives

The ultimate goal of this manual is to train teacher educators in HIV/AIDS prevention and care. It is believed that effective education can contribute to the prevention and control of HIV/AIDS; this manual acts as an important tool for achieving this effectiveness.

More specifically, this manual aims to:

- ▶ help teachers analyze basic information, core messages, values and practices related to HIV/AIDS prevention education
- ▶ help teachers prepare teaching-learning plans, develop materials and devise assessment tools
- ▶ inculcate a caring and supportive attitude towards people living with HIV/AIDS (PLWHA)
- ▶ integrate HIV/AIDS prevention education in teacher training colleges in countries of this region
- ▶ sharpen teacher's skills in using life skills techniques and learner-centred activities and
- ▶ integrate HIV/AIDS prevention and care education with the use of school curriculum

Development of the Manual

Principles followed in developing this manual were:

- ▶ Begin by clearly identifying the goals and objectives that teachers are expected to achieve based on selected HIV/AIDS and STIs content.
- ▶ Choose the methods, activities and media for use in the manual.
- ▶ Develop assessment tools to attain the objectives.
- ▶ Write the modules and evaluate them.
- ▶ Revise the manual based on the evaluation data.
- ▶ Target trainees who are teachers.

The Target Trainees

The manual for the training of teachers both at pre-service and in-service levels.

It can be used by itself or adapted to suit the needs of the teachers who are teaching in government and private schools.

Content

This manual consists of eleven modules. In totality, it contains the basic facts and information needed for the acquisition of knowledge and development of attitudes, values, skills and practices (KAVSP) related to the prevention and control of HIV/AIDS. These modules emphasize knowledge, life skills and attitudes for HIV/AIDS/STIs prevention and care through perceptual understanding, deliberations, and exercises. The content and training procedures focus on providing knowledge and life skills, and shaping attitudes on HIV/AIDS/STIs.

Specifically, the life skills on HIV/AIDS/STIs include:

- ▶ building awareness on HIV/AIDS and STIs
- ▶ identifying sexual health – healthy and unhealthy sexual behaviors, risky behaviors or perceptions, sexual intercourse
- ▶ practicing safe sex, use of condoms, having faithful partners, say ‘No’ to unsafe sex
- ▶ changing sexual behavior to reduce risks
- ▶ preventing illicit drug /substance use
- ▶ avoiding consequences of risk-coercive behaviors
- ▶ managing stress and risks that may come during adolescence, like early marriage, premarital sex, unsafe sex and unplanned pregnancy
- ▶ communicating problems and feelings to parents, family members, and peers
- ▶ building self-esteem and providing empathy to PLWHA
- ▶ developing interpersonal skills involving expression of feelings, as well as giving and receiving feedback
- ▶ analysing the attitudes and values within community social norms/beliefs, cooperation and team work.



The contents are presented in the following modules:

- Module 1 : Basics of Growing Up – Understanding Adolescence
- Module 2 : Unplanned Pregnancy and Sexually Transmitted Infections (STIs)
- Module 3 : Basic Facts about HIV/AIDS
- Module 4 : The HIV/AIDS Epidemic and its Impact
- Module 5 : HIV/AIDS, Drugs and Substance Abuse
- Module 6 : HIV/AIDS and Human Rights
- Module 7 : Care and Support for People Living with HIV/AIDS (PLWHA)
- Module 8 : Community Involvement in Combating HIV/AIDS
- Module 9 : Integration of HIV/AIDS Prevention Education within the Curriculum
- Module 10 : Learner-centred Strategies and Life Skills Techniques
- Module 11 : Assessment tools for Use in HIV/AIDS Prevention Education in School

Methods & Activities

The selection of methods, activities and media is based on the objectives, contents and assessment of the training programme. Factors to be considered when planning the activities include abilities, time, materials and facilities, but the most important among these are the objectives and the learning outcomes. The types of activities will also help attain those outcomes.

The methods should focus around active and participatory learning. This means relating knowledge to the needs of the learner. It is teaching how to learn, make decisions based on how the learner feels and what to do. Related to this is anticipatory learning, where learners do things for the present and for future purposes.

Participatory and active learning are used in the training activities. Learning is participatory and active when learners do most of the activities. They analyse, study ideas, solve problems and apply what they learn. Active learning is fast-paced, fun, and personally engaging.

Learning is not pouring information into the learner's head. There is a lot more to teaching than telling. Learning requires the learner's own mental involvement and doing things. Merely hearing something and seeing it is not enough to learn it. Learning involves processing of the information received.

Teaching is less about the content than how the students learn the content. **Cooperative learning** is a group approach to learning with common objectives, mutual rewards, shared resources and complementary roles. Group members help each other to master the lesson or activity.

A variety of learning activities and media is the spice of good teaching. Media are the means of presenting the activities. Examples of media are boards, books, video, slides, flipcharts, posters, and computers. Examples of **do activities** are:

- | | |
|----------------------|---------------------|
| 1. Learning partners | 6. Panel discussion |
| 2. Brainstorming | 7. Role plays |
| 3. Games/simulations | 8. Projects |
| 4. Group activities | 9. Surveys |
| 5. Case studies | 10. Interviews |

Module

The content of this manual is presented as modules which are used to engage the teachers in an intellectual activity that makes them try out ideas, reflect, and apply critical judgment to what is being studied. The content is selected with the purpose of providing knowledge and developing life skills and attitudes that can help learners take responsibility and demonstrate healthier behaviours. Precisely, these modules aim to teach them to make decisions about how they feel and about what to do. The module is composed of the following parts:

- ▶ Number and Title
- ▶ Lesson Time Requirement
- ▶ Module Message
- ▶ Overview
- ▶ Objectives
- ▶ Content Outline
- ▶ Learning Activities
- ▶ Evaluation and Feedback
- ▶ Facilitator Notes
- ▶ References

Evaluation and Revision

The draft of the training of teacher's (TOT) Manual was reviewed, evaluated and revised during the Regional Training Workshop on Prevention Education Against AIDS in the Philippines last 18-23 October 1996. The purpose was to improve the TOT manual. As a trainer, there are some common terms which you may want to clarify regarding evaluation. Evaluation becomes relatively easy if the objectives are so stated in behavioural terms.

Outcome evaluation refers to evaluation which is used to measure specific behavior. Examples of outcome evaluation are:

- ▶ **Knowledge tests** which can be administered before and after instruction to identify increase in knowledge.
- ▶ **Attitude scales or inventories** which can be used to indicate change in attitudes.
- ▶ **Tests of skills** which can be used to determine the effects of instruction on the ability to perform certain behavior.
- ▶ **Self-report behavior inventories** which can be used to find out if the instructions have an impact on the behavior of the learner.

Process evaluation involves an evaluation designed to document whether programme procedures are conducted according to written programme development plans, and the techniques differ somewhat from those used for outcome evaluation. Questionnaires or interviews are used to get feedback from the learner regarding the components of the programme. In this way, problems with the objectives, content, strategies or materials can be identified. Thus, true to its name, this type of evaluation focuses on improving the educational *process*.

Formative evaluation is a method of judging the worth of a programme while the programme activities are forming or happening. Formative evaluation also focuses on the *process*. It can be involved at the beginning of the programme, such as a



needs assessment, to inform development of the programme, or can be used in the midst of the programme with the intention of using data to make changes in the programme during its implementation.

Summative Evaluation is a method of judging the worth of a programme at the end of programme activities. The focus is on the *outcome*. The summative evaluation is conducted at the completion of the programme in order to determine its effectiveness in achieving the objectives. In this case, one can use **impact evaluation** or **effectiveness evaluation**. All forms of evaluation are important in the revision of the programme. Sometimes it is necessary to immediately introduce change in the programme to make it responsive to the participant's needs and expectations. Often the programme is revised after its completion to make it more effective for the next group of participants.

Adaptation of the Manual

In planning to adapt the Manual, it is important to consider the country's socio-economic and political environment; culture and tradition; and legislation and policy for the training of teachers.

Specifically, the following phases should be considered for the adaptation of the manual:

- ▶ Needs assessment
- ▶ Adaptation of the modules
- ▶ Translation of the modules
- ▶ Validation of the modules
- ▶ Design of the training activities
- ▶ Linking and networking with cooperating agencies
- ▶ Continuity and sustainability of the programme
- ▶ Budgetary requirements

Furthermore, the programme plan should be presented to the appropriate government agencies to get their approval, support and commitment. These agencies should be encouraged to designate persons who will be in-charge of the programme.

This manual is presented in two parts: the techniques for using the manual and the different training modules. The module on *'How to Use the Manual'* is divided into two sections "Roles and Responsibilities of the Trainers" and "Skills that the Trainers Should Demonstrate when Conduction Training."



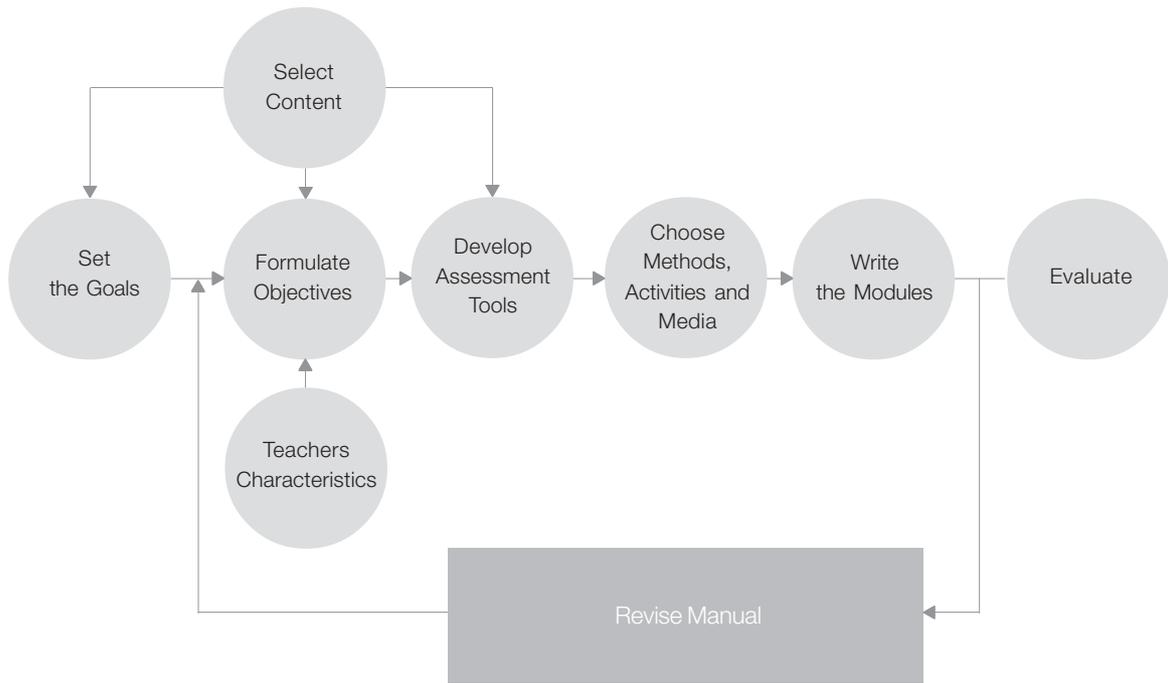


Figure 1. *Design Process in the Development of the Training Manual*

PART ONE

How to Use the Manual

Introduction

'How to Use the Manual' is divided into two sections.

- 1) Roles and Responsibilities of the Trainers
- 2) Skills that Trainers Should Demonstrate when Conducting Training.

Roles and Responsibilities of the Trainers

The roles and responsibilities of the trainers are focused on the planning, organization, implementation, monitoring and evaluation of the training activities. Specifically, the roles and responsibilities of the trainers are to do the following:

- ▶ Formulate the criteria for the selection of the participants
- ▶ Study the training modules, paying particular attention to the objectives and assessment; content and activities; and notes for the facilitator
- ▶ Prepare needed materials and plan for equipment needed in the training
- ▶ Demonstrate varied methods and activities
- ▶ Use the Training Modules as a ready reference and guide
- ▶ Plan the follow-up and evaluation of the training

A "Suggested Training Schedule of Activities" is presented in **Annex A**. The trainers may design their own schedule of activities based on the training objectives and the training policy or scheme of the country. Furthermore, the pre-test "*HIV-AIDS Self-Report*" should be given together with the Registration Form (see **Annex B**). Ask the teachers to finish with these two documents before the Opening Programme. Keep the Opening Programme short.

Prepare the **orientation** and conduct the training activities, which may include the following:

- ▶ Clarifying the goal and objectives of the training;
- ▶ Stressing the need to come **on time** to the training;
- ▶ Identifying the venue/s for the various training activities;
- ▶ Getting to know the teachers and their **expectations** from the training (see **Annex C**);
- ▶ Conducting a mini-demonstration lesson (see **Annex D**);
- ▶ Introducing the Lesson Observation Form (see **Annex E**);
- ▶ Grouping of participants who will study and present the modules and demonstrate the activities (see **Tables 1** and **2**);
- ▶ Collecting data for revision of the modules;
- ▶ Collecting the sample lesson plans;

- ▶ Administering the HIV/AIDS Self-Report (Post-test) and Training Evaluation (see **Annex F**);
- ▶ Introducing the Registration Form (see **Annex G**);
- ▶ Making the **Closing Programme** simple and participatory;
- ▶ Preparing the Certificate of Participation and identifying who will get it based on daily **attendance**; and
- ▶ Preparing the daily attendance form and requesting the participants to sign every session they attend.

The Skills of Trainers

As a trainer you should be able to demonstrate the following:

▶ Developing and supporting a sense of group spirit

It is important that, as a facilitator, you build and maintain the group's identity by establishing an atmosphere of mutual trust and respect. This means that the training environment will be warm and allow participants to express their views, opinions, concerns, attitudes and behaviours freely. Your behaviour will greatly influence the learning environment. Let the participants experience your enthusiasm, friendliness, interest, sincerity, acceptance and support. In order to support the group spirit throughout the training programme, you will be required to do the following:

1. Encourage the participants to share some information about themselves with the group.
2. Let the participants establish a set of rules of conduct that can be used throughout the training.
3. Support and provide positive, constructive feedback to the participants.
4. Build and maintain a sense of belonging among participants.
5. Express the need for confidentiality within the group. It is important for the participants to feel that what they say will not be used against them outside of the training session.
6. Let each person participate at his/her own pace. Encourage participants to express themselves but do not push those who need time to be comfortable with the group or working environment.
7. Respond to criticism openly and make every attempt to obtain an agreement of all parties involved. Explaining why something has been done in a particular way will often be enough to settle any concern.
8. Recall the group's suggestions, responses, feelings or questions. Previous knowledge or curiosity can be used as a starting point for subsequent learning.
9. Be sensitive to the needs of the group. Every group will have a unique collective personality with different assets and needs.





► Ensuring that the intended content is covered

It is important to ensure that all the materials of the training modules are covered. This is essential in order to develop the necessary base in the HIV/AIDS/STIs prevention and care that participants will require to become good facilitators. In order for the group to stay focused on the task, you will need to:

1. Go through the modules and the details of the activity. You have to make an assessment of entire activities and their feasibility to apply during the training. Though you can modify the learning activities, you have to make sure that the content is fully covered. You have to follow the *Facilitator Notes* and evaluate the knowledge, skills, values and attitudes by observing the activities: group work, presentations, questions-answers, and home work.
2. Link each new topic with previous topics and with real-life examples. This will make sessions more interesting and help develop a better understanding of the topic, rather than an accumulation of isolated facts.
3. Ask questions that encourage thought of the task at hand. Avoid questions that seek 'yes/no' answers.
4. Give clear, specific instructions for all activities.
5. Focus on important issues and avoid confusion about expectations.
6. Make sure that the training procedure, such as question – answer exercises, discussion and group exercises, and evaluation emphasize on building knowledge, life skills, values, attitudes and behaviour so that the participants learn and develop their ability to educate about HIV/AIDS/STIs.
7. Keep their focus on content. Conclude sessions by restating the session's theme and by integrating the suggestions and ideas that arise during the session into this framework.
8. Be flexible to conduct a warm-up game or icebreaker that will keep the participants relaxed and interested in the activity. It is not a must that the icebreaker or warm-up game be strictly carried out or tied to the specific activity of the modules.
9. Synthesize knowledge at the end of a session. Conclude each session by restating the session's theme and by integrating the ideas that arose during the session into this framework.

► Modelling effective facilitation skills

The participants in their future training sessions with other trainers and teachers will use the facilitation and communication skills that you exhibit during the training. It is, therefore, important for you to demonstrate effective facilitation skills throughout the training programme. The participant will observe and evaluate your activity as a role model. Be consistent in what you say and do. Here are some important facilitation skills.

1. **Ability to encourage discussion** This can be achieved by:
 - Asking open-ended questions which require a thoughtful response and/or guide the discussion in a particular direction; and
 - Ensuring that all participants feel their participation is welcome and desired.
2. **Ability to listen carefully** Several tools can assist you in this:
 - Restating a participant's contribution will clarify and verify your understanding of the participant's statement;
 - Listening for the content AND attitude of a message; and
 - Supporting the participant's contribution. This does not mean that you must agree with the participant, only that you respect his/her position.
3. **Ability to deal with silence** Sometimes silence can be a helpful stimulus. Don't rush to cover it up.
4. **Willingness to allow the group to make their own decisions** Facilitation is not dictation. Participants must be allowed to take responsibility for their own learning if it is to be meaningful to them.

► Handling Training Problems

Successful group facilitation requires practice. Many situations will arise during a training programme that an experienced facilitator will be able to tactfully and effectively solve. Nobody can expect to be a successful facilitator overnight, but dealing with the following situations effectively will help your training session run as smoothly as possible.

1. **A participant wants to argue with you**

This can be a positive sign as it shows that participants feel comfortable expressing their own points of view. By allowing discussion of alternate opinions, you are allowing people to think critically about what they are expected to learn. This is a very profitable teaching/learning tool so long as each side respects the other's opinion, even if their beliefs remain unchanged. However, some participants will argue merely for the sake of arguing. Although this trait can be useful to a group discussion, it can become tiresome and time-consuming, and you should tactfully control this behaviour to maintain focus and proper decorum.

2. **The group looks bored**

You may need a change of pace, a change of venue, a change of topic, or simply a break. Some questions you can ask yourself include:



- Have I been using the same teaching techniques for too long i.e., too many lectures or too many large group activities?
- Have I made some connection between my topic and the participants' lives?
- Have I been repeating material?
- Have I been enthusiastic enough, or too enthusiastic?
- Is the venue suitable i.e., too big or small, too hot or cold?
- Are there circumstances outside of the session influencing the behaviour of your group i.e., jetlag, peer relations, workplace stress?

3. ***Nobody is answering your questions***

Here are some questions to ask yourself to solve this problem:

- Am I speaking loudly or clearly enough for the group to understand me?
- Do my questions require thought to answer i.e., "How" or "Why" questions asking for "thought," "opinions," or "beliefs"?
- Am I waiting long enough for a response? Many participants will take time to think about the questions and carefully formulate an answer before volunteering their answer.
- Is the group focused on the discussion at hand?

4. ***Some participants do not seem to be involved in the discussion***

Some people are naturally quiet. They may be embarrassed to speak in front of a group, or they may simply be learning from what others are saying. Do not confront them with specific questions if they do not appear ready to respond; however, offer them the opportunity to add their opinions or feelings when the chance arises.

5. ***Some participants are monopolizing the discussion***

Some participants will naturally answer questions more quickly and more often than others will. While their responses can be valuable for their content and for sparking responses by the rest of the group, their frequent outputs can also cause others to feel left out or unable to contribute. It is your responsibility to ensure that the less assertive participants have the opportunity to make a contribution by expressing their views. You may have to discreetly ask the overzealous participant to delay their response until others have had a chance to make their own contributions.

6. *The group takes over the discussion*

This is not a problem if the discussion is proceeding productively. Instead, it shows that you have stimulated interest in the topic and the group feels comfortable expressing themselves. Take a seat, listen carefully, and enjoy your time out of the spotlight. Knowledge and ideas developed by the group are more valuable than those given in a lecture.

7. *Private conversations erupt*

Try to develop eye contact with, and move closer to, the participants who are having private conversations. These simple cues should be enough to eliminate off-topic conversations. However, RESPECT PRIVACY and do not attempt to overhear private conversations. Encourage these participants to share their views with the rest of the group.

8. *Two or more participants are arguing*

Do not choose sides! Attempt to paraphrase the position of each side to ensure that they understand what the other is saying. Often, two people with the same position will argue simply because they are not making the effort to hear the other. Ask the group for their input, but ensure that arguments are based on reason, rather than opinion.

9. *You encounter resistance*

You need to find the reason behind the resistance. Understanding the reason will help you to make adjustments to solve the problem.



Table 1. *The Group and their Module Assignment to Study, Present and Demonstrate the Activities*

Group	Module Number
I	1. Basics of Growing Up – Understanding Adolescence
II	2. Unplanned Pregnancy and Sexually Transmitted Infections (STIs)
III	3. Basic Facts about HIV/AIDS
IV	4. The HIV/AIDS Epidemic and its Impact
V	5. HIV/AIDS, Drugs and Substance Abuse
VI	6. HIV/AIDS and Human Rights
VII	7. Care and Support for People Living with HIV/AIDS (PLWHA)
VIII	8. Community Involvement in Combating HIV/AIDS
XI	9. Integration of HIV/AIDS Prevention Education within the School Curriculum
X	10. Learner-centred Strategies and Life Skills Techniques in HIV/AIDS Prevention Education
XI	11. Assessment Tools for Use in HIV/AIDS Prevention Education

Table 2. *The Group and their Assignment to Critique the Module*

Group	Module Number
I	5. HIV/AIDS, Drugs and Substance Abuse
II	6. HIV/AIDS and Human Rights
III	7. Care and Support for People Living with HIV/AIDS (PLWHA)
IV	8. Community Involvement in Combating HIV/AIDS
V	9. Integration of HIV/AIDS Prevention Education within the School Curriculum
VI	10. Learner-centred Strategies and Life Skills Techniques HIV/AIDS Prevention Education
VII	11. Assessment Tools for Use in HIV/AIDS Prevention Education
VIII	1. Basics of Growing Up – Understanding Adolescence
IX	2. Unplanned Pregnancy and Sexually Transmitted Infections (STIs)
X	3. Basic Facts about HIV/AIDS
XI	4. The HIV/AIDS Epidemic and its Impact

ANNEX A

HIV/AIDS Prevention Education in School (City /Province)

Date.....

Suggested Schedule of Activities

Time/Day	8:00-10:00	10:00-10:15	10:15-12:30	12:00-1:30	1:30-3:00	3:00-3:15	3:15-5:00
Day 1	8:00-9:00 Registration Administration of HIV AIDS Self-Report (Pre-test) 9:00-10:00 Opening Programme		Orientation and Mind Setting (see <i>Annex 6</i>) Lesson Planning: A Review		Module Assignment to the Groups for Module Presentation and Demonstration of Activities Assignment to Critique Modules (see Tables 1 and 2)		3:00-4:30 Module 1 Activity 1.1 Understanding Physical Changes during Adolescence: Body Maps
Day 2	8:00-9:30 Activity 1.2 Understanding Changes during Adolescence: Sex, Sexuality and Sexual behaviours	9:30-9:45	9:45-12:15 Activity 1.3 Understanding Sexual maturation: Images of Sex, Beliefs and Misconceptions	12:15-1:45	1:45-2:15 Module 2 Activity 11.1 Unplanned Pregnancy & Sexually Transmitted Infections (STIs)	2:45-3:00	2:45-4:45 Activity 11.2 Knowing about Sexually and STIs
Day 3	8:00-9:00 Activity 2.3 Identifying Problems and Taking Appropriate Actions 9:00-9:45 Module 3 Activity 3.1 Introduction on HIV/AIDS	9:45-10:00	10:05-11:00 Activity 3.2 Facts about HIV/AIDS Approximate 11:00-12:00 Activity 3.3 Knowing Ones Risks from HIV/AIDS	12:00-1:30	1:30-2:00 Activity 3.4 Biological Cycle of Transmission of HIV/ AIDS and Elements HIV/ AIDS Infection 2:00-3:30 Module 4 Activity 4.1 Global and Regional Impact of HIV/AIDS	3:30-3:45	3:45-5:00 Activity 4.2 Effects of HIV/AIDS and Classification
Day 4	8:00-8:45 Activity 4.3 Role Play: Effects of HIV/AIDS 8:45-9:45 Activity 4.4 Making a Personal Connection to HIV/AIDS	9:45-10:00	10:00-11:30 Module 5 Activity 5.1 Substance Abuse – Our Understanding 11:30-12:30 Activity 5.2 Beliefs and the Reality of Drugs	12:00-2:00	2:00-2:45 Continue...Activity 5.2 Beliefs and the Reality of Drugs	2:45-3:00	3:00-4:30 Module 6 Activity 6.1 Stigma and HIV/AIDS
Day 5	8:00-9:30 Activity 6.2 Minimizing Stigma and Discrimination 9:30-10:15 Activity 6.3 Learning How to Minimize Stigma and Discrimination of PLWHA	10:15-10:30	10:30-12:00 Activity 7.1 Module 7 Activity 7.1 Care and Support for People Living with HIV/ AIDS (PLWHA)	12:00-1:30	1:30-3:30 Activity 7.2 Relating PLWHA Problems and Issues with Human Rights	3:30-3:45	3:45-4:45 Continue...Activity 7.2 Relating PLWHA Problems and Issues with Human Rights



HIV/AIDS Prevention Education in School (City /Province)

Date.....

Suggested Schedule of Activities (cont'd)

Time/Day	8:00-10:00	10:00-10:15	10:15-12:30	12:00-1:30	1:30-3:00	3:00-3:15	3:15-5:00
Day 6	8:00-9:30 Module 8 Activity 8.1 Approaching the Community	9:30-9:45	9:45-10:45 Activity 8.2 Strengthening Communication Skills 10:45-11:30 Activity 8.3 Role and Responsibilities of Community Groups: Combating HIV/AIDS Problems 11:30-12:30 Activity 8.4 Analysis of Case Studies	12:30-2:00	2:00-3:00 Module 9 Activity 9.1 HIV/AIDS and Sexual Education: Educating School Children	3:00-3:15	3:15-4:15 Continue...Activity 9.1 HIV/AIDS and Sexual Education: Educating School Children
Day 7	8:00-9:30 Activity 9.2 Creative Learning Groups	9:30-9:45	9:45-11:45 Activity 9.3 Writing Creative Lesson Plans 11:45-12:30 Module 10 Activity 10.1 Group-to-Group Exchange	12:30-2:00	2:00-3:00 Activity 10.2 Preparing Instructional Activities and Media for HIV/AIDS Prevention Education	3:00-3:15	3:15-4:15 Continue...Activity 10.2 Preparing Instructional Activities and Media for HIV/AIDS Prevention Education 4:15-5:00 Module 11 Activity: 11. 1 Indicators for Assessing Student Outcomes in HIV/AIDS Prevention Education
Day 8	8:00-8:45 Continue...Activity: 11.1 Indicators for Assessing Students Outcomes in HIV/AIDS Prevention Education 8:45-9:45 Activity 11. 2 Types of Assessment Tools for Use in HIV/AIDS Prevention Education	9:45-10:00	10:00-1:00 Activity 11. 3 Developing Assessment Tools for Use in HIV/AIDS Prevention Education	1:00-3:30	3:30-5:00 Closing Programme		

ANNEX B

HIV/AIDS Prevention Education in Schools

HIV/AIDS Self-Report

Name of the School : _____

Province/City : _____

Date : _____

Part I – Knowledge

Directions: Put an X on the letter of your answer after each number

A = Agree

D = Disagree

N = Not sure

Example:

0. AIDS means acquired immune deficiency syndrome. A D N

1. HIV means human immune deficiency virus.	A	D	N
2. Sharing of needles and syringes among intravenous drug users is a risk factor in HIV/AIDS.	A	D	N
3. A person can be infected with HIV through transfusion of unscreened blood.	A	D	N
4. A HIV person should be separated from family to prevent HIV infection to other family members.	A	D	N
5. Sex with multiple partners is a risk factor in HIV/AIDS.	A	D	N
6. HIV weakens the body's natural defence against infections.	A	D	N
7. Persons with HIV/AIDS should remain anonymous for security reasons.	A	D	N
8. AIDS is a "gay disease" because it occurs ONLY among homosexuals.	A	D	N
9. HIV- positive individuals should be protected by law against discrimination at the workplace.	A	D	N
10. One can get infected with AIDS by sharing glasses, plates, spoons or other personal things with an HIV-positive person.	A	D	N
11. HIV/AIDS is not a problem among out-of-school youth.	A	D	N
12. HIV/AIDS prevention education should be given only through the school setting.	A	D	N
13. If you are strong and healthy, you cannot get HIV.	A	D	N
14. Once you have a HIV-negative test, you can never be infected with HIV.	A	D	N



15. HIV is spread by mosquito bites and other insect bites.	A	D	N
16. A person with full-blown AIDS obviously looks sick and weak.	A	D	N
17. At present, there is no cure for AIDS.	A	D	N
18. Young people are not at risk of getting HIV.	A	D	N
19. AIDS is a preventable disease.	A	D	N
20. Rich people should NOT be concerned about HIV/AIDS.	A	D	N
21. Persons with HIV should not be recruited in the military.	A	D	N
22. HIV is passed from mother to foetus via the placenta.	A	D	N
23. Drug abuse contributes to a person's vulnerability to HIV/AIDS.	A	D	N
24. AIDS is a disease of poverty and ignorance.	A	D	N
25. Persons with HIV should be allowed to serve as peer educators for HIV/AIDS prevention education.	A	D	N
26. A person with AIDS should be isolated from family to prevent HIV infection to others.	A	D	N
27. Responsible sexual behaviour is a way to stop the spread of AIDS.	A	D	N
28. "Window" period is when the body shows no signs of the disease.	A	D	N
29. Media practitioners and policy makers should be asked to support the campaign against HIV/AIDS.	A	D	N
30. Persons who have multiple sexual partners are at greater risk of getting infected with HIV than monogamous ones.	A	D	N
31. Many doctors and nurses caring for AIDS patients eventually get the disease.	A	D	N
32. One can get AIDS by hugging or shaking the hands of the infected person.	A	D	N
33. Retired people do not get AIDS.	A	D	N
34. Consistent condom use is the best way of preventing HIV infection.	A	D	N
35. Oral sex cannot spread HIV infection	A	D	N

Part II – Attitudes

Directions: Put a circle on the number of your correct answer using the following continuum:

- 1 - Strongly disagree
- 2 - Disagree
- 3 - Undecided
- 4 - Agree
- 5 - Strongly agree

Example:

We should discuss HIV/AIDS with secondary school students. 1 2 3 4 5

Item	1	2	3	4	5
1. We should be aware of getting infected with HIV/AIDS.	1	2	3	4	5
2. People have changed their feelings about AIDS in the past years.	1	2	3	4	5
3. We should have compassion and empathy for an AIDS patient.	1	2	3	4	5
4. We should NOT allow students with AIDS to go to our schools.	1	2	3	4	5
5. Media have created unnecessary fear of AIDS.	1	2	3	4	5
6. Families of AIDS patients should leave their care to the government.	1	2	3	4	5
7. We should support activities for the benefit of the AIDS patients.	1	2	3	4	5
8. We should discuss HIV/AIDS with our families and friends.	1	2	3	4	5
9. AIDS patients should be allowed to attend public gatherings.	1	2	3	4	5
10. Public money should be used for the treatment and care of AIDS patients.	1	2	3	4	5
11. Our communities are affected by problems related to HIV/AIDS.	1	2	3	4	5
12. We should be willing to take care of our family member if he/she is infected with HIV.	1	2	3	4	5
13. We can predict the trends of HIV/AIDS epidemic in the coming years.	1	2	3	4	5

Item	1	2	3	4	5
14. We should not shake hands or hug people who care for persons with AIDS.	1	2	3	4	5
15. Abuse of alcohol and other drugs can contribute to the spread of HIV/AIDS.	1	2	3	4	5
16. We should allow teachers living with HIV/AIDS to teach in schools.	1	2	3	4	5
17. HIV-positive students can sit next to his/her classmates in a classroom	1	2	3	4	5
18. We should not discriminate against students due to their sexual orientations/preferences.	1	2	3	4	5
19. We will not allow students to play with HIV-positive children.	1	2	3	4	5
20. There should be schools for HIV-positive children.	1	2	3	4	5

ANNEX C

Mind setting

Learning Activity 1 – Getting to Know You

Approximate Time: 20 Minutes

Materials:

1. Name tags and felt pen
2. List of descriptive adjectives
3. Chart on information about *me*

Preparations:

1. Cut coloured cards for nametags
2. Prepare list of descriptive adjectives
3. Make the chart on information about *me*

I am best in
My favourite food
Ten years from today, I

Introduction: It is said that the name of a person is the sweetest music to his/her ears. At the very start of the training, you should know the names of the participants. Call their names as often as you can. Perhaps, it will help you to remember them faster if descriptive adjectives are added to their names. Getting to know each other promotes team-building and creates a spirit of cooperation.

Objectives: After participating in this activity, the trainers and teachers should be able to:

1. Identify as many trainers and participants as they can in the training; and
2. Share some information about themselves with others.

Content:

1. Names of trainers and participants with descriptive adjectives
2. Information about themselves

Procedure:

1. Provide participants with name tags. Ask them to write their first and second names in big letters. The trainer should also wear a name tag.
2. Ask participants to think of two adjectives to describe themselves. The adjectives should start with the first letter of their names.

Example: Liza Rivero
Lovely Liza Reliable Rivero

3. Ask the participants to form two lines, and let them face each other.
4. Invite each participant to introduce himself/herself to the person in front. Let them introduce themselves using their name tags and their answer to the Information about Me.



5. Ask them to meet the next person in front and continue introducing themselves.
6. Ask them to go back to their seats, and ask for volunteers to name 5 participants.

Evaluation: Ask the participants how they felt after the exercise.

- Learning Outcomes:**
1. Name as many participants or all participants towards the end of the session.
 2. Introduce one or two participants using their names with their descriptive adjectives and information about them.

Facilitator's Notes:

You should show the way of introduction by introducing yourself.

Adjectives To Describe You!

- A. Able, Abreast, Accepting, Accommodating, Accomplished, Active, Adaptable, Affectionate, Affluent, Ageless, Agreeable, Alert, Aloof, Ambitious, Analytic, Apolitical, Artistic, Aseptic, Awkward
- B. Beautiful, Bankable, Bejewelled, Biographical, Blue blooded, Blunt, Boisterous, Bold, Bouncy, Brilliant, Byronic
- C. Caring, Careful, Capable, Celestial, Charitable, Chivalrous, Classic, Colourful, Complex, Complicated, Conservative, Corny Courteous
- D. Dainty, Daring, Deadly, Defiant, Dense, Difficult, Distinctive, Diplomatic, Durable, Distinguish, Dynamic
- E. Earthly, Easygoing, Ecstatic, Efficient, Elaborate, Enthusiastic, Episodic, Equivocal, Evasive, Extreme, Excellent
- F. Fabled, Fashionable, Faithful, Famous, Fantastic, Fervent, Fluent, Fortunate, Friendly, Funny
- G. Generous, Genial, Gentle, Gifted, Glamorous, Good, Graceful, Gracious, Grand, Graphic
- H. Happy, Harmless, Hasty, Healthy, Heavy, Helpful, Holy, Honest, Humble, Hungry
- I. Immaculate, Important, Impressive, Indifferent, Industrious, Informal, Innocent, Intelligent, International
- J. Jealous, Jolly, Judicial, Jubilant
- K. Kind, Keen, Knowledgeable
- L. Large, Last, Late, Lavish, Lovable, Lovely, Lawful, Light, Liberal, Little, Lively, Lucky
- M. Magical, Marital, Masterful, Mature, Meaningful, Mighty, Mild, Modest, Motherly, Muscular, Musical, Mysterious
- N. Naïve, Natural, Naughty, Neat, Neutral, Nice, Noble, Non-partisan, Nostalgic, Numerical
- O. Obedient, Objective, Obliging, Observant, Old-fashioned, One-sided, Open-minded, Optimistic, Original, Over-confident



- P. Pale, Passionate, Patient, Peculiar, Perfect, Personal, Physical, Pious, Pleasant, Polite, Popular, Private, Profound, Prompt, Proper, Pure
- Q. Quaint (Cute), Quiet
- R. Radiant, Radical, Rapid, Rare, Rational, Ready, Real, Refined, Regular, Relevant, Reliable, Reluctant, Remote, Responsible, Rich, Rural
- S. Sad, Sarcastic, Scientific, Seasoned, Secretive, Selective, Sensitive, Sentimental, Serious, Sharp, Shrewd, Shy, Silent, Simple, Small, Smooth, Sociable, Special, Strong, Successful
- T. Tactful, Talkative, Tender, Terrible, Thin, Thoughtful, Thrifty, Tiny, Tolerant, Tough, Traditional
- U. Ultimate, Unconditional, Undecided, Uneasy, Unexpected, Unfair, Unforgettable, Unusual, Unwilling, Urgent, Usual
- V. Vague, Vain, Versatile, Vicious, Victorious, Violent, Virtuous, Vivid
- W. Warm, Wary, Wealthy, Weary, Wholesome, Wise, Witty, Wonderful, Worthy
- X. Xenophobic, Xcellent, Xtraordinary
- Y. Yonder (faraway), Young
- Z. Zigzag, Zealous

N.B. You may use other words of your own choice



Learning Activity 2 – Keep on Learning

(Expectations from the Training)

Approximate Time: 30 minutes

Materials: Flip chart papers

Preparations: Write on top of two flip chart papers:
1. Expectations

Introduction: Life is a continuous process of learning. We already know many things, but can learn new things if we keep an open mind. We continue to learn from others. In this training, what do you want to learn? What are your expectations?

Objectives: After participating in this activity, the teachers should be able to:

1. List their expectations from the training; and
2. Identify new ideas or skills they want to learn.

Content:
1. Expectations from the training
2. New ideas and skills

Procedure:
1. Divide the big group into small groups of five members and let them choose a leader in each group.

2. Ask two to three small groups to brainstorm, and list what new ideas and skills they want to learn.

3. After 3-5 minutes, ask the leader of each group to move to another group and compare their lists. Add to the list other expectations, ideas and skills.

Learning Outcomes:
4. After moving to the other groups, ask the leaders who have the *master lists* to read them.

5. Paste the *master lists* under the appropriate flip chart papers. Keep the list posted during the training. You may want to refer to them later on.

Evaluation: Take feedback from the outcomes of discussion.

1. Listing of expectations from the training.
2. Listing of new ideas and skills
3. Link the participant's expectations to the objectives of the training

Facilitator's Notes:

You should also share your expectation from the training with the participants.

Observable verbs for the cognitive domain

1. Knowledge		2. Comprehension	
Recall of information		Interpret information in one's own words	
define duplicate label list match memorize	name order recognize relate recall repeat reproduce	classify describe explain express identify indicate locate	recognize report restate review select sort tell translate
3. Application		4. Analysis	
Use knowledge or generalize in a new situation		Break down knowledge into parts and show relationships among parts	
apply choose demonstrate dramatize employ illustrate interpret	operate prepare practice schedule sketch solve use	analyze appraise calculate categorize compare contrast criticize diagram	differentiate discriminate distinguish examine experiment inventory question test
5. Synthesis		6. Evaluation	
Bring together parts of knowledge to form a whole, and build relationship for new situations		Make judgements on the basis of given criteria	
arrange assemble collect compose construct create design formulate	manage organize plan prepare propose set up synthesis write	appraise argue assess attack choose compare defend estimate	evaluate judge predict rate score select support value

Depending on the meaning of use, some verbs may apply to more than one level.



Selected Verbs Used in Writing Behavioural Objectives

McNeil, J.D. & Wiles, J. (1990)

The Essentials of Teaching: Decisions, plans, methods. NY: Macmillan Publishing Co.

Creative behaviours

alter	generalize	question	regroup	rephrase	rewrite
ask	modify	rearrange	rename	restate	simplify
change	paraphrase	recombine	recorder	restructure	synthesize
design	predict	reconstruct	reorganize	retell	systematize

Complex, logical and Judgmental behaviours

analyse	combine	contrast	designate	formulate	plan
appraise	compare	criticize	determine	generate	structure
assess	conduct	deduct	discover	induce	suggest
	defend	evaluate	infer	substitute	

General discriminative behaviours

choose	describe	discriminate	indicate	match	place
collect	detect	distinguish	isolate	omit	point
define	differentiate	identify	list	order	select
			pick	separate	

Social behaviours

accept	answer	cooperate	forgive	laugh	reply
admit	argue	dance	greet	meet	smile
agree	communicate	disagree	help	participate	talk
aid	complement	discuss	interact	permit	thank
allow	contribute	excuse	invite	praise	visit
		join	react	volunteer	

Miscellaneous

aim	erase	hunt	peel	scratch	store
attempt	expand	include	pin	send	strike
attend	extend	inform	position	serve	supply
begin	feel	kneel	present	sew	support
bring	finish	lay	produce	share	switch
buy	fit	lead	propose	sharpen	take
come	fix	lend	provide	shoot	tear
complete	flip	let	put	shorten	touch
correct	get	light	raise	shovel	try
crease	give	make	relate	shut	twist
crush	grind	mend	repair	signify	type
develop	guide	miss	repeat	slip	use
distribute	hand	offer	return	slide	vote
do	hang	open	ride	spread	watch
drop	hold	pack	rip	stake	weave
end	hook	pay	save	start	work



ANNEX D

How to Conduct a Mini-Demonstration Lesson

1. Divide the class into three groups.
 - ▶ First group to act as *teachers* and do demonstration teaching
 - ▶ Second group to act as *students*
 - ▶ Third group to act as *observers* of the demonstration teaching
2. Define the roles of each group.
 - ▶ The *teacher/s* should prepare the lesson plan/s
 - ▶ The teacher/s should conduct pre-and post-demonstration conferences with the observers
 - ▶ The students should be actively participating and asking thought-provoking questions
 - ▶ The observers may prepare an Observation Form for use during the lesson (see Annex G)
3. Commend the groups for their work.
4. Try to have several mini-demonstrating teachings in one session.



ANNEX E

Prevention Education Against HIV/AIDS: UNESCO Regional Training Workshop

October 18-23, 1999

Demonstration Lesson-Observation Form

Demonstration Teacher : _____

Lesson in Health Area : _____

Time Started : _____ Time Ended : _____

Name of Observer : _____

Country : _____

Instructions

1. Based on the actual lesson, rate how each part is achieved by using the following scale:

Not at all **0** *A little* **1** *Moderately* **2** *Much* **3** *Very much* **4**

2. Give your comments/suggestions.

3. Use the tables for your rating and comments/suggestions.

I. Objectives	Rating	Comments/Suggestions
1. Define HIV and AIDS		
2. Discuss the progression of HIV infection to AIDS		
3. Discuss ways by which HIV is and is not transmitted		
4. Choose behaviours that will reduce one's risk of HIV infection		
5. Demonstrate their resistance skills against HIV/AIDS		
II. Methodology	Rating	Comments/Suggestions
A. Video Showing		
B. Class Discussion		
C. Choose and Paste		
D. Patchwork Jacket for Protection		
III. Evaluation	Rating	Comments/Suggestions
A. Agree/Disagree		
B. Explain why		

General Comments/Suggestions : _____



ANNEX F

Training Evaluation Questionnaire

Name (optional) : _____ Sex : _____
Training Venue : _____ Date : _____

Dear Teachers:

Please respond to the training evaluation questionnaire. Your frank and honest answers will help us make changes to improve the quality and relevance of training for future participants.

Part I – Please rate the following aspects of the training by checking the appropriate column and using the 5-point scale below:

Aspect	1	2	3	4	5
1. Organization of the training activities					
2. Relevance of the objectives/materials					
3. Appropriateness of topics					
4. Cooperation of participants					
5. Performance of trainers and staff					
6. Communication among participants					
7. Quality of training outputs					
8. Amount of work the participants put into the training					
9. Training facilities					
10. Food services					

Part II – Please answer these questions frankly.

1. What five aspects of the training do you find most satisfying? Rank them.

2. What do you think is the weakest part of this training? Please explain.

3. What improvements would you suggest for future training?



Registration Form

Name (print):	Nickname:	Sex
Position/Designation:		
Complete Office Address:		
Fax:	Telephone:	
Mobile Phone/Pager:	E-mail:	
Complete Home Address:		

Signature

Date

PART TWO

Training Modules

Introduction

There are 1.2 billion adolescents in the world. Eighty-seven percent of these adolescents live in developing countries. Young people are our future leaders, and it is worth developing in them the capacity to ensure a healthy and productive life that is free from encumbrances such as HIV/AIDS. An estimated 238 million youth – almost one in four – face the constraints of extreme poverty. More than 13 million children under age 15 have lost one or both parents to AIDS. A youth is infected every 14 seconds, and youth (increasingly women) account for nearly half of the new cases of HIV infection worldwide. Yet, many young people are unable to protect themselves from HIV infection. Discussing sexual behaviour is taboo in many countries, so large numbers of young people do not have the information or skills to refuse sex or negotiate safer sex practices. Concerted, scaled-up preventive efforts, as successful programmes have shown, are critical to turning back the epidemic. Designing and instituting effective HIV/AIDS education programmes for schools are global concerns.

Part Two of the manual is composed of eleven training modules on HIV/AIDS prevention education. A module is a unit of instruction that should engage the student in an intellectual activity that will make them try out ideas, reflect, and apply critical judgment to what is being studied. The modules are used to teach them how to learn, make decisions on how they feel, and what to do. Through these modules, the teachers are expected to guide, motivate, provoke, ask questions, discuss alternative answers, appraise their progress, provide enrichment activity and enforce the learning with appropriate remedial measures. The trainers should be concerned with understanding the process of teaching, which hopefully the teachers will learn so that they can use the same process with their students.

The overall aim of these modules is to help the HIV/AIDS trainers and teachers (pre-service and in-service) gain confidence in educating youth about the prevention and control of HIV/AIDS. Each module is composed of various parts, and each part is described on the following page.

Module Parts	Description	Ways of Presenting
I Number and Title	Gives relevant and interesting title	New and stimulating title
Approximate Time	Gives the time needed to study and use the module	Minutes and/or hours
II Module Message	Gives short and interesting message	Short and relevant to the content
III Overview	Explains why the module is important; shows the relationship of the module to the teacher's work; indicates the coverage of the module	Describe the content, make a concept map, ask questions, etc.
IV Objectives	States in short, simple, measurable, achievable, relevant and specific terms	Use action words, e.g. describe, choose, analyze, predict, propose, etc.
V Content Outline	Presents facts and information, skills, values, attitudes or practices	Use reader-friendly style, use outline
VI Learning Activities	Provides opportunities for teachers to do something with the new information aside from reading and listening	Require teachers to make decisions, apply principles, draw conclusion, analyze situations, reflect on events, predict trends, etc.
VII Evaluation	Evaluation is essential in sustaining interest, motivation and accountability; gives feedback on their activities to check on their performance	Confirm correct answers; give sincere praise and encouraging remarks
VIII Summary	Makes a general review of what is covered in the module; should be related to the objectives	Paragraph or outline of what has been presented; questions may be asked to summarize
IX Facilitator's Note	Provides suggestions about approaching the lesson; details instructions for warm-up activities	As a support for the teacher, the Facilitator's Note is not intended to be presented to the students

Each activity in the modules has the following parts:

- I ▶ Number and Title
Lesson Time Requirement
Materials Needed
Preparation
- II ▶ Introduction
- III ▶ Objectives
- IV ▶ Content Outline
- V ▶ Procedure
- VI ▶ Evaluation
- VII ▶ Facilitator's Note

The modules are presented in a reasonably logical manner. It is recommended that the trainers should start at the beginning and work their way through to the last module. Each module is prepared so that the trainer can follow it easily. There are eleven modules:

- Module 1 ▶ Basics of Growing Up - Understanding Adolescence
- Module 2 ▶ Unplanned Pregnancy and STIs
- Module 3 ▶ Basic Facts about HIV/AIDS
- Module 4 ▶ The HIV/AIDS Epidemic and its Impact
- Module 5 ▶ HIV/AIDS, Drugs and Substance Abuse
- Module 6 ▶ HIV/AIDS and Human Rights
- Module 7 ▶ Care and Support for People Living with HIV/AIDS (PLWHA)
- Module 8 ▶ Community Involvement in Combating HIV/AIDS
- Module 9 ▶ Integration of HIV/AIDS Prevention Education within the Curriculum
- Module 10 ▶ Learner-Centred Strategies and Life Skills Techniques
- Module 11 ▶ Assessment Tools for Use in HIV/AIDS Prevention Education



Basic of Growing Up – Understanding Adolescence and Adolescent Sexuality

Approximate Time: 5 hours 30 minutes

Module Message: As young people grow up, they experience many changes. However, they often remain unaware of how to responsibly cope with these physical and psychological changes. Sexual adjustment is important to the growth and development of an adolescent into a mature individual. Attitudes to sexuality are formed early during adolescence. The failure to communicate about sexuality issues with parents and elders results in further anxiety. Parents leave the crucial tasks of talking to their children about sexuality to the schools, and teachers, themselves, may be uncomfortable and embarrassed to discuss these issues with their students.

Overview:

Introduction

As young people grow up, they experience many changes. There are changes in the body, in the way one behaves, and in the way others expect one to be. There are also changes in interests and preoccupations. All of these are normal and part of growing up; but growing up is not easy. This is a time when one has many questions and hardly any answers. It is difficult to talk about the things upper-most in your mind. Why is my body changing? Why do I get an erection? Why do I feel attracted to the opposite sex or the same sex? Many older people are not willing to discuss these issues openly with young people. As a result, friends (peer group), TV, films, magazines and imagination become their sources of information. Often these lead to false information, unnecessary fears and situations of risk/vulnerability to HIV or other STIs.

Sexual adjustment is important to help the growth and development of an adolescent into a mature individual. Moreover, sexual maturity can lead to happiness and fulfilment in future personal and social relationships. Attitudes to sexuality are formed early during adolescence. Therefore, it is important for adolescents to learn about issues related to sexuality from parents and elders in order to be able to understand and develop a healthy attitude.

Adolescence is a period of many physical, emotional and cognitive changes. During the time of puberty, the feelings related to sexual urge become apparent. This creates restlessness for independence in young people, which is why parents and teachers consider their behaviour to be unpredictable and difficult to control as compared to younger children who would *behave as they were*



told. This development of an independent personality and identity in adolescents is often interpreted as a withdrawal from the parents and the family, and an apparent failure to understand and communicate with elders.

Much of the confusion and anxiety experienced during adolescence is on account of ignorance and/or misinformation about sexual issues. The failure to communicate about such issues with parents and elders results in further anxiety. Parents leave the crucial task of talking to their children about sexuality to the schools, and teachers, themselves, are uncomfortable and embarrassed to discuss these issues with their students.

Friends or peers are the only primary source of information about sex and sexuality for many young people. This is because adults often find it very difficult to talk about these issues to young people in a non-judgemental way. Parents and teachers need to encourage adolescent children to voice their opinions on moral issues and values by providing them with a positive environment for such discussions. Adults must strive to appreciate and understand their views.

In order to deal with the turmoil, we need to know the facts of growing up, and distinguish between myths and realities. This module deals with these issues.

Understanding Sex and Sexuality

Sexuality is about many things such as emotions, beliefs, relationships, and self-image. It is definitely more than simply sex. All human beings are sexual and develop their sexuality from a number of influences, including social, cultural, biological, economic and educational factors. Sexuality is multi-faceted and a sensitive issue, and there is often confusion about how best to address it. Adolescence is the time for experimentation and following one's curiosity.

Objectives:

After studying the module, the participants should be able to:

1. Know the facts about physical changes that take place during adolescence
2. Identify the misconceptions about sex and sexuality
3. Describe the facts about cognitive and emotional changes during adolescence
4. Define the term *sex* and *sexuality*
5. Identify the differences between *sex* and *sexuality*
6. Identify the differences between sexual maturity among young men and women
7. Identify the persons and essential qualities needed to care for HIV/AIDS infected or affected people
8. Distinguish between healthy and unhealthy sexual behaviours

- Content Outline:**
1. Human reproductive system
 2. Sex, sexuality and sexual behaviours
 3. Misconceptions on sex, sexuality and sexual behaviours

- Learning Activities:**
1. Understanding the parts of male and female reproductive system and their functions through body mapping
 2. Understanding sex and sexuality through open discussion and exercise
 3. Understanding healthy and unhealthy sexual behaviours and avoiding misconceptions about sex and sexuality
 4. Warm-up game

- Evaluation:**
- Question-answer on the following questions:
1. What are the differences between the male and female reproductive systems? Can you point to these using the body maps?
 2. When did you first notice a physical change in your body? How did you feel?
 3. How do you feel about your body and your sexuality? Why?
 4. What are the differences between healthy and unhealthy sexual behaviours?
 5. What are the misconceptions about sex and sexuality? Why?

Facilitator's Note: Follow *Facilitator's Note* to conduct icebreaker or warm-up game

ACTIVITY 1.1

Understanding Physical Changes During Adolescence

Body Maps

Approximate Time: 1 hour 30 minutes

Materials: Flip charts, markers, crayons, cello tape, scissors, and stapler

Objectives:

1. To discover the physical changes that take place during puberty
2. To be familiar with male/female sexual organs, and their functions
3. To know the biological facts about sexual maturity

Content:

1. Human reproductive system
2. Biological facts about sexual maturity

Procedure:

1. Ask the participants to be divided into two groups – males and females. Separate places can be used for doing the exercise. (30 minutes)
2. Invite each group to pick up flip charts and markers for the group task.
3. Explain that they will be making a body map for male and female separately, to show the physical changes that have occurred in their bodies since they were 10 years old.
4. It is preferable that the female group make, the map of the male body and vice versa.
5. The body map can be easily drawn – either asking one person from the group to lie down on the floor or to stand up. The body map of a person should be drawn to show a person without clothes.
6. Have the group review and improve the body map if so necessary. Explain that technical names and drawings are not necessary; they may use the language they normally use to communicate with each other.
7. Ask each group to put up their respective charts on a wall or spread them out on the floor. Then have one person from each group present their map.
8. The presenter will mark out the physical changes on the body map, and speak about them clearly.
9. If possible, you should display a colourful body map on the wall or on the floor alongside the other two maps that show the physical parts of the male and female bodies. Alternatively, you can prepare this chart yourself before the start of the training, or you can buy one from a bookshop.
10. Encourage the participants to discuss in their groups the following questions. (30 minutes)



The following questions can be used for discussion:

- ▶ How did you feel while drawing the body map? Why?
- ▶ How did you feel about sharing the body maps with each other? Why?
- ▶ Why are there differences between the male and female reproductive systems? Can you point these out using the body maps?
- ▶ When did you first notice a physical change in your body? How did you feel?
- ▶ How do you feel about your body and your sexuality? Why?
- ▶ Do you discuss your body and sexuality with your friends?
- ▶ Have you ever discussed these issues with any adult? Why and why not?
- ▶ During puberty, what questions came to your mind, and were you able to get answers? Who did you talk to?
- ▶ *Were you curious about the changes in the body of the opposite sex? What questions came to your mind and who did you speak with?*
- ▶ *Do you know of any beliefs or taboos associated with these body parts? If yes, what are they?*
- ▶ *Why are there so many beliefs and taboos associated with sexual body parts and sexuality?*
- ▶ *How do you feel about the opposite sex? Why?*

11. Ask each group for a brief presentation of their outcomes of discussion. (10 minutes each)

Evaluation:

1. What is the importance of studying body mapping?
2. In what ways are body changes useful in your life?

Learning Outcomes:

1. Familiarity with the human reproductive system – important parts of male and female reproductive system and their functions
2. Facts about physical and biological changes – sexual maturation – that take place during adolescence
3. Use of body mapping as an effective tool for health workers in creating awareness about the body and health problems
4. Knowledge and skills for dealing with intimate health issues such as sexual health and gynaecological problems among women

Facilitator's Note:

This exercise enables all the group members participate. It also allows you to get an understanding of the way in which the participants view their bodies, as well as their feelings related to sexual changes. Body mapping is a participatory tool, and has been used extensively by health workers in creating awareness about the body and health problems. It is especially effective for dealing with intimate health issues such as sexual health and gynaecological problems among women.



Using biological facts, briefly summarize the physical changes that take place during adolescence. Ask the participants if they have any questions on the subject. It is good to facilitate this exercise in a mixed group. It allows the males and females to know about each other's bodies. Sometimes the participants feel too inhibited and shy in each other's presence. This may be due to cultural and religious reasons. Ask the participants if they are comfortable in the mixed group, and proceed accordingly. If the participants are not comfortable in a mixed group, you may have to do the exercise in separate groups, and you may need the help of a co-facilitator.

ACTIVITY 1.2

Understanding Changes During Adolescence: Sex, Sexuality and Sexual behaviours

Approximate Time: 1 hour 30 minutes

Objective:

1. To develop a common understanding and definition of the terms “sex,” “sexuality” and “sexual behaviours.”
2. To know sexual words – formal and slang – and relate them to body parts and sexual functioning
3. To understand the emotional and cognitive changes during adolescence
4. To differentiate the physical, emotional, psychological and cognitive changes among boys and girls

Materials: Flash cards, markers, blackboard/whiteboard, chalks, or large flip charts, plenty of condoms for ice-breaking games

Procedure:

1. Conduct ‘*The Toilet Paper Game*’ to warm up the class (see Facilitator’s Note for instructions).
2. Invite the participants to sit in a circle.
3. Explain that the objectives of the session are to explore their personal understanding of the terms, and that there are no right or wrong answers.
4. Give one flash card to each participant; ask them to express their understanding of the term ‘sex’ and ‘sexuality’ through either writing or drawing on the flash cards. (5-10 minutes)
5. Ask the participants to read out or show their card, and display them on the wall chart.
6. Allow the participants for query and discussion, and summarize the outcomes of discussion. (30 minutes)
 - ▶ *How did you feel while doing this exercise? Why?*
 - ▶ *What does the collage depict – ‘sex’ or ‘sexuality’?*
 - ▶ *Do you think there is a difference between ‘sex’ and ‘sexuality’? Why or why not?*
7. Then distribute cards to all participants and ask them to write as many sexual words as possible.
8. The participants should also write formal, as well as slang, words; this will avoid stigmatization and improve interpersonal communication with respect to health issues.



9. Facilitate a discussion using the following questions. (30 minutes)
 - ▶ *How did you feel about doing this exercise in a mixed group? Why?*
 - ▶ *Are there any differences in the changes (emotional and cognitive) between the males and the females? What?*
 - ▶ *Who are more emotional? Why and why not?*
 - ▶ *How did you handle the emotional changes?*
 - ▶ *Did you notice any changes in the way the participants spoke during discussion?*
 - ▶ *What are the strengths and weaknesses of this discussion?*
 - ▶ *What are the outcomes? How would you summarize?*

Evaluation:

1. Why it is important to understand about sex and sexuality?
2. What is the educational and communicative importance in knowing about sexual terminology?

Learning Outcomes:

1. Familiarize learners with the facts of sex and sexuality
2. Develop a common understanding of ‘*sexuality*’ and sexual behaviours
3. Differentiate between healthy and unhealthy sexual behaviours

Facilitator’s Note:

1. Provide the following instruction to conduct the icebreaker **“The Toilet Paper Game”**:
 - ▶ Pass the roll of toilet paper around the circle of people.
 - ▶ Tell each person to rip off however many pieces they want (this is what will determine the *length* of the game).
 - ▶ Don’t tell anyone what they are doing, don’t even let on that it is a game if you can help it. This makes it even funnier.
 - ▶ Once everyone is finished, you can explain the game.
 - ▶ For every piece they are holding, they have to tell the group something about themselves-any secrete other people do not know at all.
 - ▶ The more sheets, the more facts needed. You just make your way around the circle getting to each person in turn.
 - ▶ You can also have a prize for the person who pulls the most pieces and is able to put a fact to each one!!!
2. The exercise on **Activity 1.2** can be done in a mixed group.
3. If participants feel uncomfortable, you can do the exercise separately for men and women.
4. You should make the participant cautious that they often end up describing “*sexuality*” while defining “*sex*.”
5. While summarizing, the facilitator should provide the standard definitions of “*sex*” and “*sexuality*” and facts about cognitive and emotional changes during adolescence.



ACTIVITY 1.3

Understanding Sexual Maturation: Images of Sex, Beliefs and Misconceptions

Agree, Disagree, Don't Know

Approximate Time: 2 hours 30 minutes

Materials: Flash cards, markers, large flip charts, scissors, old magazines or leaflets with pictures, the body maps prepared during the previous session may be re-used, sticky tape, list of statements, signs that indicate agree/disagree/don't know

Objective:

1. To have an understanding of their sexual behaviours
2. To distinguish between healthy and unhealthy sexual behaviours
3. To identify misconceptions about sex and sexuality in the group
4. To clarify misconceptions and beliefs

Procedure: **First session** (1 hour 30 minutes)

1. Explain that the objectives of the session are to familiarize learners with healthy and unhealthy sexual behaviours, and clarify misconceptions about sex and sexuality.
2. Divide the participants into groups of three.
3. Give each group some flash cards/notebook sheets, markers/crayons, scissors, erasers, old magazines /leaflets etc.
4. Ask them to draw, create (from the magazines/leaflets) or write something related to sexuality/sex. (30 minutes)
5. Their creations can be funny, sad, ugly, happy, or curious, as long as they are able to relate it to sexuality/sex (the focus is to express their ideas and creative work, not to have a professional product).
6. Ask the participants to stay in their groups, gather around, and discuss what they did (make sure that each group has discussed healthy and unhealthy sexual behaviours).
7. Ask each group to summarize the outcomes of the discussion (explain that you would like to keep a record of their concerns on the flip chart).
8. Then ask each group to display their drawings/creations on the wall and to give a brief presentation. (10 minutes for each group)



Second session (1 hour)

1. Invite the participants to put up the three signs (agree/disagree/don't know) around the room.
2. Explain that the signs will be used in the exercise on myths and reality about sex and sexuality.
3. Make note that all societies have myths regarding the subject of sexuality. Many beliefs and misconceptions surround the subject.
4. The exercise will explore these misconceptions and provide the facts.
5. Explain that you will read out some statements. The participants should listen to the statements and decide whether they agree, disagree or don't know. Ask the participants to review their response. Depending on their response, they should stand under the corresponding sign (these signs have already been pasted on the walls around the room).
6. After each statement, ask the respondents to give the reasons for their agreement, disagreement or confusion.
7. After each statement, you should provide the correct response.
8. As part of the evaluation, ask the participants to complete the list of statements and to sit in a circle. Facilitate a discussion using the following questions:
 - ▶ What are your observations on the exercise just completed?
 - ▶ Have you learnt something from this exercise? What?
 - ▶ How do you feel about your understanding of sex and sexuality?
 - ▶ Did you gain any insights into why you believe or disbelieve certain things?
 - ▶ After the exercise, will you be able to clarify misunderstandings and doubts to your friends?
 - ▶ How will you inform your friends about the new things you learnt through this exercise?

Evaluation:

As part of the evaluation, you should observe the participation and discussion during the end of the second session to assess whether participants have gained the relevant knowledge.

Learning Outcomes:

1. Understanding of healthy and unhealthy sexual behaviours
2. Familiarity with misconception related sexuality and sex, and their clarification
3. Developing life skills to address the issues that are encountered during puberty and adolescence



Facilitator's Note:

This exercise is non-threatening and can be done in a mixed group. Ask the participants to make sure that the piece of creative work should explain the meaning of their creation, and everyone should maintain consensus as you move from one to the other.

1. To learn about the issues raised, participants should be encouraged to discuss the subject of each drawing.
2. This exercise is useful for familiarizing the participants with the similarities and differences between males and females, sex and sexuality.
3. It allows the participants the space necessary for reflection and correction.
4. The discussion should address basic biological differences, or differences created through social and cultural norms and beliefs.
5. If the participants prefer not to talk about themselves, you can encourage them to talk about issues that they might have heard or read about.
6. The discussion should cover issues such as gender, pregnancy, sexually transmitted infections/diseases, HIV/AIDS, rape, sex work, men who have sex with men (MSM), homosexuality, bisexuality, lesbianism, menstruation, nocturnal emissions.
7. You must prepare the list of statements and correct responses before starting the second part of this session.
8. You should also give reasons why answers may be right or wrong.
9. You can always seek the help of the participants.
10. Ask the participants if anyone got all the responses correct.
11. You can give a small reward to that person, or to the person who got the maximum number of correct responses.

Resource Material for Activity 1.1

Correct knowledge about sex starts from an understanding of male and female anatomy. Such knowledge is also essential for understanding how the reproductive organs function, how to explain pregnancy and how to help adolescents develop life skills.

In relation to the process of growing up, the main points that may be included are:

1. Sex organs of boys and related functions/processes:

Penis:	The male organ for sexual intercourse
Scrotum:	The pouch located behind the penis that contains the testicles, provides protection to the testicles, and controls the temperature necessary for sperm production and survival
Testes:	Two round glands which descend into the scrotum following birth, produce and store sperm starting in puberty, and produce the male sex hormone testosterone
Seminal vesicle:	A sac-like structure lying behind the bladder; secretes a thick, milky fluid called seminal fluid that forms part of the semen
Prostate gland:	A gland located in the male pelvis that secretes a thick milky fluid that forms part of the semen. Semen is a milky white fluid passed out of the penis at the time of ejaculation. Semen contains sperm, prostate gland secretions and seminal fluid.
Erection:	The process by which the penis fills with blood and grows taut in response to thoughts, fantasies, temperature, touch or stimulation.
Ejaculation:	The release of semen from the penis caused by sexual excitement. This can occur in situations other than intercourse. It may occur at night and is commonly known as a <i>wet dream</i> ; however, ejaculation does not occur only because of a sexual dream, and is more accurately referred to as <i>nocturnal emission</i> . It is a natural and normal occurrence.

2. Sex organs of girls and related functions/processes:

Labia majora:	Two larger sets of folds on either side of the labia minora that provide protection to the clitoris and both the urethral and vaginal openings.
Labia minora:	Two smaller sets of folds that directly protect the urethral and vaginal openings.
Clitoris:	A small structure located at a point where the labia minora meet; the point of sexual stimulation for the female.
Vaginal opening:	Located between the urethral opening and the anus; point of entry during sexual intercourse and point of outlet during menstruation and childbirth.
Vagina:	Passageway extending from the uterus to the outside of the body; canal through which a baby passes during delivery and menstrual fluid flows. Capable of expanding during intercourse and childbirth, it lubricates during sexual arousal.



Pelvis:	The basin shaped bone structure that provides support and protection to the internal reproductive organs and other organs.
Hymen:	A membrane that stretches across and partially closes the vagina. Though it can tear during physical activity or sexual intercourse, in its intact state, it is closely associated the virginity. Different societies have many myths about the hymen.
Cervix:	The mouth or opening into the uterus; protrudes from the uppermost part of the vagina.
Uterus:	A pear-shaped muscular organ located in the pelvic region; beginning at puberty, the lining sheds periodically (usually monthly) during menstruation; the fertilized egg develops into a baby here during pregnancy.
Fallopian tubes:	Passageways for the egg from the ovaries to the uterus, place where fertilization occurs. An ectopic pregnancy results when a fertilized egg implants in the tubes, rather than in the uterus.
Ovaries:	Two oval-shaped organs located in the female pelvic region. Produce the female sex hormones, estrogen and progesterone; alternate release of eggs at the time of puberty.
Ovum or egg:	Roughly the size of a pinhead. If the egg meets sperm, then conception occurs. If the egg is not fertilized, i.e. does not encounter the sperm, then it dissolves and is discharged during menstruation.
Ovulation:	During ovulation, an ovary releases a mature egg which then is available for fertilization; occurs approximately 14 days before a menstrual period begins, but is frequently irregular in young girls. The first ovulation may or may not coincide with the first menstrual period; usually one egg is released every month.
Fertilization:	The union of the sperm with the ovum that takes place in the fallopian tubes.

Menstruation:

Significance:	It's onset signals the female's physical development for reproduction.
Function:	Periodic shedding of the uterine lining, called menstrual fluid, which forms in preparation of a fertilized egg
Age of onset:	Varies from the age of 9 to 17 years
Termination:	Temporary during pregnancy, after a long illness, physical stress, or mental trauma; permanent termination between the ages of 45 to 55 years
Range of cycle:	Varies: average is 28 days; intervals may be irregular in young girls
Duration of flow:	Varies: average is 2 to 7 days; amount of flow also varies and some girls/ women experience cramps caused by uterine contractions
Hygiene:	A daily bath is an absolute necessity, but it may be necessary to bathe more frequently. Use sanitary protection, which must be changed frequently.

Adolescence:

The period between 10 to 19 years of age is called adolescence. The word is derived from the Latin word *adolescere*, which means *to grow*. During this time, a number of physical, cognitive and social emotional changes take place in the body.

Physical changes:

In a span of 7 to 9 years, boys and girls grow up to be young men and women. For a brief period of two or three years, they experience what is known as *the growth spurt*. Adolescents experience a quick gain in height and weight. The growth spurt begins two years earlier for girls than for boys, but it lasts longer for boys. Within nine years, the boys gain an average of 36 cm in height and 25 kg in weight; similarly girls gain an average of 24 cm in height and 21 kg in weight. However, these are only average values, and wide variations in these figures should not be considered abnormal.

The rapid acceleration in height and weight is accompanied by changes in body proportions. The different parts of the body have their own sequence of growth rate. Some grow slowly, while others grow quickly. At this age, before the arms and legs reach their full length, hands and feet become almost adult size. Girl’s hips become wider in relation to their shoulders.

There is a slight change in facial features. The jaw and the nose become larger, while the mouth widens and the chin becomes more prominent.

Along with changes in the body size, physical changes in the reproductive system also occur, leading to sexual maturity. For the first time in life, obvious differences in girls and boys emerge. Sexual maturation consists of two types of changes in the reproductive system: those that relate to the primary sex organs (the penis and the testes in males and the vagina and the ovaries in females) and those visible on other parts of the body, or secondary sex characteristics. These include breast development in females, growth of facial hair and beards in males, and growth of underarm and pubic hair for both sexes. Girls also begin their monthly menstruation cycle. For boys, semen secretion begins to take place (while urinating, boys may find a few drops of whitish fluid as discharge that can be frightening for some). Many boys experience nightly emissions of semen while dreaming – so called “*wet dreams*.” Erections also become frequent, especially (but not exclusively) when one is excited.

The skin become oilier, and pimples may appear on the face and sometimes on the back. These changes happen because of changes in the body’s natural chemicals, known as hormones. Voice also begins to change in both boys and girls. The voice of boys becomes hoarse and full, while in girls it becomes high-pitched and clear. Both boys and girls have hormones, but they have different amounts of different hormones.



Resource Material for Activity 1.2

Human Sexuality: Human sexuality is a function of one's whole personality that is life long, beginning from birth. It includes:

- ▶ How one feels about oneself as a person
- ▶ How one feels about being a man or a woman
- ▶ How one gets along with members of either gender. Sexuality also includes genital and reproductive health, such as intercourse and child bearing. It is the way one thinks, feels and behaves

The sexual attitudes of children are formed from the earliest stage of childhood, but sexual urges do not make their appearance until the age of puberty. At this point, many changes occur in the young boy and girl. There is a sudden increase in growth. The secondary sexual characteristics appear, and the shape of the body becomes increasingly that of a woman or man.

In the male, puberty and adolescence begin with the appearance of nocturnal emissions. The penis, testes, and scrotum enlarge, and pubic, axillary and body hair appears. The occurrence of body hair in the face, chest, and extremities is conditioned by hereditary and racial characteristics and is, therefore, quite variable. The voice of the young boy breaks and attains a deeper tone. The body, itself, becomes more distinctly muscular.

At about this time, the young man begins to experience a distinct sexual urge or drive. The sexual forces awakened in him make him rather suddenly conscious of the strong sensual pleasure that can be associated with his genitals. There is in the adolescent a heightened sexual excitability, which in the male tends to lead to masturbation. This is particularly true of the male because his sexual drives are more distinctly genital. In the adolescent female, the sexual urges are more diffused, and more associated with emotion and daydreams of romantic situations.

The awakened sexual drive produces in the youth, particularly in young men, a certain restlessness of character so that they are often considered by their elders as different and difficult. Their moods are variable. They are impulsive. They find it difficult to concentrate their attention on anything for any great lengths of time. Often, even their school performance suffers. The young man is usually more interested in his friends, engaging in strenuous physical activities like basketball, swimming, and similar sports.

In both, the first signs towards an independent personality and existence appear which tend to materialize as an emotional withdrawal from home and family. An apparent failure to communicate with their parents or elders is a hallmark of this developmental period.

Indeed, this is the critical period when parents should exhibit the greatest understanding possible. They should recognise the special features of this awakening sexuality, and not misinterpret adolescent behaviour as merely evidence of rebelliousness.

As psychosexual maturity is attained, increasingly love and sex become more clearly identified with one another among boys and girls. Some men who have become so conditioned to sexual expression at the purely physical level, unaware that they are maturing psychosexually, become ashamed and embarrassed by the fact that when they do fall in love later, that emotion seeks sexual expression. Since their previous experience has always been for the mere pleasure of sex, they feel that they are unworthy of this sexuality as expressed in the object of their love.



Other men never quite reach the degree of sexual maturity where sex is an expression of a deep interpersonal relationship with a woman. These men will continue to seek purely physical or biological sexual gratification throughout their lives in a context outside of the emotion. This means that they have been stunted in the development of their sexuality, and that their personalities are immature.

Listed below are the definitions that you may want to use during the discussion on sex and sexuality.

Sex, noun – being male or female, males or females collectively. (Oxford Dictionary). **Sex, noun 1** identify the sex of the animal gender. **2** attraction based on sexuality, sexual attraction, sexual chemistry, sexual desire, sex drive, sexual appetite, libido. **3** lessons in sex/sex education facts of life, sexual reproduction, reproduction. **4** have sex with him/ a relationship without sex intimacy, coitus, coition, coupling, copulation, carnal knowledge, making love, mating, and fornication. (The Concise Oxford Thesaurus, Oxford University Press, 1995)

Sexuality, noun 1 differences based on sexuality, sex, gender, sexual characteristics. **2** famous for her sexuality, sexual desire, sexual appetite, sexiness, carnality, physicalness, eroticism, lust, sensuality, voluptuousness, sexual orientation, sexual preferences. (The Concise Oxford Thesaurus, Oxford University Press, 1995)

Developmental stages: The developmental stages manifest general tendencies, but they do not necessarily describe a particular child. The stages may overlap.

Early adolescence: Onset of puberty, female ages 8-12; male ages 10-14.

- ▶ Starts to move towards peers
- ▶ Vacillates between clinging and rebellion
- ▶ Strives for independence
- ▶ May be confused, preoccupied with body, wonders “Am I normal?”
- ▶ May experiment with same-sex sexual behaviour
- ▶ Begins to think abstractly

Middle adolescence: Female ages 13 -16; male ages 14 - 17.

- ▶ Continues effort to establish separate identity for parents
- ▶ Often becomes idealistic and altruistic
- ▶ Interested in dating, exploring sex
- ▶ Loves intensely, “desperately”
- ▶ Continues to develop abstract thinking

Late adolescence: Female ages 16 and over, male ages 17 and over

- ▶ Declares independence
- ▶ Establishes a set body image
- ▶ Loves more realistically, develops commitment
- ▶ Peer group becomes less important, more selective of friend
- ▶ Develops more consistent framework of values, moral, ethics
- ▶ Able to think abstractly
- ▶ Defines life goals

Developmental tasks

Independence:	Adolescents need to become less dependent on parents. They begin to shift from parents to peers or to belief systems in order to achieve independence. This shift is strong and may involve rebellion.
Identity:	Adolescents struggle to define themselves and what they want to accomplish. They are answering the questions: “Who am I? What can I be?” This process involves experimenting. Adolescents need to develop gender role identity, a positive body image, and a sense of esteem and competence.
Intimacy:	Adolescence is a time of preparation for loving relationships. Adolescents are learning to express and manage emotions. They are developing the capacity to love and be loved, and to be intimate in relationships with others.
Integrity:	Adolescents must develop a foundation for sorting out values. Parents have provided a base for this. However, there is a tremendous amount of other input at this time – peers, media, school, etc. Adolescents are deciding what to believe in and how to behave.
Intellect:	The adolescent’s intellectual capacity is increasing and changing from concrete thinking to include abstract thinking. Many adolescents become capable of conceptual thinking and of understanding logic and deductive reasoning. This increased ability may heighten self-esteem. Some adolescents tend to overvalue their intellectual theories and see things from an idealistic point of view. (UNESCO, 1991)

Emotional changes: Increased hormonal activity during adolescence produces changes in the emotional state of the adolescent. They experience frequent changes in moods, ranging from feelings of extreme happiness to extreme sadness. At times, they find themselves bursting into a rage or tears. Later they wonder why they did what they did.

Sex drive emerges in both boys and girls. Sex drive is an impulse related to the sexual need. It is a natural biological instinct. The immediate outcomes of the sex drive for the adolescent are:

- ▶ Attraction towards members of the opposite sex (for heterosexuals) or same sex (for homosexuals)
- ▶ Crushes or infatuations (can be with persons of opposite sex or same sex)
- ▶ Desire for sexual experimentation (this is critical in the context of HIV/AIDS and STIs)
- ▶ Need for physical contact and intense emotional relationships with peers/friends of the same or the opposite sex

During this period, friends and peers become more important. Acceptance and popularity among peers become very important. To gain acceptance in the peer group, one starts adopting the prevalent norms and behaviours of the group (using slang, smoking, hairstyle, dress etc.) This is also one of the reasons for experimenting with sex and drugs. The stress is on looking and sounding different from children and adults. The need for independence intensifies and awareness about the self increases.

Cognitive changes: One of the main features of adolescent thought is systematic thinking. The adolescents develop the capability to organize their thoughts, reflect on them and then come to a decision that they may implement. For example, if a 16 year old is given money to go shopping, he/she will go to the market, look at the things available, choose what he/she likes and then buy it. A 6 year old may just buy the first thing he/she lays his/her eyes on.



Adolescents are also capable of abstract thinking: the ability to imagine phenomena that are concrete, which are hypothetical or imaginary. This includes comprehension of concepts in mathematics, physics, geography etc. Adolescents become more creative, and seek to experiment with new and different things/ideas etc. They develop coping strategies to deal with change and sudden occurrences. Adolescents develop the abilities to seek relationships and keep them.

Changes also emerge in the way they communicate. Often they develop a special vocabulary that reflects their disdain for adult society. They coin phrases and words that express their exclusivity and strengthen their bonds with their peer group.

Examples of Sexual Behaviour

Masturbation: Masturbation can be defined as self-stimulation by an individual to cause sexual sensations. The use of the word masturbation usually suggests that the person is manipulating his or her genitals to the point of intense pleasure or orgasm. According to some experts, masturbation allows a healthy way to express and explore sexuality, and to release sexual tension without all the associated risks of sexual intercourse.

- ▶ Masturbation can help relieve stress
- ▶ Reduce embarrassing spontaneous erections for teen males
- ▶ Reduce the number of unwanted wet dreams for young men

Masturbation Myths:

- ▶ Masturbation is considered a bad habit to most people.
- ▶ Masturbation isn't "real sex" and only losers masturbate.
- ▶ Masturbation will stunt growth.
- ▶ Masturbation is responsible for either sterility or impotence.

Heterosexual: Heterosexual behaviour means sex with a person of the opposite gender (i.e. male and female). This usually ends in penile penetration and discharge of semen into female's vagina.

Homosexual: Homosexual behaviour means sexual intercourse between two persons of the same gender. Male homosexuals, i.e. MSM, are more significant from the point of view of HIV infection because they may have genital and anal sex, oral sex or mutual masturbation, where flow of semen from one person to the other is involved.

Oral Sex: Sex does not only refer to the union of genitalia. It also includes genital-oral contact. Oral-genital sex is where one person's genital is in contact with the mouth of the other person.

Promiscuity: Promiscuity means indulging in promiscuous (casual and indiscriminate) sexual relations.

Sex workers: Desertion, divorce, destitution, drug addiction, delinquency and deceit are the 6 D's that are primarily responsible for the existence of sex workers. There are also other causes like poverty, uncaring family members, mental illness, etc. These days, sex workers do not only refer to female prostitutes, but to males as well.



Sexual Words Exercise Format

S.N.	English Words	Translation in Native Language	Meaning in local language	Formal words	Slang words
1	Sexual Contact				
2	Masturbation				
3	Anal sex				
4	Homosexuals				
5	Kiss				
6	MSM				
7	Penis				
8	Vagina				
9	Semen				
10	Condom				
11	Sex workers				
12	HIV/AIDS				

Resource Material for Activity 1.3

Guiding Principles for Working on Issues of Sexuality:

- ▶ **Affirmative Approach to Sexuality:** Sexuality is part of everyone's life. Sexuality is complex. It can be a pleasurable, satisfying, and enriching part of life. An affirmative (means 'not denying') approach improves sexual well-being.
- ▶ **Diversity:** Different women and men have different needs, identities, choices, and life circumstances. Therefore, not all women and men have similar sexual desires and concerns.
- ▶ **Autonomy and Self-Determination:** Women and men have the right to make their own free and informed choices about all aspects of their lives, including their sexual lives and preferences, as long as they do not harm others.
- ▶ **Gender Equity:** Programmes that are based on gender equity recognize and provide for women and men/girls and boys to have equitable access to information, services and education that promote sexual well-being.
- ▶ **Responsiveness to Changing Needs:** Women and men's needs for information and services on sexuality change over time and throughout the life cycle.
- ▶ **Prevent Violence, Exploitation and Abuse:** Violence, exploitation and abuse are often the conditions under which people, especially women and girls, experience their sexuality or initiated into sexual activity.
- ▶ **Comprehensive Understanding of Sexuality:** Programmes and services must address and integrate emotional, psychosocial and cultural factors in planning and service delivery.
- ▶ **Non-Judgmental Services and Programmes:** People have differing value systems and make different choices about sexuality. Providers must respect these values and refrain from judging others or imposing their own values on them.
- ▶ **Confidentiality and Privacy:** Sexuality touches upon intimate aspects of people's lives. Individuals have a right to privacy and confidentiality.
- ▶ **Cultural Sensitivity:** Cultural perceptions about issues of sexuality differ among different groups and communities. This should be recognized and respected.
- ▶ **Accessible Programmes and Services:** Accessibility entails more than availability of services. It includes quality, confidentiality, staffing, and catering to a range of needs.
- ▶ **Core Values:** The basic values of choice, dignity, diversity, equality and respect underlie the concept of Human Rights. These values affirm the worth of all people. In the context of sexuality, these words have meaning as well:
 - ▶ **Choice:** Making choices about one's sexuality freely, without coercion, and with access to comprehensive information and services, while respecting the rights of others.
 - ▶ **Dignity:** All individuals have worth, regardless of their age, caste, class, gender, orientation, preference, religion and other determinants of status.
 - ▶ **Equality:** All women and men are equally deserving of respect and dignity, and should have access to information, services, and support to attain sexual well-being.
 - ▶ **Respect:** All women and men are entitled to respect and consideration despite their sexual choices and identities.



Men Who Have Sex with Men (MSM)

Introduction: MSM are an often hidden group in many countries. While some men are open about their sexuality and belong to openly gay communities, many other men are not. Many men who have sex with men do not see themselves as homosexual: they may be married and have children, and yet occasionally have sex with other men. These men may not know of the risks they are taking in relation to their own health and that of their families in terms of HIV/AIDS and other STIs.

Factors: Many factors contribute to make HIV/AIDS a risk for MSM, including:

- ▶ **Sex:** Unprotected anal intercourse (i.e. without using condoms and lubricants) is high-risk activity for transmitting HIV and other STIs because often internal bleeding occurs in the anus, making HIV transmission easier than when having vaginal or oral sex.
- ▶ **Health Care:** Lack of STI testing facilities for identifying and treating STIs and/or failure to attend clinics for fear of being identified as MSM.
- ▶ **Denial:** In many countries, the existence of same-sex intercourse is denied by the authorities and society.
- ▶ **Stigma:** Because of denial and/or the outrage of the community at MSM, many suffer from low self-esteem and attempt to keep their sexuality in secret from their families and the wider society. This decreases the chance that a caring attitude will develop towards the self, and increases the likelihood of practising unsafe sex.
- ▶ **Tradition:** Pressure from family and society to get married and have children, particularly on sons, contributes to the secrecy about MSM. If MSM marry and continue to have unprotected sex with other men, they also put their wives and children at risk of HIV.
- ▶ **Lack of information:** Mainstream media and programme messages about HIV/AIDS tend to revolve around heterosexual sex. MSM often do not have information about the dangers of unprotected sex with other men and, therefore, may be ignorant of the risks.
- ▶ **Injecting drug use:** MSM may also be injecting drugs and may contract HIV from sharing needles and syringes even if they use condoms.
- ▶ **Sex work:** Some MSM work as sex workers and are at great risk of contracting or transmitting HIV and other STIs if they have unprotected sex with their clients, or with other partners.
- ▶ **Police:** Many MSM have suffered police harassment and have little knowledge of their legal rights. Police have threatened to expose MSM or have extorted money from them. In some countries, anal sex is illegal. This is a major hurdle to incorporating messages about safe anal sex into mainstream campaigns.
- ▶ **Condoms:** MSM who are aware of the need to use condoms may be unable to get access to them. Like heterosexual men, some MSM are reluctant to use them because they feel it reduces pleasure.
- ▶ **Lubricants:** To make anal sex with a condom possible, water-based lubricants should be used. These are often difficult to find or expensive. Some men use oil-based fluids as lubricants, like vaseline or other creams, which affects the condom and leads to breakage.



Statements on Sex, Sexuality and Sexual Behaviours:

List of statements that may be used for this exercise

(This list is only a guide, and you may add/delete statements depending on the group and social conditions):

- Once a girl has had her period, she can become pregnant.
- Masturbation makes a boy impotent.
- Masturbation is something that only boys do.
- A girl should not engage in physical activity during her period,
- A drop of semen is equal to 60 drops of blood. Therefore, the loss of semen weakens the body and should be avoided.
- The size of the penis is important and determines masculinity or virility.
- Boys can tell when a girl is having her period.
- One should not bathe during menstruation.
- Nocturnal emissions are a disease and require treatment.
- Thinking about sex is dirty.
- A girl cannot get pregnant if she has sex only once or only a few times.
- It is possible to get pregnant by kissing.
- During menstruation, a girl becomes *unclean* or *impure*.
- If a boys has swelling in his breast, it is nothing to worry about.
- Women are responsible for the sex of the child.
- Men who have sex with men or think of having sex with men are not normal.
- If a girl does not bleed after initial intercourse, she is not a virgin.
- Men who have sex with many women are depraved or abnormal.
- It is immoral to have sexual fantasies.
- All girls must start menstruating by the time they are 13 years old.
- Using condoms during intercourse for preventing infection from STIs/HIV infection reduces pleasure.
- Only immoral and perverted persons get STIs.
- Only men can use contraceptives.
- The *pill* is good protection against STIs.
- Girls should not eat spicy food because it increases their sexual desire.
- Sex is the only way to express love and affection.
- Going to sex workers is safe for the society because it prevents rape and molestation.
- Abstinence is the only method of birth control that is 100% effective.
- Once you have had gonorrhoea and have been cured, you cannot get it again.
- A girl can get pregnant even if a boy does not ejaculate or *come* inside her.
- STIs can be cured if the infected man has sex with a virgin.
- Most of the women who are HIV are prostitutes.
- STIs can only be transmitted via the genitals.
- Girls and boys can have sexually transmitted infections without showing any symptoms.



Sexual maturation in girls and boys occurs in the following sequence:

Girls

- ▶ Breast development: Breast enlargement continues throughout adolescence
- ▶ Appearance of pubic hair
- ▶ Growth in the vagina and the uterus
- ▶ Growth in the other parts of the female genitalia, i.e. labia and clitoris
- ▶ Menarche or the first menstruation: Contrary to what most people believe, menarche is not the first sign of puberty in girls, but appears fairly late in the sequence of pubertal events. The event consists of a flow of sticky blood in small amounts from the vagina. There are many rituals linked with the onset of menarche in many societies. It is a subject of many taboos and misconception.
- ▶ Ova (eggs) begin to ripen. The release of the mature ovum from the ovary (ovulation) begins a few months after menarche.
- ▶ Broadening and rounding of hips
- ▶ Growth of underarm hair

Boys

- ▶ Increase in the size of the testes and wrinkling of the scrotum
- ▶ Appearance of hair in the pubic area
- ▶ There is an increase in the size of the penis, the external sex organ. It continues to grow for several years.
- ▶ Enlargement of the prostate and seminal vesicles (which together produce semen; the fluid that contains the sperm).
- ▶ Appearance of facial hair and axillary hair (also called underarm hair). The facial hair emerges most prominently on the cheeks, the chin and the upper lip.
- ▶ Spermarche is the first spontaneous discharge of semen through the penis. It generally occurs during sleep and the person may be unaware at the time.
- ▶ Appearance of hair on the chest and legs
- ▶ Cracking of the voice: This happens because the larynx (voice box) enlarges and vocal chords lengthen. The change causes a lowering of the pitch so that the voice becomes deep. While this change from high to low pitch is taking place, the voice cracks uncontrollably.

MODULE TWO

Unplanned Pregnancy and Sexually Transmitted Infections

Approximate Time: 3 hours 30 minutes

Module Message: Every day, one million people contract a sexually transmitted infection (STI); people with STIs are at an increased risk for HIV. Safer sex includes practices that reduce the risk of contracting STIs, including HIV (the virus that causes AIDS). STI increases the chances of transmission of HIV (10 fold in cases of genital ulcers, 5 fold in cases of discharge). People can protect themselves from HIV/AIDS with relevant knowledge, positive attitudes, rational decisions and responsible actions, provided there are an enabling environment/supportive context.

Overview:

Introduction

Unplanned pregnancy, sexually transmitted infections and HIV/AIDS are all important issues during adolescence. Adolescence is the time for experimentation and following one's curiosity. It is important to address these issues as they are intrinsically linked with unsafe behaviours and practices, which can lead young people to get a virus that leads to HIV/AIDS.

Notions of sexuality, sexuality education, sexual health and rights have different meanings in different contexts. Different people in different societies understand these notions differently. As a result, there is a need to understand sexuality in the broader context of culture, tradition, religion and morals.

Listed below are some bullet points that can help you to prepare for the session. Personal protection for those who are at risk depends to a great extent on the determination of the individual to act responsibly and also on whether the context of the individual allows him or her to change or avoid risky behaviours. The concepts discussed in this module will help participants understand that HIV/AIDS is preventable. Knowledge needed for choosing a lifestyle that is compatible with HIV prevention will be discussed. Participants should consider the importance of following up these decisions with consistent and appropriate behaviour.

- ▶ Young people are especially vulnerable to STIs and HIV/AIDS. Adolescence and youth are times of discovery, emerging feelings and exploration of new behaviour and relationships. Sexual behaviour is an important part of this, and exploring one's preferred behaviour may involve risks; the same is true of experimentation with drugs legal and illegal.

- ▶ Some young people may become infected with STIs or become pregnant. The same behaviour that causes teenage pregnancies and STIs also causes HIV, the virus that leads to AIDS.
- ▶ Young people often think of themselves as invincible. The general attitude is (not only of young people) that “*AIDS cannot happen to me.*”
- ▶ STIs and HIV/AIDS are no longer restricted to certain groups. It is the behaviour that puts people at risk, not their membership in a certain group. It is not who you are, but what you do that matters.
- ▶ Around 60% of the new HIV infections worldwide are occurring in young people. (UNAIDS 2004)

At the end of 2004, there were 39.4 million people (adults 37.2 million, of whom women 17.6 million and children under 15 years 2.2 million) living with HIV or AIDS. People newly infected with HIV numbered 4.9 million (adults 4.3 million and children under 15 years 640,000). Similarly the AIDS deaths in 2004 were 3.1 million (adults: 2.6 million and children under age 15: 510 000). (UNAIDS 2004) HIV infection is growing rapidly among women because they are both biologically and socially more vulnerable to infection, and often lack control over their own sexuality. Every day, one million people contract a STI; people with STIs are at an increased risk for HIV. STIs occur in all plants and animals that reproduce sexually, including humankind. Unfortunately, STIs among people has come to be regarded as a moral issue.

STIs are among the most common infections that occur among men and women of reproductive age (18-44) in many countries of the world. Those who are infected, however, often underestimate the national prevalence of such infections and their own personal risk of acquiring infection. This is because infections are often asymptomatic and social stigma about people with STIs exists, i.e. only bad people get STIs. Men and women of all ages, racial and ethnic backgrounds, and income levels acquire STIs.

Safer sex includes practices that reduce the risk for contracting STIs, including HIV. These practices reduce contact with the partner’s body fluids, including ejaculate from a man’s penis (semen), vaginal fluids, blood, and other types of discharge from open sores. Safer sex reduces, but does not totally eliminate, risk.

Unprotected anal and vaginal sex with an infected person carries a high risk for disease transmission. Unprotected oral sex carries a lower risk, but is not risk-free. The most reliable way to avoid transmission of STIs, including HIV, is to abstain from sexual intercourse – vaginal, oral, or anal sex – or to be in a long-term, mutually monogamous (sexually exclusive) relationship with an uninfected partner.

Exposure to infection with HIV can be avoided in many ways. Personal protection for those who are at risk depends to a great extent on the determination of the individual to act responsibly and also on whether the context of the individual allows him or her to change risky behaviours. The concepts discussed in this

module will help participants understand that HIV/AIDS is preventable. Knowledge needed for choosing a lifestyle that is compatible with HIV prevention will be discussed. Participants should consider the importance of following up these decisions with consistent and appropriate behaviour.

Objectives:

After studying the module, the participants should be able to:

1. Identify factors leading to teenage pregnancy during puberty
2. Know the physical, psychological, social and economic implications of teenage pregnancy
3. Explain the ways to avoid teenage pregnancy
4. Know STIs, their common symptoms and their causes
5. Identify misconceptions about STIs and clarify them
6. Understand the relationship between HIV and STI
7. Be aware of the ways to avoid teenage pregnancy and STIs prevention
8. Have an understanding of sexual behaviours (different forms of sex and unwanted pregnancy), and their implications
9. Formulate responsible actions in response to HIV/AIDS and STI problems

Content Outline:

1. Impact of pregnancy during adolescence
2. Gender dimension of adolescence teenage pregnancy (effects on mother, babies and family)
3. Concept and types of STI
4. Relationship between STI and HIV/AIDS
5. Problems and obstacles in preventing HIV/AIDS
6. Decision-making regarding HIV/AIDS prevention

Evaluation:

Question-answer on the following questions:

1. What are the causes of unwanted pregnancy?
2. Do women or men get the blame if a woman becomes unexpectedly pregnant? Why?
3. How can you avoid unwanted pregnancy?
4. What do you mean by STIs? What are common types of STIs and their symptoms?
5. What are the prevention and treatment measures for STIs?
6. What is the relationship between HIV/AIDS and STIs?
7. Why can STIs increase the risk of HIV infection?
8. Explain the problems and relevant actions associated with prevention of HIV/AIDS.



- Learning Activities:**
1. Understanding of the impact that pregnancy during adolescence can have on their lives
 2. Awareness about the gender dimension of adolescent teenage pregnancy (effects on mother, babies and family)
 3. Understanding of the meaning and symptoms of STIs and their types
 4. Ways and means of STI prevention
 5. Understanding of safer sex practice
 6. Problems and obstacles in preventing HIV/AIDS

Facilitator's Note: You can follow the *Facilitator's Note* to conduct an icebreaker or warm-up game.

ACTIVITY 2.1

Understanding the Implications of Unwanted Pregnancy During Adolescence

I Am Having A Baby

Approximate Time: 30 minutes

Materials: Blackboard and chalk, whiteboard and markers, Guidelines on Role Play

Objectives: After completing the activity, the participants should be able to:

1. Identify factors leading to teenage pregnancy during puberty
2. Know the physical, psychological, social and economic implications of teenage pregnancy
3. Be aware of the ways to avoid teenage pregnancy

Procedure: Ask the participants to divide into two groups.

1. Ask Group 1 to think about the physical and psychological implications of teenage pregnancy, and prepare to act it out in a 10-minute role play.
2. Ask Group 2 to think about the socio-economic implications of teenage pregnancy for their role play.
3. Give both groups 20 minutes to prepare for their respective role plays.
4. Bring the groups back and present the role plays.
5. Note the highlights or emerging concerns in both the role plays. After both groups have presented, encourage them to clarify their doubts and questions.
6. Summarize the outcomes of presentation (use Resource Material 1.1)

You may use the following questions to facilitate a discussion:

- ▶ How do you feel about this exercise?
- ▶ How can one plan for a pregnancy?
- ▶ In your peer group, how do you view pregnancy? Do you discuss its possibility and the consequences?
- ▶ In your opinion, would a pregnancy affect a man the same way as a woman? What would be different? What would be similar?
- ▶ What are the causes of unwanted pregnancy?
- ▶ Do women or men get the blame if a woman becomes unexpectedly pregnant? Why?
- ▶ How can you avoid unwanted pregnancy?



Evaluation:

Ask the participants to write two points on what knowledge and/or skills they learned from the activity.

Learning Outcomes:

1. Understanding the impact that pregnancy during adolescence can have on lives.
2. Awareness about the gender dimension of adolescent teenage pregnancy (effects on mother, babies and family).
3. Skills on avoiding unplanned pregnancy (using contraceptives, negotiation with partners, etc).

Facilitator's Note:

For younger mothers, there can be serious physical consequences from pregnancy. Since their sex organs are not yet mature, young girls are more likely to experience complications during pregnancy and childbirth that can result in death.

ACTIVITY 2.2

Knowing about Sexually Transmitted Infections (STIs)

Knowing STIs

Approximate Time: 2 hours

Materials: Flip charts, markers, box with questions, answer sheet, provision for prize

Objective: After completing the activity, the participants should be able to:

1. Define the terms STI
2. Explain common symptoms of STIs and their causes
3. Describe various types of STIs
4. Understand the prevalent knowledge/beliefs/misconceptions in the group about STIs
5. Understand the relationship between HIV and STI

Process:

Divide into two groups. Explain that they will play a game to gain understanding about STIs. (30 minutes)

1. Ask the groups to select a leader who will choose the question for the team. Also, ask them to choose a name for their group.
2. Ask the two groups to sit facing each other. Place the box of questions in the centre of the two groups.
3. Keep the question and answer sheet with you. Inform the groups that the decision of the facilitator regarding the scores shall be final.
4. Put up a flip chart for keeping scores – divide it into two columns using the names of the groups.
6. The facilitator will provide the correct answer if both groups fail to give the correct answer.
7. Review all the points they mentioned and summarize the definitions and types of STI by using the handout.
8. Next divide the participants into three groups and ask them to briefly discuss together their topic. (maximum 10-15 minutes)
 - ▶ *What do people think about STIs and what are their beliefs about transmission and treatment of STI?*
 - ▶ *Did you know as much about sexually transmitted diseases as you thought you did? Why or why not?*



- ▶ *How would you start a conversation with your friends/peer group know STIs? What will you say or not say?*
- ▶ *What are the best ways of avoiding STIs? Why?*
- ▶ *Can you be sure who the source of infection is? Why or why not?*
- ▶ *What are the symptoms of STIs? How should STIs be treated?*
- ▶ *Did the exercise clarify your misconceptions or beliefs about STIs? Do you still have some beliefs that require clarification?*

9. Summarize by using the Facilitator's Note.

Evaluation:

1. Conduct a card game to test misconceptions about STI
2. Examine participant knowledge of STIs

Learning Outcomes:

1. STIs – the definition, symptoms, types, myths and prevention
2. Increased awareness about preventing STIs

Facilitator's Note:

1. The exercise is planned to allow the participants to share information with each other. They also receive information that is correct. This exercise can be done in a mixed group or separately in gender-based groups.
2. Follow the rules below to conduct the exercise:
 - ▶ Each group will be asked a question alternatively.
 - ▶ If a group fails to answer correctly, the question will be passed to the other group.
 - ▶ Each team will have 2 minutes to produce the correct answer.
 - ▶ Each correct answer will be worth 10 points. If the question is passed to the other group and correctly answered, it will receive 10 bonus points (10+10)
 - ▶ The scores will be added after the final question has been answered.
 - ▶ The winners will receive a reward.



ACTIVITY 2.3

Identifying Problems and Taking Appropriate Actions to Prevent STIs, Including HIV/AIDS

Approximate Time: 1 hour

Materials: Overhead projector and transparency of Resource Material 2.3, flip chart paper and pens, penis model

Objectives After doing this activity, the participants should be able to:

1. Identify problems and difficulties that prevent a person from protecting oneself from STIs, including HIV infection.
2. Prepare appropriate actions to overcome the problems in STI/HIV/AIDS prevention.
3. Develop skills on correct use of condoms

Content Outline:

1. Problems and obstacles in avoiding STI/HIV/AIDS
2. Responsible decisions and actions to protect oneself from STI/HIV/AIDS
3. Skills on using condoms properly

Procedure:

1. Introduce Resource Material 2.3 (10 minutes)
2. Explain that one's actions may be affected by one's knowledge, attitudes, decisions, situational context and power the person has over his/her environment and sexuality.
3. Divide the participants into three groups and give them time to fill out Resource Material 2.3 on flip chart paper.
4. Call on each group to present their output. (35 minutes)
5. Compare the group's responses and summarize the session. (15 minutes)

Evaluation: Ask some participants to demonstrate the correct use of condoms on the penis model

Learning Outcome:

1. Practical measures on protecting oneself from STIs, including HIV infections
2. Correct demonstration use of condoms on the penis model.



Resource Material: 2.1

Understanding the Implications of Unwanted Pregnancy during Adolescence

Babies born to a teenage mother have lower birth weights than those born to older mothers. Sometimes young girls are frightened of pregnancies, and attempt unsafe abortions (using coat hangers, sticks of wood or chemical substances). This can damage their uterus, resulting in problems with future pregnancies. In many countries, abortion may still be illegal. Research the legality of this issue.

If a pregnant teenager or woman is unmarried, they may experience mental anguish and trauma. Society and her family may look down upon her or pressure her to have an abortion. Her friends may ostracize and ridicule her. She may have to discontinue her education. Parents may try to force her to marry the father of the expected child or someone else to avoid shame and ridicule. The marriage may lead to problems, as both the girl and the boy are ill-prepared for the responsibilities of parenthood. They may not be able to get a job or earn a living, and may not be able to care for the child.

The consequences of teenage pregnancy are extreme for a girl. The best way of avoiding teenage pregnancy is to abstain from sexual intercourse. If two people do decide to have sex, they should discuss birth control and protection. They might use a condom, the pill, a female condom, etc.

For facilitation of this exercise, gather information about the societal norms and practices on pregnancy. Also, get practical information on clinics and health centres where a young woman and man can seek guidance and help in case of pregnancy.

You can introduce the subject of contraceptives at this stage, but be aware of the cultural and religious dimensions of the subject.



*Be a faithful partner
to be safe from STIs/HIV infection*

Resource Material 2.2a

Knowing about Sexually Transmitted Infections (STIs)

The tables below can be used for **Activity 2.2**. *Table I* below can be given as reading material after the exercise is over, and the questions and answers can be used for the exercise. *Table II* provides the names of commonly contracted STIs and their symptoms, may be used for making the game cards and can also be given as a handout.

Table I: Questions and Answers

Questions (to be copied on slips of paper and mixed in a bowl for the groups)	Answers (to be kept by the facilitator with the questions for scoring and giving information)
What are STIs? Give a correct description.	STIs are those infections that are mostly transmitted through sexual contacts. These are sexual intercourse and intimate body contact, especially if exchange of body fluids takes place. The sexual contact includes contact between the penis and vagina, anus or mouth through vaginal sex, anal sex, and oral sex.
What is another name for sexually transmitted infections?	Venereal diseases and or Sexually Transmitted Diseases (STDs)
What does venereal disease mean?	Diseases of Venus, the goddess of love
Name a few STIs.	Gonorrhoea, Syphilis, Herpes, HIV/AIDS, Genital Warts, Chancroid
Are all STIs curable?	No, most are curable, but exceptions are the viral STIs such as herpes, HIV/AIDS and Hepatitis B.
Do you know immediately that you have an STI?	Not always! You may have an STI, but may have no symptoms for a long time (e.g., chlamydia for both sexes, gonorrhoea for women).
List the possible symptoms of an STIs.	Burning sensation while urinating. A clear or creamy discharge from the penis. Blisters, ulcers or swelling on or around the genitals. Warts around the penis, vagina or anus.
Why are some STIs dangerous?	If not detected and treated, the infection can spread and can, for example, cause sterility in women. Syphilis can lead to death. The presence of an STI also facilitates HIV transmission.
Is HIV/AIDS an STI?	Yes, when the virus is transmitted by sexual intercourse. It can also be transmitted in non-sexual ways, as well.
Name the most effective ways to protect yourself from STI infection.	The ABCs of HIV/AIDS and STI prevention: Abstinence (no sex), Being faithful (mutual monogamy, only if both partners are free of infection), Condom use (correctly and consistently).



Questions (to be copied on slips of paper and mixed in a bowl for the groups)	Answers (to be kept by the facilitator with the questions for scoring and giving information)
What is the first thing you should do when you think you have an STI?	See a doctor to get proper diagnosis and treatment. Inform your sexual partners that you may be infected.
Your doctor prescribed medicines for 10 days but the symptoms disappear after 5 days of medicine intake. Can you stop taking the medicines?	No, STI germs are hard to kill. Therefore, the medicine must be taken for the duration prescribed by the doctor.
Why are people who have an STI more vulnerable to HIV infection?	Many STIs cause sores (openings on the skin, as well as in or around the genitals). These sores make it easier for HIV to enter the body.
Can a pregnant woman who has an STI transmit the infection to the baby?	Yes, children born to infected mothers can become infected with an STI during delivery. The HIV virus can also be passed on to the baby through breast-feeding.
You can have sex while you are being treated for an STI.	No, you can infect your partner even while you are being treated. Therefore, you should not have sex until you are completely cured.
STIs can be cured by having sex with a virgin.	No, this is a total fallacy. In fact, it is likely that you will infect the virgin with STI.
You can contract STIs only if you go to sex workers for sex.	No, STIs can be contracted from anyone who has the infection, including your regular partner.
You will not contract STIs if you are careful and wash your genitals with soap and water after having sex.	No, STI viruses/germs cannot be removed through washing or bathing.
Only women can spread STIs.	No, STIs can be spread by any person who is infected.
Birth control pills are a good method for STI prevention for women.	No, Birth control pills do not prevent STI. Only the use of condoms can reduce the risk of STIs.
You can buy medicines from the drug store to treat the STI infection without going to the doctor.	No, STI must be diagnosed and treated by a qualified doctor.

Table II: Common STIs and their Symptoms

Name of the STI	Symptoms
Syphilis	Hard, painless, clean, ulcer/lesion on the penis/vaginal area, inside rectum or mouth Persistent fever Sore throat Patches of hair loss Rashes on palms, soles, chest and back (bacterial infection)
Chancroid	Ulcers – painful, multiple, soft Painful swelling of lymph nodes (one side) (bacterial infection)
Herpes Genitalis	Multiple ulcers, shallow erosions, incurable, severe pain, fever, difficulty in urinating (viral infection)
Gonorrhoea	Thick yellow discharge from penis/vagina, pain in urination and or during sex (bacterial infection)
Chlamydia	Abnormal discharge from the penis/vagina (also infertility), bleeding/pain during intercourse, pain while urinating (bacterial infection)
Hepatitis B	Severe infection shows: Loss of appetite, nausea/vomiting, fever, joint pains, jaundice symptoms, dark urine, pain in abdomen (viral infection)
Urethritis	Mild/severe pain while urinating, pus/mucous discharge from penis/vagina (bacterial infection)
Proctitis	Itching/burning around anus, pus/mucous discharge in stools, mild/severe pain during bowel movement, occasional diarrhea or fever; 3 out of 10 men show no symptoms (bacterial infection)
Genital warts	External warts around anus or penis/vagina (viral infection)
Crabs	Lice in the hairy parts of the body, itching mainly at night (parasitic)
Scabies	Itchy red spots or rash on wrists, ankles, hands, penis/vagina, chest and back (parasitic)
HIV	Damages immune system, incurable, leads to AIDS



Resource Material 2.2b

Knowing about STI

Initially STIs were called STDs (Sexually Transmitted Diseases), but this term did not capture sexually transmitted illnesses that did not exhibit symptoms. Therefore, the term STI is preferred. STI differs from UTI (Urinary Tract Infection) & RTI (Reproductive Tract Infection) as these infections need not be sexually transmitted.

STIs are infections that are spread from one person to another through unprotected sex with someone who is infected. The unprotected sex may include vaginal, oral and anal sex.

Modes of STI Transmission

- ▶ STIs spread if a person has unprotected sexual intercourse with an infected partner through sexual contact, including contact between the penis and vagina, anus or mouth. The sexual act can be vaginal, anal or oral.
- ▶ Transmitting an STI requires direct contact of mucus membranes or open cuts/sores with infected blood or other body fluids (semen, vaginal secretion).

Some STIs can also be transmitted by

- ▶ Sharing of contaminated needles (Syphilis, Hepatitis B, C, D, and G, HIV)
- ▶ Transfusion of infected blood (Syphilis, Hepatitis B,C,D, and G, HIV)
- ▶ Infected mother to child (Syphilis, Gonorrhoea, Hepatitis B, C, D and G, and HIV)

Reasons why STIs remain untreated

- ▶ Men and women with STIs may not have symptoms, so they do not seek treatment.
- ▶ Clinics that report STI cases may not be easy to reach.
- ▶ People with STIs usually first go to alternative health care providers, or buy drugs themselves from pharmacies without a doctor's prescription.

When are the people at risk of getting STIs?

- ▶ Having multiple sex partners
- ▶ Having unprotected sex (sex without condom)
- ▶ Use of drugs before sex (and no use of condom)





Misconceptions about STIs

- ▶ Having sex with virgin girls or boys cures STIs
- ▶ STIs can be transmitted using the same toilet
- ▶ One can get an STI by swimming in the same pond/pool
- ▶ Masturbation can cause STI
- ▶ One can get STI from just sleeping together
- ▶ Witch bites can cause STIs
- ▶ NAGA (king of snakes) bites can cause STIs
- ▶ One can get STIs from sitting on the warm seat of an STI patient
- ▶ One can get STI if one urinates immediately in the urine of an STI patient

Signs and Symptoms of STIs

General (male and female)

- ▶ Burning/pain during urination, increased frequency of urination
- ▶ Blisters/sores (ulcers) on the genitals – painful/painless
- ▶ Swollen/painful glands in the groin
- ▶ Itching in the groin area
- ▶ Non-itchy rash on the body
- ▶ Warts in the mouth, or around the penis, vagina or anus
- ▶ Flu-like symptoms – fever, body ache, headache

Female

- ▶ Unusual vaginal discharge (yellow, frothy, curd-like, pus like, foul smelling, blood tinged)
- ▶ Lower abdominal pain
- ▶ Irregular bleeding from the genital tract
- ▶ Burning/itching around the vagina
- ▶ Painful intercourse

Males

- ▶ Discharge from the penis – pus-like substance or thin whitish fluid

Other Symptoms of STIs include:

1. ***Lower abdominal pain in the female***
Pain in lower abdomen. Referral to a doctor and use of condom needed.
2. ***Inguinal swelling***
Swelling of groin. Referral to a doctor for both partners and use of condom needed
3. ***Painful scrotal swelling***
Pain and swelling of scrotum following a sex act. Referral to doctor for both partners and use of condom needed.

No symptoms:

Symptoms are usually noticeable in men; in women, sometimes the infection stays without symptoms and is noticeable only after her partner is diagnosed with an STI.

STIs can not spread by: using a public latrine, insect bites, sins of a past life, masturbation, eating *hot* food, bad blood, working in a hot atmosphere!

STIs can not be cured by: eating certain types of food, application of certain oils, having sex with a virgin girl or boy.

Complications of untreated STIs

- ▶ Pelvic inflammatory disease (PID) – swelling of uterus, tubes, and ovaries causing abdominal pain, vaginal discharge and fever
- ▶ Infertility (male and female)
- ▶ Ectopic pregnancy (pregnancy developing outside uterus)
- ▶ Abortion, stillbirth, early childhood deaths
- ▶ Eye infection of newborn – blindness (gonorrhoea)
- ▶ Damaged reproductive organs in both sexes
- ▶ Birth defects
- ▶ Cancer of cervix
- ▶ Chronic abdominal pain
- ▶ Death due to sepsis, ectopic pregnancy or cervical cancer

Relationship between STIs and HIV

- ▶ Like HIV/AIDS, STIs are also transmitted by the same route
- ▶ Same modes of prevention and same behaviours
- ▶ STI increases the chances of transmission of HIV (10 fold in the case of genital ulcers, 5 fold in cases of discharge)
- ▶ Risks of getting HIV increases if there are open wounds in an STI-infected person
- ▶ Many STIs can be cured, but HIV/AIDS cannot be cured
- ▶ Generally, partner treatment is also needed to successfully treat STI infection
- ▶ People most-at-risk for STIs and HIV are the same
- ▶ Consistent condom use is the best prevention method for HIV and STIs
- ▶ STIs may be more severe and more resistant to treatment in HIV patients due to their often lower level of resistance to diseases
- ▶ STI prevention is one of the main strategies in fighting the HIV/AIDS epidemic

Resource Material 2.3

Basic information about HIV/AIDS and the use of condom as preventive measure

1. How does a person become infected with the HIV virus?

There are only three ways of transmission:

- ▶ Having unsafe sexual intercourse with an *infected* person
- ▶ Through *infected* blood
- ▶ From an *infected* mother to her child (mother to child transmission)

2. How is HIV spread through unsafe sexual contact?

- ▶ Contact between the *penis* and *vagina* in heterosexual intercourse
- ▶ Contact between the *penis* and the *rectum* in anal intercourse between man and woman (heterosexual) or man and man (homosexual)
- ▶ Contact between *seminal fluid* or *vaginal secretion*, including menstrual blood and the mucous membranes of the *mouth* in oral intercourse

A woman has a greater chance of being infected by an HIV-infected male than a man being infected by an HIV-infected woman because of biological characteristics and socio-economic vulnerability.

3. How is HIV spread through infected blood?

- ▶ Transfusion of *infected* blood from one person to another. Blood donation has no risk of acquiring HIV infection.
- ▶ Un-sterilized syringes and needles
- ▶ Sharing the same syringe and needle among injecting drug users (IDUs)
- ▶ Skin penetration by an infected needle, or other skin-piercing instruments (e.g. razor or tattooing, body-piercing instruments)

4. How is HIV spread from an infected mother to an unborn child?

- ▶ Before birth: through the placenta
- ▶ During birth: exposure of the baby to the infected body fluids of its mother
- ▶ After birth: through breast-feeding



5. How is the HIV virus *not* transmitted? What are the misconceptions people have regarding HIV/AIDS/STD?

- ▶ Shaking hands, embracing
- ▶ Sharing towels, bedding, linen toilet articles, glasses, crockery
- ▶ Caressing, petting, kissing
- ▶ Masturbation
- ▶ Coughing, sneezing, tears
- ▶ Use of public toilets, swimming pools, community showers
- ▶ Donating blood
- ▶ Scratches and bites from mosquitoes or pets
- ▶ Caring for person with AIDS or HIV-positive people.

6. Is HIV/AIDS preventable and/or curable?

At present, vaccines for the prevention of HIV infection and drugs for the treatment of AIDS are being tested for their safety and efficacy. Even while some of the opportunistic infections that accompany AIDS can be treated with appropriate drugs, the individual usually succumbs to multiple infections and general debility within 5-15 years. Therefore, the only way to protect from AIDS is to prevent oneself from being infected with the virus.

7. What is prevention?

Prevention refers to any measures undertaken to protect individuals or groups from being exposed to the HIV virus.

8. How does one protect oneself and one's family from HIV/AIDS?

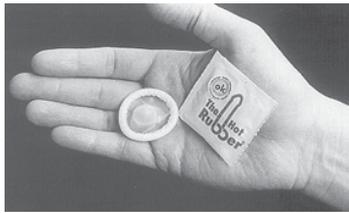
The major route of transmission is through sexual intercourse, and one can follow, '*the ABCs of HIV/AIDS/STI prevention*'

- ▶ **A: Abstinence**
Abstain from sexual intercourse (vaginal, anal and oral). Penetrative sex of various kinds including vaginal, oral or anal sex should be avoided. This can, under normal circumstances, only be a temporary measure.
- ▶ **B: Be faithful**
Have sexual intercourse only with an uninfected faithful partner
- ▶ **C: Condom use**
Use condoms correctly and consistently for all types of penetrative sex.



9. What do *safe sex*, *protected sex* and *safer sex* mean?

- ▶ **Safe sex:** Sex activities/behaviour (no risk) that prevents a partner's blood, semen or vaginal secretions from coming into contact with your blood and, thereby, prevents transmission of infection. E.g. masturbation, massage, rubbing, hugging, touching genitals, etc.
- ▶ **Protected sex:** Sexual intercourse with a condom
- ▶ **Safer sex:** Broadly defined as the behaviour that reduces the risk of any unwanted consequences of sexual activity. Reduce the risk by using a condom correctly and every time one has sex.



Use condoms for safer sex

10. Use of Male Condom

- ▶ Be sure you have a condom before your need it.
- ▶ Each time you have sex, a new and unused condom should be put on the penis before it enters the vagina, rectum, or mouth. Do not reuse the same condom.
- ▶ Put the condom on only when the penis is erect.
- ▶ When putting on the condom, hold it so that the rolled rim is on the outside.
- ▶ If the male is not circumcised, first pull the foreskin of the penis back.
- ▶ Do not pull the condom tightly against the tip of the penis, but pinch the end of the condom when unrolling it – this leaves a small, empty space to hold the semen.
- ▶ Unroll the condom all the way to the base of the penis.
- ▶ If the condom tears during sex, the penis should be withdrawn immediately and a new condom put on.
- ▶ After ejaculation, the male partner should hold to the bottom of the condom as the penis is pulled out, so that the condom does not slip off.
- ▶ Carefully take the condom off without spilling any semen
- ▶ Wrap the condom in paper (such as a tissue or newspaper) until it can be disposed of in a closed garbage bag.

The following tips will help prevent a condom from breaking or leaking:

- ▶ Store condoms in a cool, dark, dry place. Heat, light, and humidity can damage condoms.
- ▶ If possible, choose pre-lubricated condoms that are packaged so that light does not reach them.
- ▶ If lubricant is needed, use a water-based lubricant (KY Jelly, glycerine).
- ▶ Open the wrapper carefully so that the condom does not tear (do not use teeth or scissors to open the package).
- ▶ Do not use condoms that are sticky, discoloured, or damaged in any way.

MODULE THREE

Basic Facts about HIV/AIDS

Approximate Time: 3 hours 15 minutes

Module Message: It is important to know about the meaning of HIV/AIDS, as well as situations and behaviours that are associated with high risk and vulnerability to HIV/AIDS.

Overview: People need to understand why and how AIDS can affect them. Although incidence is relatively high among the world's poorest and least educated populations, HIV/AIDS also affects affluent societies. Anyone can be affected by the AIDS virus regardless of age, gender, sexual orientation and economic status. Hence, in this module, the basic facts about HIV/AIDS will be discussed – how it is transmitted, how it is not transmitted and who are most likely to be affected.

There are certain behaviours that can put one at risk for acquiring HIV and other STI infections. Those behaviours are unprotected sex (sex without using a condom), having multiple partners, transfusion of infected blood, injecting drug use, needle-sharing and other forms of substance abuse.

Objectives: After studying the module, the participants should be able to:

1. Explain basic facts about HIV/AIDS and STI
2. Define terms related to HIV/AIDS and STI
3. Understand why it's important to know
4. Assess behaviours/practices in terms of their risk level
5. Identify external factors that could increase the risk of HIV/STI infection
6. Identify vulnerable or high risk behaviours
7. Identify the elements in the chain of HIV/AIDS infection
8. List ways by which the biological cycle of HIV infection can be broken

Content Outline:

1. Introduction to HIV/AIDS
2. Basic facts about HIV/AIDS and STI
3. Terms related to HIV/AIDS and STI
4. Facts versus myths about HIV/AIDS
5. Risks of contracting HIV/AIDS
6. Elements in the chain of HIV/AIDS infection
7. Breaking the biological cycle of HIV/AIDS
8. High risk and vulnerable behaviours for contracting HIV/AIDS

- Learning Activities:**
1. Brainstorming on HIV/AIDS and the importance of knowing about it
 2. Game on HIV/AIDS myth or fact
 3. Self-evaluation activity on high risk behaviours
 4. Buzz session: Who is at risk and vulnerable to HIV/AIDS?
 5. Analysing the elements in the chain of infection
 6. Breaking the biological cycle of HIV/AIDS transmission
 7. Buzz session: Who is at risk and vulnerable to HIV/AIDS?

- Evaluation:**
1. Feedback from the discussion and presentation
 2. Risk assessment by the participants and no-risk, low-risk and high-risk game
 3. Listing of basic facts and life skills developed

Facilitator's Note: Follow *Facilitator's Note* to conduct icebreaker or warm-up game

ACTIVITY 3.1

Introduction on HIV/AIDS

Approximate Time: 45 minutes

Materials: Chart paper, glue stick, small coloured cards, scissors

Preparations:

1. Make copies of *Resource Material 3.1 'Definition of HIV/AIDS and its Importance'*
2. Be prepared to give and provide correct information regarding HIV/AIDS by reading the background materials in this manual carefully.

Objectives: After doing this activity, the participants should be able to:

1. Define HIV/AIDS and know its meaning
2. Differentiate between HIV and AIDS
3. Describe why it is necessary to understand HIV/AIDS

Content Outline:

1. Meaning of HIV/AIDS
2. Importance of knowing about HIV/AIDS

Procedure:

1. Explain the purpose of the session to the participants
2. Ask the participants for plenary discussion and question/answer. (30 minutes for discussion and summarization)
3. Ask the following questions as a guide for discussion:
 - ▶ Ask each participant to share what they have heard about HIV/AIDS?
 - ▶ When did they hear?
 - ▶ From what channel or means did they hear?
4. Note all points on the board or chart paper.
5. Read each of the points in a clear, loud voice, and ask them to reconfirm whether they are right or wrong.
6. Correct mistaken ideas.
7. Ask the participants if they can state what the acronyms of AIDS (Acquired Immune Deficiency Syndrome) and HIV (Human Immunodeficiency Virus) mean (see *Resource Material 3.1*). (10 minutes for discussion)
8. Read each of the points, and ask them to reconfirm whether they are right or wrong.
9. Distribute two or three cards to each participant and ask them to write a few words or phrases stating why it is important to be informed about HIV/AIDS. (10 minutes)
10. Paste all the cards on the wall and summarize. (5 minutes)



Evaluation:

What is the difference between HIV infection and AIDS?
What are the symptoms of HIV infection and AIDS condition?

Learning Outcome: Knowledge and understanding about HIV/AIDS

Facilitator's Note:

1. The facilitator should assume that the learners have already attended sessions on HIV. They could know some information, but they will likely still have misconceptions.
2. Given below are only typical answers that may come out of brainstorming among the participants. This is only a guideline, and they may not be the precise answers as written below. Do not interrupt, even if answers are absurd. By the end of the activity, the facilitator should provide the correct answers. Keep in mind that HIV and AIDS are not the same; HIV is a virus, and AIDS is a condition that develops after getting the HIV virus. It leads to death because there is no cure available.
 1. A disease that transmits from one person to another through irresponsible sex
 2. A disease received from infected people
 3. An STI that has no cure
 4. A disease that infects the sexual organs
 5. A disease that may be transmitted through unscreened blood and syringes
 6. A disease that may transmit from another HIV-infected person
 7. Heard a few years back from the project personnel and outreach educators
 8. Heard through radio/TV
 9. Heard while observing the street drama
 10. Heard while watching cinema
 11. Heard from a peer who died of HIV
 12. Heard from a health person while a friend was getting treatment for an STI
 13. Heard from a client who wanted to use condoms
 14. HIV/AIDS appeared some 30 years before
 15. HIV/AIDS appeared 15 years before
 16. HIV/AIDS appeared 20 years before
 17. Not known to me



ACTIVITY 3.2

Facts about HIV/AIDS

Approximate Time: 1 hour

Materials: Small box, chart paper, small coloured cards, cut outs of “*Myths on HIV/AIDS or Fact on HIV/AIDS,*” “*Ways HIV/AIDS Transmits*” and “*Ways HIV/AIDS Does Not Transmit,*” overhead and transparencies, scissors, adequate numbers of condoms to play game

Preparations:

1. Conduct the warm-up game ‘*Try to Pop the Condom.*’ (see Facilitator’s Note for instruction)
2. Copy the “*Myth or Fact Game*” (*Resource Material 3.2*) on small cards, and cut out each of the statements.
3. Place the slips of paper in a card box.
4. Prepare enough copies of *Resource Material 3.2a “Basic Facts about HIV/AIDS.”*
5. Use *Resource Material 3.2c “Finding the Answers.”* Copy the terms in Group A on coloured cards. Copy the meanings in Group B on another group of coloured cards.
6. Be prepared to give correct information regarding HIV/AIDS by reading the background materials in this manual carefully.

Objectives: After doing this activity, the participants should be able to:

1. List the main ways of preventing HIV/AIDS
2. Describe facts about HIV/AIDS
3. Distinguish myths about HIV/AIDS from facts
4. Describe terms related to HIV/AIDS

Content Outline:

1. Modes of HIV/AIDS transmission
2. Facts about HIV/AIDS
3. Myths about HIV/AIDS

Procedure:

1. Divide the group into two teams (Group A and Group B).
2. Fix two pieces of flash cards; “*Myths on HIV/AIDS*” and “*Facts on HIV/AIDS,*” on the wall
3. Instruct each participant to draw a slip of paper from the box and read the statement to her/him
4. Ask the participant then to state aloud either “*MYTH*” or “*FACT*” and paste in one of the two appropriate columns – “*MYTH*” or “*FACT,*” – on the wall chart. Note all points on the board or chart paper.



5. You and the rest of the participants should judge whether he/she is correct.
6. Distribute handout on *“Basic Facts of HIV/AIDS”* (Resource Material 3.2b).
7. Give participants about 5-10 minutes to read, and then ask them to choose a fact to share with the group.
8. Fix two flash cards, *“Ways HIV/AIDS Transmits”* and *“Ways HIV/AIDS Does Not Transmit,”* on the wall
9. Ask each participant to pick up the cards and write *“Ways HIV/AIDS Transmits”* and *“Ways HIV/AIDS Does Not Transmit”*
10. Instruct each participant to stick each card in one of the two appropriate columns. *“Ways HIV/AIDS Transmits”* and *“Ways HIV/ Does Not Transmit.”* Note all points on the board or chart paper.
11. Ask all of them to review whether they would like to shift a card from one column to the other after judging right or wrong.
12. Ask selected participants to summarize the outcomes of the lesson.
13. Summarize by presenting Transparency 3.3 (Resource Material 3.3).

Evaluation:

The participants should be evaluated on the basis of their knowledge demonstrated during group work and presentation

Learning Outcome:

Finding the answer:

1. Explanation of the modes of HIV/AIDS transmission
2. Listing the facts about HIV/AIDS
3. Clarification of myths and misconceptions about HIV/AIDS

Facilitator’s Note:

1. Use the following instructions to play the *“Pop the Condom”* game.
 - ▶ Provide each guest with a condom that they must blow up, tie, and break.
 - ▶ In each balloon is a strip of paper that has a simple saying.
 - ▶ One condom has the strip written *“Happy Birthday”* and that person receives a prize.
 - ▶ Take adequate number of condoms and insert the strips of paper.
 - ▶ Sayings that you can use on the strips of paper inside the balloons include, *“too bad,” “better luck next time,” “sorry, no cigar,” “nothing for you,”* etc.
 - ▶ It’s great to watch participants try to pop the condom by sitting, standing, stomping, etc.
2. You should prepare the cut outs of *“Myths on HIV/AIDS,” “Fact on HIV/AIDS,” “Ways HIV/AIDS Transmits”* and *“Ways HIV/AIDS Not Transmit.”* To the extent possible, you should prepare the sample cards in the form of the picture cuttings given in the table below and summarize the session at the end of the activity.



ACTIVITY 3.3

Knowing One's Risks from HIV/AIDS

Approximate Time: 1 hour

Materials: Picture/visual, transparencies, overhead projector, Resource Materials 3.1-3.3, four wall cards stating No Risk (Safe), Low Risk, and High Risk

Preparation:

1. Make one (1) picture/visual of each of the entries in *Resource Materials 3.3a* and *3.3b*, "How HIV is Spread" and "How HIV is Not Spread"
2. Make transparencies of *Resource Materials 3.3a* and *3.3b* "How HIV is Spread" and "How it is Not Spread"
3. Make enough copies of *Resource Material 3.3* for the self-activity
4. Prepare "Risk-No Risk" game cards

Objectives: The participants should be able to:

1. Match behaviours/practices to their level of HIV/AIDS risk
2. Identify external factors that could increase risk of HIV/AIDS infection
3. Describe the important risk behaviours associated with HIV/AIDS infection

Content Outline:

1. Modes of HIV/AIDS transmission
2. Important risk behaviours
3. Knowing one's risk from HIV/AIDS

Procedure:

1. First of all, explain the purpose of the session and mention that you are going to play a game for the activity.
2. Fix three flash cards on three corners of the room; no-risk, low-risk, and high-risk behaviour.
3. Ask the participants to choose one risk perception card from the card box.
4. Ask each participant to move to one of the corners – "no-risk," "low-risk," "high-risk" – and give the reason for their choice.
5. Ask all of them to review whether they would like to move from one corner to the other.
5. Review the responses of the participants and correct them if needed.
6. Explain that some points depend on the circumstances, e.g. Oral sex may or may not be high risk; similarly, having multiple sex partners may be low risk if there is consistent and correct use of condoms.
7. Use transparencies to summarize the ways by which HIV is spread or is not spread.



8. Distribute *Resource Material 3.3*.
9. Ask the participants to answer the self-activity, giving them approximately 5 minutes to complete the task.
10. Clarify misconceptions.
11. Discuss external factors that could increase the risk of HIV/AIDS infection.

Evaluation: Feedback based on the responses and participation in the no-risk/ low-risk/ high risk exercise.

Learning Outcome:

1. Ways of how HIV/AIDS spreads
2. Ways of how HIV/AIDS does not spread
3. Level of risk of common behaviours and practices
4. External factors that increase risk of HIV/STI infection

Facilitator's Note: Ask the participants to give reasons for no-risk, low-risk and high-risk responses.

ACTIVITY 3.4

Biological Cycle of Transmission of HIV/AIDS and Elements HIV/AIDS Infection

Approximate time: 30 minutes

Materials: Pen, flip chart paper, overhead projector and transparency of *Resource Material 3.4*

Objectives: After doing the activity, the participants should be able to:

1. Describe the elements of the HIV/AIDS chain of infection
2. Identify preventive measures that will break the HIV/AIDS chain of infection

Content Outline:

1. Elements in the HIV/AIDS chain of infection
2. Measures to break the HIV/AIDS chain of infection for prevention

Procedure:

1. Explain the purpose of the session.
2. Explain the elements in the chain of HIV infection using the transparency of *Resource Material 3.4*.
3. Ask the participants to identify and illustrate the elements of the HIV/AIDS chain of infection on flip chart paper.
4. Ask the participants to go through *Resource Material 3.2*, if needed.
5. Ask to review the elements of the chain of infection of HIV/AIDS.
6. Explain that HIV/AIDS transmission can be stopped by appropriate preventive measures directed against specific modes of transmission. Refer to *Resource Material 3.3*.
7. Divide participants into four task groups.
8. Assign one mode of transmission to each task group.
9. Ask each group to write down on flip chart paper the specific measures against the mode of transmission they mentioned. Allow 5 minutes for this.
10. Ask each group to present their work.

Evaluation: Ask selected participants to summarize the knowledge and skills they obtained through the activity.

Learning Outcome:

1. Identification of the elements in the HIV/AIDS chain of infection
2. Summarizing preventive measures for breaking the chain of HIV/AIDS infection

Facilitator's Note: Make sure that all participants go through the resource materials provided to them.



Resource Material 3.1

Definition of HIV/AIDS and its Importance

1. Definitions of HIV/AIDS: HIV stands for Human Immuno-deficiency Virus

- ▶ **H** stands for *Human*: It means it is transmitted from one human being to another
- ▶ **I** stands for *Immunodeficiency*: It breaks down the immune system, or makes it “*deficient*.” As a result, the body cannot protect itself from diseases.
- ▶ **V** stands for *virus*: It means a microscopic organism that causes disease in your body.



AIDS stands for Acquired Immune Deficiency Syndrome

- ▶ **A** stands for “*Acquired*.” In other words, not hereditary, but acquired through a specific behaviour. It is the result of contact with a source external to the person, such as sexual partners.
- ▶ **I** stands for “*Immune*.” It is the ability to fight against diseases. It refers to the body’s natural defence system, which provides protection from disease-causing organisms.
- ▶ **D** stands for “*Deficiency*.” It means a loss in ability to fight against diseases due to the breakdown of the immune system. It describes the lack of response by the immune system to organisms that impair the body’s ability to protect itself against diseases.
- ▶ **S** stands “*Syndrome*.” It means a group of signs or symptoms which result from a common cause or appear in combination and present as a clinical manifestation of a disease.

HIV is the virus that causes AIDS. It weakens our immune system, the body’s natural defences against disease-causing organisms. A person with HIV can still feel and look healthy for a long period of time. He or she can continue to carry on with life’s daily activities. Therefore, if someone has the virus, he/she is HIV positive. HIV is the virus that causes AIDS. There is no cure for AIDS.

2. Important points regarding HIV/AIDS:

- ▶ AIDS is spreading rapidly throughout the world, specifically in the developing world.
- ▶ There is no cure for AIDS.
- ▶ There is no vaccine against HIV/AIDS.
- ▶ Nobody is completely safe from HIV/AIDS, and it is preventable.

3. Knowing about the HIV/AIDS epidemic is very important for young people:

Young people are at the centre of the HIV/AIDS epidemic. They are the most vulnerable because they often do not have access to information, knowledge, and skills related to HIV/AIDS. Furthermore, adolescence is a period when many young people are likely to experiment with sex and drugs. Young people are also the world’s greatest hope in the struggle against AIDS.

► **Young people have sex**

For many people in Southeast Asia, as well as all over the world, sexual activity begins during adolescence; i.e., before young people reach their 18th birthday. In many countries, unmarried girls and boys are sexually active even before the age of 15. Many parents and adults wish to ignore that young people have sex. However, to stop the HIV/AIDS epidemic from spreading and to protect young people, it is essential to accept these facts. Providing sexually active young people with the knowledge, skills and means by which to protect themselves and their partners against HIV infection is a very important step in slowing down the spread of the epidemic.

► **Most young people do not have sufficient knowledge about HIV/AIDS**

Awareness of the existence and threat of HIV, as well as information and knowledge about how HIV is spread and how its transmission can be prevented, is still lacking in many populations. Many young people still have misconceptions about HIV/AIDS. Some young people believe that HIV/AIDS can be cured, that it spreads by mosquito bites, or that a healthy looking person cannot be infected with HIV.

Lacking knowledge and skills, adolescents are less likely to protect themselves from HIV than adults. The older adolescents are, the more likely they are to protect themselves. Furthermore, research has shown that there is a direct correlation between level of education and condom use.

► **All young people have a right to know**

Young people have a right to know how they can protect themselves and others, and how to mitigate the impact of HIV/AIDS. They need to:

- Know about their own body
- Know about gender stereotypes
- Know about sex and sexuality
- Know about basic facts on HIV/AIDS and other STIs, and the necessary skills to protect themselves
- Know their HIV status and where to find testing facilities
- Know where to get medical, emotional, and psychological support if they are living with HIV/AIDS
- Know how to shield their families and peers from HIV/AIDS
- Know about HIV/AIDS education programmes and their rights
- Know how to involve their peers in campaigning against HIV/AIDS
- Know that they cannot get HIV/AIDS by sharing a desk, textbook, food, water or bathrooms with a classmate living with HIV/AIDS.

Many parents express concern that sex education will lead to greater sexual activity, or even promiscuity among teenagers. However, the opposite is the case: HIV and/or sexual health education delays the onset of sexual activity, reduces the number of sexual partners, decreases the number of unplanned pregnancies, reduces STI rates, and increases responsible behaviour.



Resource Material 3.2a

HIV/AIDS Myth or Fact game

Note: You may not wish to use all of the questions. Select those that seem most appropriate to the age level and maturity of the group.

1. A person can get HIV from sitting next to a person who has it.
2. A person can be infected with HIV by having sex with a commercial sex worker.
3. An unborn child can get HIV infection from his/her mother if she is infected.
4. Household insects such as bedbugs and cockroaches can be HIV carriers and transmit the disease to people.
5. If a mosquito bites a person with HIV/AIDS and then bites somebody else, the second person it bites may get AIDS.
6. Men who have sex with women with HIV/AIDS get HIV.
7. You can get HIV by using a phone which has just been used by someone with HIV/AIDS.
8. You can get HIV if a person with AIDS coughs or sneezes near you.
9. You can be infected with HIV from a toilet seat.
10. You can get HIV from kissing an infected person on the cheek.
11. You can be infected with HIV by drinking from the same glass as a person who is HIV by drinking from the same glass as a person who is HIV-positive.
12. You can get HIV by having oral sex with a person who has it.
13. You can get HIV if you come in contact with an infected person's tears.
14. Persons who have sex with many different people are at greater risk of exposure to HIV infection.
15. You can get HIV by eating food cooked by someone who has AIDS.
16. You can be infected with HIV from hot tubs or swimming pools.
17. You are likely to get HIV if you sleep in the same bed as someone with HIV/AIDS.
18. You can get HIV by hugging a person who has it.
19. School children can be infected with HIV by sitting next to or by playing ball with another student who is HIV-positive.
20. A person can get HIV by having sexual intercourse with an infected person.
21. Brothers and sisters of children with HIV/AIDS also get AIDS.
22. Doctors and nurses who treat AIDS patients often get HIV infection.
23. A baby can get HIV by breastfeeding from an HIV-positive mother.
24. You can get HIV by shaking hands with an infected person.

25. You can be infected with HIV from sharing needles used in IV injections or blood transfusion.
26. An HIV-positive person looking healthy does not transmit the virus to others through sexual contact.
27. A person with a HIV-negative blood test during the “*window period*” is not likely to transmit the virus through blood transfusion.
28. An unborn child can acquire HIV if the mother is HIV-positive.
29. AIDS affects only the poor and uneducated.
30. Needle-sharing among injecting drug users contributes to the spread of HIV infection.

Facilitator's Key		
1. Myth	11. Myth	21. Myth
2. Fact	12. Fact	22. Myth
3. Fact	13. Myth	23. Fact
4. Myth	14. Fact	24. Myth
5. Myth	15. Myth	25. Fact
6. Fact	16. Myth	26. Myth
7. Myth	17. Myth	27. Myth
8. Myth	18. Myth	28. Fact
9. Myth	19. Myth	29. Myth
10. Myth	20. Fact	30. Fact

Note: Add local beliefs that are commonly mentioned in your country.

Resource Material 3.2b

Basic Facts on HIV/AIDS

Did you know that...

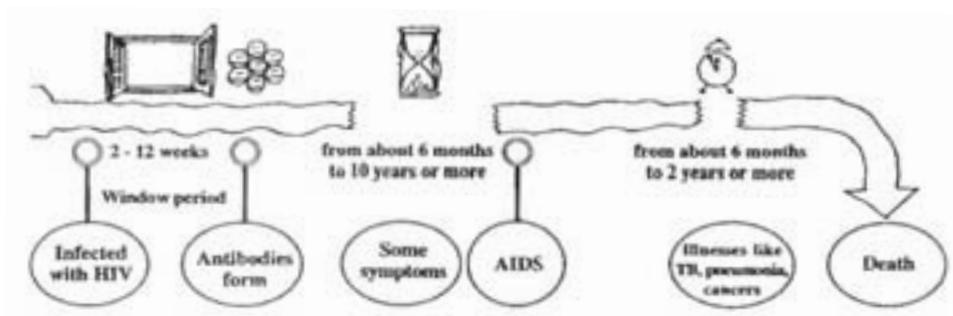
- HIV, like other viruses, is very small – too small to be seen with an ordinary microscope? It may live in the human body for years and can be transmitted to others before any symptoms appear. As it slowly affects the body's defence mechanisms, the body becomes unable to fight disease and infections.
- To reproduce, HIV must enter a body cell, which in this case is an immune cell. By interfering with the cells that protect us against infection, HIV leaves the body poorly protected against particular types of diseases which these cells normally can fight off easily.
- Infections that develop due to HIV's weakening of the immune system are called "*opportunistic infections.*" Examples are respiratory, gastro-intestinal, and skin infections.
- Persons infected with HIV may not exhibit symptoms of the disease for many years, and can therefore infect others without knowing it.

Do you know that...

- AIDS is caused by a virus called HIV which attacks and, over time, destroys the body's immune system.
- A person has AIDS when the virus has done enough damage to the immune system to allow infections and other diseases to develop.
- Such infections make the person ill and lead to his/her death.
- For every person diagnosed with AIDS, there are many others who have HIV infection without knowing it.
- There are several factors, such as health status and health-related behaviours, that influence the development of AIDS in those who are infected with the virus. It is estimated that 50% develop AIDS within 10 years.
- The mortality rate is very high (50 percent of adults diagnosed with AIDS die within 18 months after being diagnosed). For children, the survival period is shorter.
- At present, THERE IS NO VACCINE OR CURE FOR AIDS, although vaccine materials and several drugs are being tested.

1. What is the *Window Period*?

This is the time that the body takes to produce measurable amounts of antibodies after infection. For HIV, this period is usually 2-12 weeks; in rare instances, it may be longer.



If an HIV antibody test is taken during the *window period*, it will be negative since antibodies are not yet present at a detectable level. However, the infected person may transmit HIV to others during that period.

Most people will develop detectable antibodies by 30 days after infection with HIV, and nearly everyone who is infected with HIV (99%) will have antibodies detected by 3 months after infection.

People taking the test are advised, if the result is negative, to return for follow-up in three months, and are encouraged to avoid risk behaviours during these three months. The most common test for HIV antibodies is called the ELISA test.

2. Spread of HIV

HIV is not spread through everyday school and social activities. It is not spread through casual contact with persons, neither through air nor water. It is also not spread just by being around an infected person.

The skin protects us from infectious agents, including HIV. Simple first-aid and routine cleaning suffice. Use a barrier such as a clean cloth, gauze, plastic wrap, or latex gloves between you and someone else's blood, whether you know this person is infected or not. This is called 'universal precaution,' treating someone as if he/she is infected with HIV. Always wash your hands with soap and water after giving first-aid, whether you wear gloves or not.

3. Why mosquitoes do not spread AIDS?

Probably the most commonly asked question about AIDS is whether the virus spreads through mosquitoes or other blood-sucking insects. Fortunately, the answer is NO. Here is why.

Malarial parasites require certain species of mosquitoes to complete their life cycle. The parasites are sucked into the mosquito's body through the blood meal, develop and multiply in gut cells, and migrate to the salivary glands to be injected into the next person's blood stream. HIV multiplies only in human immune cells and infection is acquired through contact with body fluids (semen, blood, vaginal fluids).

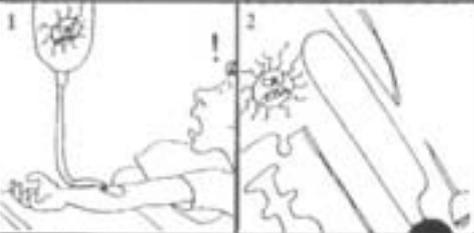
Studies show that even with the presence of an AIDS patient in a household where insects/mosquitoes abound, no infection occurs except where there are sexual partners or transmission between mother and child.

Resource Material 3.2c
Finding the Answers

Group A	Group B
HIV stands for	Human Immuno-deficiency Virus
AIDS stands for	Acquired Immune Deficiency Syndrome
IMMUNE DEFICIENCY	Lack of response by the immune system to disease-causing organisms
SYNDROME	Manifestation of a particular disease or condition
IMMUNITY	The body's ability to resist disease
COMMUNICABLE DISEASE	A disease that is passed from one person to another
WHITE BLOOD CELLS	Part of the blood that is responsible for destroying infections that enter the body
ABSTINENCE	Choosing not to have sexual intercourse

Resource Material 3.3a

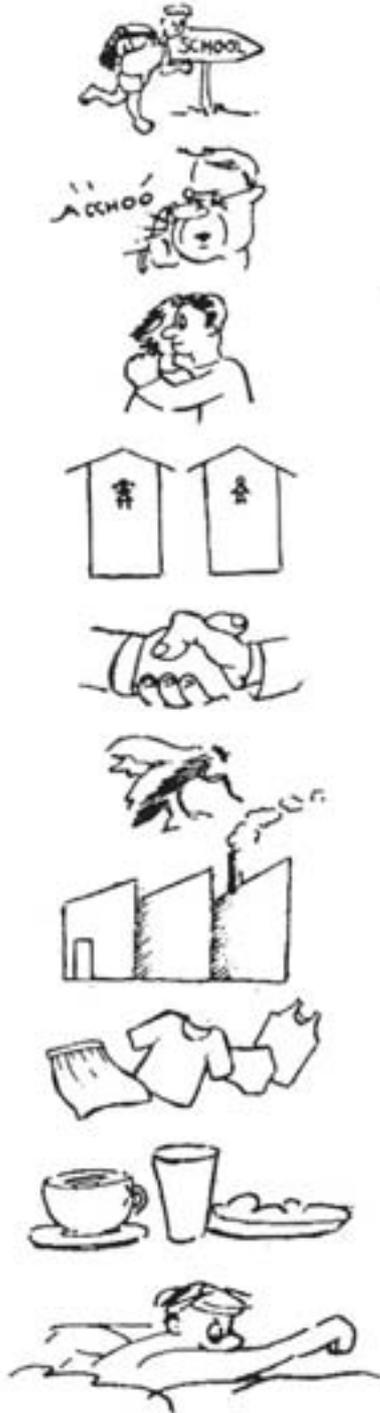
How HIV is Spread

<p>Sexual Intercourse</p>	 	<ul style="list-style-type: none"> ▶ Most people get HIV by having unprotected sexual intercourse. ▶ Unprotected sexual intercourse means having vaginal or anal sex without a condom. ▶ HIV may also be transmitted through oral sex, if there are ulcers inside the mouth.
<p>Infected blood</p>	 	<ol style="list-style-type: none"> 1. One can get HIV through a blood transfusion with infected blood. 2. One can get HIV by using instruments used on someone with HIV for ear-piercing, tattoos or circumcision that have not been properly sterilized. 3. One can get HIV by using needles or syringes used by someone who is infected.
<p>Infected mother to her unborn or newborn child</p>		<ul style="list-style-type: none"> ▶ A baby born to an HIV-infected mother may become infected in the womb before birth, during birth, and sometimes through breastfeeding.



Resource Material 3.3b

How HIV is NOT Spread



- ▶ Attending school
- ▶ Coughing or sneezing
- ▶ Sweat or tears
- ▶ Hugging each other
- ▶ Using toilet or shower facilities
- ▶ Shaking hands
- ▶ Mosquito or other insects
- ▶ Using phones, computers, chairs, desks
- ▶ Sharing clothes
- ▶ Eating foods prepared or served by infected person
- ▶ Sharing forks, knives, spoons and cups
- ▶ Swimming
- ▶ Using sports and gym equipment

Resource Material 3.3c

G1: For each of the behaviours/practices listed below, indicate in the accompanying box the level of risk associated with it. The three risk levels are:

NR (No Risk) LR (Low Risk) HR (High Risk)

- 1. Using toilets in a public washroom
- 2. Touching or comforting someone with HIV/AIDS
- 3. Having sex with a person without a condom
- 4. Having sex with more than one partner
- 5. Dry kissing
- 6. Sharing needles for intravenous drug use
- 7. Swimming with an HIV-positive person
- 8. Sharing needles for ear piercing and tattooing
- 9. Abstaining from sexual intercourse
- 10. Going to school with an HIV-positive person
- 11. Being bitten by a mosquito
- 12. Donating blood
- 13. Having sex using a condom properly
- 14. Eating food prepared by an HIV-infected person
- 15. Having unprotected anal sex with a female or male
- 16. Abstinence
- 17. Feeding a person who is HIV-positive
- 18. Sex between mutually faithful uninfected partners
- 19. Oral sex without a condom
- 20. Anal sex without a condom



Resource Material 3.4

Elements in the Chain of Infection



MODULE FOUR

The HIV/AIDS Epidemic and Its Impact

Approximate Time: 4 hours 45 minutes

Module Message: The HIV/AIDS pandemic is a common growing concern of the global community, including countries in Asia and the Pacific. It has affected the physical, emotional, moral, social, and economic well-being of the individual, family, community, nation, and world.

Overview: Close to half of 37.2 million adults living with HIV are women, according to the latest UNAIDS/WHO report released November 2003 in Geneva. The AIDS Epidemic Update 2004 shows that the number of women living with HIV has risen in each region of the world over the past two years, with the steepest increase in East Asia, followed by Eastern Europe and Central Asia. In East Asia, there was a 56% increase over the past two years, followed by Eastern Europe and Central Asia with 48%. HIV/AIDS affects the physical, emotional, moral, social, and economic well-being of the individual, family, community, nation, and world. Reluctance to talk about HIV/AIDS due to cultural and social barriers does impede understanding of the disease and of behaviours that put an individual at risk of exposure to the human immunodeficiency virus. Some people avoid the subject matter for fear of censure, because of both sensitive and controversial issues surrounding it, or because they are often wrongly convinced that it is not relevant to their personal lives. Understanding the global epidemic of HIV/AIDS will help people to deal with this growing threat.

This module will enable the participants to understand the effects of HIV/AIDS on individuals, families, and society as a whole, as well as the impacts on the physical, emotional, moral, social and economic aspects of people's lives. This module will also help the participants feel comfortable in discussing the HIV/AIDS situation with other members of the group from a geographic, societal, and individual perspective.

Objectives: After studying the module, the teachers should be able to:

1. Explain the status and trends of the HIV/AIDS epidemic in the world, and in the Asia-Pacific Region
2. Discuss issues related to HIV/AIDS, including general feelings and fears about HIV/AIDS
3. Describe the effects of HIV/AIDS and classify them

4. Explain the physical, emotional, cultural, social and economic effects of HIV/AIDS to the individual, family, community, nation, and world
5. Explain the importance of school-based interventions

Content Outline:

1. Status and trends of the HIV/AIDS epidemic in the world and in the Asia-Pacific Region
2. Effects of HIV/AIDS
3. Classification of the effects of HIV/AIDS
4. Issues relating to HIV/AIDS
5. Impacts on women, young people and the education system
6. Feelings and fears about HIV/AIDS

Learning Activities:

1. Group work on the global and regional impact of HIV/AIDS
2. Brainstorming on the effects of HIV/AIDS and their classification
3. Plenary session on the impacts and issues of HIV/AIDS
4. Role play and making a personal connection to HIV/AIDS

Evaluation:

1. Ask to write on a card one point to indicate briefly the physical, emotional, social, moral and economic effects of HIV/AIDS on the:
 - a. individual
 - b. family
 - c. community
 - d. nation
 - e. world
2. Complete any one of the following and explain your answer briefly:
 - I learned...
 - I feel...
 - I wish...
 - I discovered...
 - I hope...
 - I believe...
 - I will...
 - I plan...
 - I predict...
 - I foresee...

Facilitator's Note:

1. Follow *Facilitator's Note* to conduct icebreaker or warm-up game
2. You should endeavour to provide updates on the global and regional impacts of HIV/AIDS to make the discussion more contextual. The information provided indicate the types of data and issues for discussion on HIV/AIDS and its effects.



ACTIVITY 4.1

Global and Regional Impact of HIV/AIDS

Approximate time: 1 hour 30 minutes

Materials: Overhead projector, *Resource Materials 4.1a, 4.1b, 4.1c, 4.1d.*

Preparation: Organize a slide presentation illustrating the nature and extent of the HIV/AIDS pandemic

Introduction: Today, almost every country is affected by HIV/AIDS. It is a pandemic wherein both children and adults are afflicted and have died. What are the trends and impact of HIV/AIDS in Asia? Why is this disease a continuing threat to young people? Can one make some predictions regarding the disease?

Objectives: After participating in this activity, the teachers should be able to:

1. Explain the main patterns of the HIV/AIDS epidemic in Asia and Pacific
2. Discuss the prospects for the future
3. Explain need for HIV/AIDS and sex education
4. Identify ways of providing preventive education to youth
5. Illustrate the main component of Focusing Resources on Effective School Health (FRESH) initiatives.

Content Outline: The global and regional impact of HIV/AIDS

1. Global summary of the HIV/AIDS epidemic
2. Trends and status of HIV/AIDS in the Asia-Pacific Region, and future prospects
3. Reasons for providing HIV/AIDS and sex education to young people
4. Steps for educating youth about prevention
5. FRESH initiative

Procedure:

1. Divide the big group into 5 groups and give each teacher a copy of *Resource Material 4.1a., 4.1b, 4.1c and 4.1d "The HIV/AIDS Pandemic: HIV/AIDS in the Asia-Pacific Region."*
2. Assign each group one topic to study based on the listing under Content Outline. (30 minutes)
3. Ask each group to do the following:

Group 1 – Describe the global and regional impact of HIV/AIDS based on recent statistics.

Group 2 – Analyze the trends by indicating:

- ▶ The patterns of spread
- ▶ Affected countries/areas
- ▶ Effects on people

Group 3 – Explain HIV/AIDS as a threat to young people and describe the role of prevention education.

Group 4 – Explain why some places are severely affected, and others less so.

Group 5 – Predict some situations related to HIV/AIDS.

4. Convene the groups and ask each group to make a three- to five-minute presentation using the transparencies prepared earlier and other visual aids to make their presentations clear and interesting.
5. Ask others who are not presenters to comment on the topic being presented. (10 minutes each)
6. Commend the presenters for good work done.
7. Ask one or two participants to summarize the activity. (10 minutes)

Learning Outcome:

1. Understanding of the global and regional impact of HIV/AIDS
2. Awareness on the issues, effects and impacts of HIV/AIDS at various levels and their classification

Evaluation:

1. Group participation and outcomes of the discussion
2. Complete any one of the following:
 - ▶ I learned...
 - ▶ I discovered...
 - ▶ I feel...
 - ▶ I will...
 - ▶ I wonder...
3. Write a word or phrase that immediately comes to mind when you read any of the following:
 - ▶ HIV/AIDS...
 - ▶ Risk behavior...
 - ▶ Young people...
 - ▶ Preventive education...
 - ▶ Developing countries
 - ▶ Women
 - ▶ AIDS death
 - ▶ UNAIDS
 - ▶ Condom
 - ▶ Pandemic

Facilitator's Note: Make sure that the purpose of this session is to give broader views on HIV/AIDS impact so that the discussion does not get restricted to only one selected aspect.

ACTIVITY 4.2

Effects of HIV/AIDS and Their Classification

Approximate time: 1 hour 30 minutes

Materials: Pens, flip chart paper

Preparation: Provide copies of *Resource Material 4.2a* and *4.2b* to all participants in advance and form their groups in advance

Objectives: After doing this activity, the participants should be able to:

1. Explain the HIV epidemic's impact on society and on the education system
2. Discuss the role of the education sector in fighting the epidemic
3. Make a list of HIV/AIDS effects based on personal perceptions or observations

Content Outline: Impact of HIV/AIDS on society and education, and role of education in preventing HIV/AIDS

Procedure:

1. Conduct a warm-up game '*Immune System*' (See Facilitator's Note for instruction)
2. After completing the game, divide the class into three groups for group work:
 - ▶ Group A "*Impact of HIV/AIDS on Education and Role of Education for HIV/AIDS Prevention*"
 - ▶ Group B and Group C "*Effects of HIV/AIDS*" on the individual, family, community, nation, and world in terms of the physical, emotional, social, cultural and economic aspects of life
3. Instruct each group to choose a member who will record the group's ideas on flip chart paper and later act as a spokesperson.
4. Provide *Resource Materials 4.2a* and *4.2b* as a handout for brain storming and for group work. (30minutes)
5. Give each group flip chart paper and pens.
6. Ask Group B and C to use the presentation chart. (*Resource Material 4.2b*)
7. Have each group present their findings. (10 minutes each)
8. Summarize the outcomes of discussion.

- Learning Outcome:**
1. Review of the physical, emotional, social, cultural and economic effects of HIV/AIDS on: a) individual b) family c) community d) nation e) world.
 2. Summary of the impact of HIV/AIDS on education and society, and list the various effects of HIV/AIDS

- Evaluation:**
1. What is HIV/AIDS's impact on children, youth and women?
 2. How can education help prevent HIV/AIDS?

Facilitator's Note: Follow these instructions for warm-up game '*Immune System.*'

- ▶ Draw a picture of a stick figure on a card and stick it on the back of one person.
- ▶ Write "immune system" on 4-5 other cards and stick them on the backs of other participants.
- ▶ Write 4-5 more cards with "malaria", "tuberculosis" (TB), "diarrhoea" and "HIV" and stick them on the backs of other participants.
- ▶ Instruct the participants with immune cards to hold hands and circle around the person with the stick figure card.
- ▶ Then instruct the persons with disease cards to try to break through the circle. If the circle is broken, points score as follows:

diarrhea	–	1 point
malaria	–	2 points
tuberculosis	–	3 points
HIV/AIDS	–	5 points
- ▶ For each prevented break, the immune system earns 2 points; however, for every prevented HIV/AIDS break, one person from the immune system must leave the circle.
- ▶ The stick figure player can also fight off diseases out of the circle.
- ▶ The game ends after one team reaches 50 points.
- ▶ You should explain about the *immune system* and *HIV infection* after the completion of the role play.

ACTIVITY 4.3

Role Play: Effects of HIV/AIDS

Approximate Time: 45 minutes

Preparation:

1. Cut out small pieces of paper to be used for illustrating role play topics:
 - a. Physical effects of HIV/AIDS
 - b. Social effects of HIV/AIDS
 - c. Socio-emotional effects of HIV/AIDS
 - d. Economic effects of HIV/AIDS

Objectives: At the end of the activity, the participants should be able to:

1. Relate understanding of HIV/AIDS and persons affected with HIV/AIDS to life situations
2. Demonstrate the effects of HIV/AIDS

Content Outline: Effects of HIV/AIDS

Procedure:

1. Divide the class into four groups.
2. Ask each group to draw lottery for a role play topic.
3. The guidelines for the role play are as follows:
 - ▶ *Each group will be given 10 minutes to prepare a role play about the topic that they have drawn.*
 - ▶ *The role play should last 5 minutes.*
 - ▶ *Each participant should speak loudly and clearly.*
 - ▶ *Use creativity to enhance the clarity of the message in the role play.*
4. Ask each group to present the role play.

Elicit some reactions to the role plays and congratulate the groups after the session.

Evaluation: Presentation by the participants and the points they made should be the basis for evaluation

Learning Outcome: Understanding of the appropriateness of role playing as a teaching/learning method

Facilitator's Note: Clearly explain the purpose of role play. Ask the participants to express their feelings and understanding about HIV/AIDS based on previous sessions.

ACTIVITY 4.4

Making a Personal Connection to HIV/AIDS

Approximate Time: 1 hour

Materials: Coloured cards, pens

Preparation: Cut out coloured cards for distribution to the participants.

Introduction: Participants of the workshop just like everyone else in the community will certainly have opinions, feelings, fears and unanswered questions about several aspects of HIV/AIDS. This activity allows them to make a personal connection to HIV/AIDS by putting down in writing (a) what they want to know most, and (b) what they fear most. This information will be optimally utilized by the facilitators to (a) answer the query and (b) allay the fears as much as possible.

Objectives: At the end of the activity, the participants should be able to share feelings and fears about HIV/AIDS

Content Outline: Feelings and fears about HIV/AIDS

Procedure:

1. Ask each participant to get a coloured card of his/her choice.
2. Tell each participant to reflect and discuss issued relation to HIV/AIDS first.
3. Ask each participant to write on one side of the card what he/she would like to learn about HIV/AIDS in the training, and on the other side, his/her greatest fear about being exposed to HIV/AIDS. Participant's names should not be written on the cards. Give them 5 minutes to do this.
4. Collect the cards and read to the group the anonymous responses.
5. Start with things that they would like to learn about HIV/AIDS and refer to the relevant modules that address the questions.
6. Read the participants' feelings and fears about HIV/AIDS.
7. Encourage discussion centred on why these feelings and fears about HIV/AIDS exist.

Evaluation:

1. Give one example of any one of the aspect of HIV/AIDS effects – social, physical, economic or emotional
2. Make a one-line slogan about HIV/AIDS based on the insights that they learned from the activities in this module
3. Ask one participant to give a three-sentence summary about the discussion regarding fears and feelings towards HIV/AIDS

Learning Outcome: Greater understanding of:

1. Social aspect – issue of rejection and discrimination
2. Physical aspect – being incapacitated
3. Economic aspect – difficulty in looking for a job
4. Emotional aspect – feeling hopeless, afraid and irritable

Facilitator's Note:

1. Make sure that the participants have indicated all aspects of HIV/AIDS effects.
2. Encourage the participants to discuss cases that support their views on the effects of HIV/AIDS.

Resource Material 4.1a

The HIV/AIDS Pandemic

A Global Overview:

According to *UNAIDS Update 2004*, there were 39.4 million people (37.2 million adults, 17.6 million women and 2.2 million children under 15 years) living with HIV or AIDS. The people newly infected with HIV were 4.9 million (4.3 million adults and 640,000 children under 15 years). Similarly, the AIDS death toll in 2004 was 3.1 million (adults 2.6 million and children under 15 years 510 000).

HIV/AIDS Situation in Asia and the Pacific Region

1. The current situation

A handful of countries are still seeing very low levels of HIV prevalence, even among people at high risk of exposure to HIV. These countries have golden opportunities to pre-empt serious outbreaks.

National HIV infection levels in Asia are low compared with some other continents, notably Africa. However, the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living with HIV. Latest estimates show some 8.2 million (5.4 million-11.8 million) people were living with HIV at the end of 2004, including 2.3 million (1.5 million-3.3 million) adult women. Of this overall population, 1.2 million (720,000-2.4 million) people became newly infected in the past year. AIDS claimed some 540,000 (350,000-810,000) lives in 2004. Among young people 15-24 years of age, 0.3% of females (0.2-0.6%) and 0.4% of males (0.3-0.8%) were living with HIV by the end of 2004.

Asia is vast and diverse, and HIV epidemics in the region share that diversity with the nature, pace and severity of epidemics differing across the region. Overall, Asian countries can be divided into several categories, according to the epidemics they are experiencing. While some countries were hit early (for



ASIA					
HIV and AIDS statistics and features, end of 2002 and 2004					
	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS
2004	8.2 million [5.4-11.8 million]	2.3 million [1.5-3.3 million]	1.2 million [720 000-2.4 million]	0.4 [0.3-0.6]	540 000 [350 000-810 000]
2002	7.2 million [4.6-10.5 million]	1.9 million [1.2-2.8 million]	1.1 million [540 000-2.5 million]	0.4 [0.2-0.5]	470 000 [300 000-690 000]

example, Cambodia, Myanmar and Thailand), others are only now starting to experience rapidly expanding epidemics. These countries must mount swift, effective responses. They include Indonesia, Nepal, Viet Nam, and several provinces in China. In Myanmar and in parts of India and China, HIV has become well-entrenched in some sections of society, despite modest efforts to halt the virus' spread. Other countries are still seeing extremely low levels of HIV prevalence, even among people at high risk of exposure to HIV, and have golden opportunities to pre-empt serious outbreaks. These countries include Bangladesh, East Timor, Laos, Pakistan, and the Philippines (MAP, 2004)

Some countries, by sheer virtue of size, simultaneously fit several of these descriptions: China and India are examples. These two countries, home to some 2.35 billion people, are experiencing several distinct epidemics, some already very serious.

HIV prevalence in populations at risk in various Asian countries, 2001–2003

	Bangladesh 2002	East Timor 2003	Mongolia 2003	PDR Lao 2001	Pakistan 2003	Philippines 2003	Sri Lanka 2003
Female sex workers	0–0.7%	3%	0	0–1.1%	0	<1%	0–0.2%
Men who have sex with men	0–0.2%	0.9%	—	—	—	0	—
High-risk men*	0	0	0	0	—	0	0
STI clinic clients	0	—	0	—	—	—	0–1%
Drug injectors	0–4%	—	—	—	0	0	—

* Bangladesh: Truck drivers, launch workers, boyfriends of sex workers. East Timor: Taxi drivers and soldiers. Laos: Truck drivers. Philippines: Military recruits. Sri Lanka: Transport workers and male military.

Sources: Lao People's Democratic Republic National Committee for the Control of AIDS Bureau 2001; Philippines Department of Health 2002 and national surveillance reports; Bangladesh National AIDS/STD programme 2003; Pisani and Dili STI survey team 2004a.

2. Projection of the future

Projection models have shown that an additional 18.5 million people will be infected with HIV in South and Southeast Asia by 2010 if prevention is not scaled up. Recent estimates project that, if prevention is not scaled up or programmes are not successful, China alone will have 10 to 15 million HIV/AIDS cases, and India is likely to have 20 to 25 million cases by 2010.

Nevertheless, immediate intervention could avert a large number of future infections and thus the course of the AIDS epidemic could be reversed. Comprehensive prevention packages would reduce the number of new infections in the region by 69 per cent (meaning that only 5.7 million people, instead of 18.5 million, would be newly infected by 2010).

3. The epidemic can be curbed through an appropriate response

There is evidence that prevention programmes are successful and that the epidemic can be curbed.

Countries such as Thailand and Cambodia serve as good regional examples that the HIV epidemic can be curbed by strong and focused campaigns before it becomes too big. Thailand's well-funded, politically supported and comprehensive prevention programmes have saved millions of lives, reducing the number of new HIV infections from 143,000 in 1991 to 29,000 in 2001.

Resource Material 4.1 b

Thailand's Response to HIV/AIDS: Progress and Challenges

A critical review of Thailand's response against the HIV/AIDS epidemic shows that the emergence of firm and focused political commitment, the active roles adopted by top political leaders, the high levels of national budgetary funding, the mobilization of non-health ministries around HIV/AIDS, and the involvement of NGOs in policy-making and programming are key factors in the country's success.

It was spirited political leadership and commitment at the national level that led to the huge increases in domestic funding and support for the HIV/AIDS programme. Heavy Government investment in the response was also a key factor. The trend of substantial increase in investment served as one of the cornerstones in the bid to persuade a wider range of stakeholders across the country and civil society to mobilize around the HIV/AIDS programme. A wide range of actors and institutions were marshalled into a broad-based response. A joint effort of various public agencies, civil society organizations (including AIDS NGOs and groups of people living with HIV/AIDS), and businesses (including the media and entertainment enterprises) gained influence in the National AIDS Committee and contributed to help shape policies and programmes.

Activism and mobilization by civil Thai society (particularly people living with HIV/AIDS), community groups, AIDS activists and NGOs have often initiated activities when public sector services were absent or deficient. A massive public education and information campaign launched across the country to large audiences was an essential aspect of the country response. Pragmatism guided the prevention programme, even though commercial sex remained officially illegal. Rather than base an AIDS response on stifling commercial sex, the Government more sensibly sought to regulate the commercial sex trade in line with the AIDS strategy. The bid to boost condom use in commercial sex was made across the country and applied to all known sex establishments.

Reliable information about the unfolding epidemic primed greater political commitment, informed policies and guided the overall strategy. The information generated helped raise public awareness and captured the attention of political leaders and public opinion leaders (as did a series of projections to gauge the likely evolution and impact of the epidemic). The strategy built on the existing health infrastructure. In the case of the prevention programmes, a strong sexually-transmitted disease clinic system proved vital. These clinic networks were used to serve both as avenues for the 100%. Learning by doing was one of the key success factors in Thailand's response to AIDS prevention. Without having a comprehensive policy, Thailand built large parts of its national prevention programme on the groundwork and experiences of a series of early, often province-wide initiatives. Early lessons learned were used for adapting and improving programmes. Openness about condoms and sex was a positive step. Crucially, there were not the big cultural hindrances that have been present in many other countries. (UNDP; HIV Report, 2004)

Resource Material 4.1c

EFA Global Monitoring Report 2003/4

All countries have agreed to eliminate gender disparities in primary and secondary education by 2005. The *EFA Global Monitoring Report* sets out the powerful human rights case for achieving parity and equality in education. This report indicates that removing gender gaps in education are part of a much broader reform effort underway in many countries. Meeting our international commitments, gendered strategies for EFA are critically presented in this report.

The international community is committed to eliminating gender disparities in primary and secondary schooling by 2005, and to achieving gender equality by 2015. Education is a human right, enshrined in international treaties and conventions that are legally binding on signatory states. The report emphasizes the solid human rights framework that underpins education and identifies the social and economic benefits of educating girls and women.

The report analyses multiple dimensions of inequality. Problems affecting the exercise of rights to education include: constraints in the family and within society that affect girls' access to school; early marriage, which massively impedes the educational progress of girls; the global HIV/AIDS scourge; armed conflict; and disability. Rights issues within education focus on how school systems take girls' specific needs into account through curricula, teaching methods and the learning environment. They also concern how girls perform in school, and how achievement translates into equal opportunities in the social and economic spheres. Legislative change and reform is essential for gender equality. The report notes that the state's role is important in at least three principal ways: *creating the enabling environment* for promoting female education through legislative and policy reform for gender equality; *investing in redistribution*, by allocating targeted resources for female education and special measures to reduce inequities; and *introducing educational reforms* which respond to the particular circumstances of girls and women.

Measures to improve the experience of schooling for both girls and boys require a gender perspective in the design of schooling interventions. In many countries, pregnant girls face expulsion from formal education. Sex education is critically important to enable healthy relationships based on mutual respect and, particularly in contexts of HIV/AIDS, to provide relevant and useful information to young people about reproductive health. The report has analysed how the state has played a leading role in most of the countries that have made considerable progress in promoting gender parity and equality in education. Countries must create an enabling environment for promoting gender equality, invest in redistribution strategies and mitigate the burden of conflict, economic crisis and HIV/AIDS. (UNESCO, 2003).

Resource material: 4.1d

Focusing Resources on Effective School Health (FRESH) Initiative

The FRESH goal is to improve learning and educational achievement by improving the health and nutritional status of school-age children. The FRESH partnership was developed by the World Bank, WHO, UNICEF and UNESCO, and launched at the World Education Forum in Dakar in April 2000.

The FRESH framework is the starting point for developing an effective school health hygiene and nutrition programme. It provides a framework through which individual countries will develop their own strategy to match local needs, with support from intersectoral partnerships within the four core components of FRESH:

- (i) Health-related school policies in schools
- (ii) Provision of safe water and sanitation to provide a healthy learning environment
- (iii) Skills-based approach to health, hygiene, and nutrition education
- (iv) School-based health and nutrition services

1. Focusing Resources on Effective School Health: A FRESH Start to Enhancing the Quality and Equity of Education

Education for All means ensuring that all children have access to basic education of good quality. This implies creating an environment in schools and in basic education programmes in which children are both able and enabled to learn. Such an environment must be effective with children, friendly and welcoming to children, healthy for children, inclusive and protective of children and gender sensitive. The development of such child-friendly learning environments is an essential part of the overall efforts by countries around the world to increase access to, and improve the quality of, their schools.

Poor health and malnutrition are important underlying factors of low school enrolment, absenteeism, poor classroom performance, and early school dropout, as reflected in the World Declaration on Education for All. Programmes to achieve good health, hygiene and nutrition at school age are, therefore, essential to the promotion of basic education for all children.

Good health and nutrition are not only essential inputs, but also important outcomes of basic, good quality education. First, children must be healthy and well-nourished in order to fully participate in education and gain its maximum benefits. Early childhood care programmes and primary schools that improve children's health and nutrition can enhance the learning and educational outcomes of school children. Second, education of good quality can lead to better health and nutrition outcomes for children, especially girls, and thus for the next generation of children, as well. In addition, a healthy, safe and secure school environment can help protect children from health hazards, abuse and exclusion.

2. The Basic Framework for an Effective School Health and Nutrition Programme

The framework described here is the starting point for developing an effective school health component in broader efforts to achieve more effective, child-friendly schools. Much more could be done, but if all schools implement these four interventions, there would be a significant immediate benefit, and a basis for future expansion. In particular, the aim is to focus on interventions that are feasible to implement even in the most resource-poor schools, hard-to-reach rural areas, and inaccessible urban areas, and that promote learning through improved health and nutrition. These are actions known to be effective, and actively endorsed by all the supporting agencies: this is a framework from which individual countries will develop their own strategy to match local needs.



3. Core Framework for Action:

Four components that should be made available together, in all schools and several supporting strategies that can support the implementation of these components

A. Core Components:

- (i) **Health-related school policies** – Health policies in schools, including skills-based health education and the provision of some health services, can help promote the overall health, hygiene and nutrition of children. Good health policies, however, should go beyond this to ensure a safe and secure physical environment and a positive psycho-social environment, and should address issues such as abuse of students, sexual harassment, school violence, and bullying. By guaranteeing the further education of pregnant schoolgirls and young mothers, school health policies will help promote inclusion and equity in the school environment. Policies that help to prevent and reduce harassment by other students and even by teachers, also help to fight against reasons that girls withdraw or are withdrawn from schools. Policies regarding the health-related practices of teachers and students can reinforce health education: teachers can act as positive role models for their students, for example, by not smoking in school. The process of developing and agreeing upon policies draws attention to these issues. These policies are, thus, best developed by involving many levels, from policy makers at the national level to teachers, children, and parents at the school level.
- (ii) **Provision of safe water and sanitation** – The school environment may damage the health and nutritional status of school children, particularly if it increases their exposure to hazards such as infectious disease carried by the water supply. Hygiene education is meaningless without clean water and adequate sanitation facilities. It is a realistic goal in most countries to ensure that all schools have access to clean water and sanitation. By providing these facilities, schools can reinforce health and hygiene messages, and act as an example to both students and the wider community. This, in turn, can lead to a demand for similar facilities from the community. Sound construction policies will help ensure that facilities address issues such as gender access and privacy. Separate facilities for girls, particularly adolescent girls, are an important contributing factor to reducing dropout at menses and even before. Sound maintenance policies will help ensure the continuing safe use of these facilities.
- (iii) **Skills-based health education** – This approach to health, hygiene and nutrition education focuses upon the development of knowledge, attitudes, values, and life skills needed to make and act on the most appropriate and positive health-related decisions. Health in this context extends beyond physical health to include psycho-social and environmental health issues. Changes in social and behavioural factors have given greater prominence to such health-related issues as HIV/AIDS, early pregnancy, injuries, violence, tobacco and substance use. Unhealthy social and behavioural factors not only influence lifestyles, health and nutrition, but also hinder education opportunities for a growing number of school-age children and adolescents. The development of attitudes related to gender equity and respect between girls and boys, and the development of specific skills, such as dealing with peer pressure, are central to effective skills-based health education and positive psycho-social environments. When individuals have such skills, they are more likely to adopt and sustain a healthy lifestyle during schooling and for the rest of their lives.
- (iv) **School-based health and nutrition services** – Schools can effectively deliver some health and nutritional services, provided that the services are simple, safe and familiar, and address problems that are prevalent and recognized as important within the community. If these criteria are met, then the community sees the teacher and school more positively, and teachers perceive themselves as playing important roles. For example, micronutrient deficiencies and worm infections may be

effectively dealt with by infrequent (six-monthly or annual) oral treatment; changing the timing of meals, or providing a snack to address short-term hunger during school – an important constraint on learning – can contribute to school performance; and providing spectacles will allow some children to fully participate in class for the first time.

B. Supporting Strategies:

- (i) **Effective partnerships between teachers and health workers and between the education and health sectors** –The success of school health programmes demands an effective partnership between the Ministries of Education and Health, and between teachers and health workers. The health sector retains the responsibility for the health of children, but the education sector is responsible for implementing, and often funding, school-based programmes. These sectors need to identify respective responsibilities and present coordinated action to improve health and learning outcomes for children.
- (ii) **Effective community partnerships** – Promoting a positive interaction between the school and the community is fundamental to the success and sustainability of any school improvement process. Community partnerships engender a sense of collaboration, commitment and communal ownership. Such partnerships also build public awareness and strengthen demand. Within the school health component of such improvement processes, parental support and cooperation allow education about health to be shared and reinforced at home. The involvement of the broader community (e.g. the private sector, community organizations and women’s groups) can enhance and reinforce school health promotion and resources. These partnerships, which should work together to make schools more child-friendly, can jointly identify health issues that need to be addressed through the school and then help design and manage activities to address such issues.
- (iii) **Pupil awareness and participation** – Children must be important participants in all aspects of school health programmes, and not simply the beneficiaries. Children who participate in health policy development and implementation; in efforts to create a safer and more sanitary environment; in health promotion aimed at their parents, other children, and community members; and in school health services, learn about health by “*doing*.” This is an effective way to help young people acquire the knowledge, attitudes, values and skills needed to adopt healthy lifestyles, and to support health and Education for All.

Resource Material 4.2a: *Effects of HIV/AIDS*

A. On the individual:

- ▶ Immunodeficiency (a weakening of the immune system, the body's natural defences against infections) leading to secondary infections (such as diarrhoea, skin cancer, pneumonia)
- ▶ 50% of adults diagnosed with AIDS die within 18 months if they do not have access to antiretroviral (ARV) therapy.
- ▶ Rejection by friends and loved ones; isolation from social or community activities
- ▶ About 15% to 30% of children born to HIV-positive mothers will be HIV-positive themselves if there is no prevention of mother-to-child transmission (MTCT) programme.
- ▶ Psychological issues including:
 - Fear of pain and dying (especially dying alone)
 - Feelings of loss related to their ambitions, confidence, physical attractiveness, potency, sexual relationships, status in the community, financial stability, future plans, and independence
 - Anger towards themselves in the form of self-blame for acquiring HIV, and towards others for perceived abuse of their body or privacy
 - Suicidal tendency – may be seen as a way of avoiding pain and discomfort or to lessen the shame and grief of loved ones
 - Loss of self-esteem and feelings of self-worth caused by rejection from colleagues or loved ones combined with the physical impacts of HIV-related diseases such as disfigurement, physical wasting, and loss of strength
 - Hypochondria – an obsessive state due to a preoccupation with health and of avoiding infections
 - Grief about the losses they have experienced or are anticipating
 - Guilt over the possibility of having infected others, over the behavior that may have resulted in infection, and over the hardship their illness will cause loved ones, especially children
 - Depression due to the absence of a cure, and the resulting feelings of helplessness and loss of personal control
 - Anxiety over the:
 - Short-term or long-term prognosis
 - Risk of infection with other diseases
 - Risk of infecting others with HIV
 - Loss of physical and financial independence
 - Declining ability to function efficiently
 - Future social and sexual unacceptability
 - Loss of privacy
 - Availability of appropriate medical/dental treatment
 - Ability of loved ones to cope
 - Fear of dying in pain or without dignity
 - Possibility of abandonment and isolation

- ▶ Dismissal from employment or denial of employment for no other apparent cause
- ▶ Fear, anxiety, paranoia, and loss of self-esteem on the part of uninfected people close to HIV-positive individuals
- ▶ Further acts of discrimination against members of certain groups, such as men who have sex with men (MSM), injecting drug users (IDUs), and CSW.
- ▶ Denial of entry into certain countries

B. On the Family:

- ▶ Psychological stress of all family members caused by anger, sorrow, frustration, and inability to cope with the needs of the infected individual
- ▶ Discrimination and rejection faced by all family members involved with the care of the infected individual
- ▶ Economic problems due to high cost of drugs and hospitalization, frequently combined with an inability to continue working

C. On the Community:

- ▶ Funds from other areas of public need are drained by costs associated with AIDS prevention, diagnosis, treatment, and care
- ▶ Strain on the health care system and insurance companies
- ▶ Loss of economic output and productivity due to illness in prime working years

D. Impact on women:

- ▶ HIV/AIDS/STIs affect women more due to psychological, socio-cultural and economic reasons
- ▶ Women are more vulnerable to HIV/STI infection due to biological reasons
- ▶ Women do not have control over sexual relations; society always cares for the sexual desires of the man and is centred around his pleasure
- ▶ Early marriage or marriage of young girls with mature adult men also increases physiological vulnerability
- ▶ Sexual abuse or violence within and outside marriage is common in South Asia
- ▶ Economic reasons also make women vulnerable to HIV/STIs because struggling with daily survival can lead them to high-risk activities
- ▶ Economic dependence and lower social status make women unable to challenge a husband's extra-marital affairs or insist on condom use even when they know they are at risk
- ▶ Women are expected to do the entire household affair; they have considerable responsibility to look after their children and husband and, thus, the burden of caring for family members dying of HIV/AIDS goes to women

E. Impact Alleviation:

According to *UNAIDS Progress Report 1996-1997*, “research in Africa and Asia has provided information on the impact of HIV/AIDS, both at the societal level and at the level of specific populations. We know now that affected households have substantially reduced incomes; that school-age children are taken away from school to restore income; that death due to AIDS produces a large number of orphans; that children often become heads of households; and that elderly people may be left to take care of themselves. The coping strategies for these households are reduction of consumption, exhaustion of savings, selling of assets (land, vehicles and livestock) and borrowing of money. It is against this background that UNAIDS and its co-sponsors have undertaken a number of projects, including support for key studies and publications aimed at sharing experience among regions, countries and districts in an attempt to alleviate the impact of AIDS.”

Economically:

- ▶ Women lack access to wage employment, and the responsibility for child and family upkeep force dependence upon male partners for economic stability. Such circumstances obstruct any effective HIV prevention.
- ▶ Some women are compelled to turn to commercial sex work as an economic strategy, exposing themselves to a high risk of HIV infection.

Economic Impacts of AIDS

Sector	Individual	Community	National
Health	Increased expenditure	Increased expenditure	Need to expand health infrastructure
Education	Absenteeism	Decreased value of future human resources	Loss of trained people
Trade & Industry	Loss of Productivity	Increased emigration	Effects on Tourism
Agriculture	Loss of Productivity	Reduction in cultivated land	Threat to food security



Costs and Stages of HIV Infection

Cost	Before Infection	Infection	Illness	Death
Direct	Control & preventive measures	Testing & Outpatient care	Inpatient care	Funeral & associated expenses
Indirect	Precautionary savings	Lower Productivity of ill members	Lower Productivity & loss of income	Income foregone
	Insurance	Reduction in Consumption & investment	Reduction in consumption & investment	Drop in family income
	Acceptance of less-risky, but less well-paid jobs	Opportunity cost of looking after ill member	Opportunity cost of looking after ill member	Poor health of surviving members
		Psychological cost to ill & other family members	Psychological cost	
		Costs to Others unwittingly affected by ill member		

Source: UNAIDS

Resource Material 4.2b

The Impact of HIV/AIDS on the Education System

Countries that fail to bring the epidemic under control while prevalence rates are still relatively low run a risk of facing a large challenge in the future. Once the epidemic has become widespread, it has a tendency to spread much faster because more individuals and many different groups of society are affected.

The HIV/AIDS epidemic does not only affect individuals – it affects every part of, and every institution in, society. Achievements in human development are being undermined as countries lose young, productive people to the epidemic, economies stumble, households fall into deeper poverty, and the costs of the epidemic mount. This easily develops into a spiral, as worsening socio-economic conditions render people and communities more vulnerable to the epidemic.

1. The impact on the education system

HIV/AIDS poses a severe threat to the education system. The impact of the epidemic on the African education systems clearly shows that Asian countries need to learn from its lessons and be proactive. If nothing is done about the epidemic, the impact of HIV/AIDS may become as severe as it has proven to be in sub-Saharan Africa.

- ▶ **Education Demand** – HIV/AIDS has a negative effect on students. The number of students in schools decreases. As the epidemic advances, there will be a greater number of sick children, and many children, especially girls, may be taken out of school to care for sick relatives or to take over household responsibilities (thus increasing their vulnerabilities, for example, through exploitation). Financially, fewer families will be able to support their children's education. For psychological and stigma-related reasons, children are less willing to enter and remain in school; they may be distracted and, therefore, less able to learn.
- ▶ **Education Supply** – The education sector will experience a loss of human resources as teachers, school administrators and supporting staff die, fall sick, or are psychologically traumatised by family and community deaths due to AIDS and, therefore, become unable to work. Furthermore, schools will receive less support from families and communities.
- ▶ **Education Content** – The content of current curricula must be reformed to reflect the learning needs related to the HIV/AIDS epidemic, such as health and sex education messages, coping with illness and death in the family, non-discrimination towards people living with HIV/AIDS, gender roles/issues, and life skills.
- ▶ **Education Quality** – If the education sector cannot support AIDS-affected teachers or supply adequate replacements for those who fall ill or die, the overall morale of people working in the education sector and, with that, the quality of the education system, will be reduced. Furthermore, if curricula does not provide the knowledge and skills that young people need in an AIDS-affected society, the quality of education provided to them will also decrease.
- ▶ **Education planning** – HIV/AIDS has an impact on ministries, departments, agencies, and policy makers responsible for proper planning and allocation of education resources and services. Anticipating and then dealing with the impact of the epidemic on the demand, supply, content, and quality of education at this level are time-consuming tasks, requiring much time and expertise.

Chart for group work presentation

Classification of the Effects of HIV/AIDS

	Physical	Emotional	Social	Cultural	Economic
Individual					
Family					
Community					
Nation and World					

Resource Material 4.2c

The Important Role of the Education Sector in Fighting the Epidemic

Given the absence of a cure and a vaccine, education is the most effective tool to fight the HIV/AIDS epidemic.

1. Why education can combat HIV/AIDS

The education system has the advantage of reaching out to many children and young people early, at a time when few are infected and before they engage in behaviour that may put them at risk of getting HIV. It can help prevent infection among young people, in both the long term and the short term.

Young people are in the process of acquiring knowledge and developing a set of values and life skills that will guide them through life. A fully inclusive education system can help young people to develop life skills to better protect themselves. Since education shapes attitudes and values, it can also help reduce discrimination against people living with HIV/AIDS.

Studies from around the world show that young people provided with correct information, knowledge, and skills will not only delay starting their sexual activity, but once they start having sex, they will also be more likely to protect themselves against sexually transmitted infections, including HIV/AIDS.

2. What the education sector can do

The Ministry/Department of Education can do a number of things to prevent HIV/AIDS from spreading, to help the people who are already affected or infected, and to alleviate the impact of HIV/AIDS on society at large, and on the education sector, in particular.

First, Ministries of Education must recognise the fact that HIV/AIDS is a serious problem and that sexually active young people are particularly vulnerable to HIV/AIDS.

In order to protect young people and education personnel from HIV/AIDS, education ministries will need to develop effective policies, leading to the development of comprehensive and appropriate curricula, and ensure that they are properly implemented.

3. Planning and managing HIV/AIDS education

- ▶ Ensure strategic, operational, and anticipatory planning processes which lead to early warning of impact, as well as realistic and realizable operational plans and policies
- ▶ Reserve adequate budgetary provision with streamlined access to resources
- ▶ Appoint full-time mandated HIV and education officers within major institutions and make sure that their responsibilities regarding HIV/AIDS are clearly laid out in their job descriptions

Remember that the Education Ministry/Department is responsible for incorporating preventive education in the school curriculum and facilitating implementation.

4. Incorporating HIV/AIDS prevention and care in the national curriculum

- ▶ Integrate HIV/AIDS issues in a broader health education approach, also include malaria, tuberculosis, reproductive health, substance abuse, and sexually transmitted infections
- ▶ Train teachers on how to deal with HIV-positive students and colleagues, and how to teach about HIV/AIDS, life skills, and related issues, and integrate this content into the teacher training curriculum
- ▶ Develop adequate teaching and learning materials related to HIV/AIDS knowledge and skills based on a life skills approach and with supporting materials for use outside the school setting.

Resource Material 4.2d

Guidelines for Prevention Education

1. Why prevention education works?

- ▶ A general basic education has an important preventive impact. It can equip people to make healthy decisions concerning their own lives, bring about long-term healthy behaviours, and give people the opportunity for economic independence and hope.
- ▶ Education is among the most powerful tools for reducing girls' vulnerability. Girls' education helps to slow and reverse the spread of HIV/AIDS by contributing to economic independence, delayed marriage, and family planning.
- ▶ Schooling offers an appropriate infrastructure for delivering HIV/AIDS prevention efforts to large numbers of the uninfected population – school children – as well as to youth, who are the age group at most risk in many countries.
- ▶ Education is highly cost-effective since the investment in prevention is many times smaller than the cost of caring for the sick

2. Guidelines for prevention education

- ▶ The purpose of preventive education is to promote a healthy lifestyle and responsible behaviour and to prevent disease.
- ▶ This is achieved by providing the knowledge, attitudes, skills, and means to encourage and sustain behaviour that reduces risk of infection, by providing social support and care and by reducing stigma and discrimination.
- ▶ It is important to start early, that is, before girls and boys become sexually active or drop out of school.
- ▶ An effective preventive education approach must be comprehensive, multi-sectoral, open, and flexible, and it must address all factors that increase vulnerability to HIV/AIDS, such as sexual behaviour, the position of women and minority groups, gender issues, community and family circumstances, education, poverty, discrimination, drug and alcohol abuse, peer pressure, etc.
- ▶ Education personnel must be equipped with communication skills, including a capacity to listen and to learn and an ability to effectively address sensitive issues.
- ▶ Best practices from other countries and regions can be borrowed and adapted, but the unique cultural context of country needs to be taken into account.
- ▶ General education programmes, as well as specialised efforts targeting high-risk behaviours, must be created.
- ▶ Prevention education can and should be strengthened by combining various channels such as schools, media, informal networks, etc.



- ▶ HIV/AIDS education does not stop in the classroom. HIV/AIDS should be integrated both into the curriculum and into extracurricular activities within the school setting such as youth camps, peer education, theatre, study tours, exhibitions, contests, sports, etc.
- ▶ Preventive education should emphasize life skills.

3. What makes talking about HIV/AIDS easier?

- ▶ Adequate training for male and female teachers and facilitators
- ▶ Good skills and sound knowledge of teachers and facilitators
- ▶ High-quality teaching and learning materials
- ▶ Respect for and rapport with students
- ▶ Patience and understanding
- ▶ A non-judgmental attitude
- ▶ A positive environment

MODULE FIVE

HIV/AIDS, Drugs and Substance Abuse

Approximate Time: 3 hours 30 minutes

Module Message: It is very important to understand that the patterns of production, consumption and administration of illicit drugs have changed rapidly in the past and continue to change rapidly around the world. Because of this, youth face an increasing high risk and vulnerability to HIV/AIDS.

Overview: The total number of drug users in the world is now estimated at some 185 million people, equivalent to 3.0% of the global population, or 4.7% of the population ages 15 to 64. The new estimates confirm that cannabis is the most widely used substance (close to 150 million people), followed by ATS i.e. amphetamine-type stimulants (about 30 million people for the amphetamines, primarily methamphetamine, and 8 million, ecstasy). Slightly more than 13 million people uses cocaine and 15 million opiates (heroin, morphine, opium, synthetic opiates), including some 9 million who take heroin.

The consumption and injecting of illicit drugs is increasing around the world. Injecting drug use has now been documented in 129 countries, 79 of which also reported HIV transmission through contaminated needles, syringes and other injecting equipments (WHO/UNAIDS/UNODC, 2004). It is estimated that there are approximately 13 million injecting drug users worldwide, of which 8.8 million are in Eastern Europe, Central, South and South-East Asia combined, 1.4 million in North America and 1 million in Latin America. Seventy-eight (78%) percent of the total IDUs are living in developing countries. (UNODC 2004)

Patterns of production, consumption and administration of illicit drugs have changed rapidly in the past, and continue to change rapidly. Countries where the most rapid changes are occurring, involving the biggest populations, are in the developing world, especially in South and South-East Asia and Latin America. Many Western countries experienced epidemics of heroin injecting beginning in the late 1960s and continuing through the 1980s and 1990s. Many Asian countries began to experience such epidemics in the late 1980s, and this trend is continuing. The injecting of heroin is now a problem in over 100 countries worldwide, with an estimated 10 million people regularly injecting heroin globally; over 80 of these countries have reported HIV infection among these IUDs.

Objectives: After studying the module, the participants should be able to:

1. Define terms related to drug and substance use, injecting drug use and their consequences

2. Explain the status of production, consumption and administration of illicit drugs and the increasing trends of high risk and vulnerability to HIV/AIDS in South and South-East Asia and Latin America
3. Identify the association between drugs, sex, sexual abuse and HIV/AIDS
4. Identify vulnerable or high risk behaviours of using substance or IDUs
5. Find ways of preventing drug and substance use and injecting drug use

Content Outline:

1. HIV/AIDS, drugs and substance abuse
2. Threat of drugs and substance abuse to youth
3. Facts and myths on drugs, substance and IDUs
4. Programmes for harm reduction
5. IDUs, their partners and safer sex practice
6. Illicit drug use in different parts of the world and scale of HIV spread among IDUs
7. Risk and protective factors related to adolescent drug/substance abuse

Learning Activities:

1. Understanding drug/substance abuse, the effects of substance abuse on lives and ways of harm reduction
2. Analyzing the correct information, myths and facts about drugs

Evaluation:

1. Question-answer on the following questions:
 - ▶ *Have you heard the term 'drug abuse'?*
 - ▶ *When did you first hear the term and from whom did you hear it?*
 - ▶ *If you think someone you know is abusing drugs, what will you do?*
 - ▶ *What are different types of programmes to foster harm reduction principles and to prevent HIV infection among IDUs?*

Facilitator's Note: Follow Facilitator's Note to conduct icebreaker or warm-up game.

ACTIVITY 5.1

Substance Abuse – Our Understanding

Approximate Time: 1 hour 30 minutes

Materials: “Myth and Fact Statements” and information/answer key for myth and fact statements, flipchart paper, markers, cloth bag or a small box, adequate number of condoms for icebreaker

Preparations:

1. Prepare two sets of questions to guide the group discussion. Place the slips of paper in a card box.
2. Prepare enough copies of Resource Material 5.1a and 5.1b (“Some Concepts: HIV/AIDS and IDUs” and “High Risk Behaviour and Sharp Rise in HIV”)

Objectives After doing this activity, the participants should be able to:

1. Define terms related to drug and substance use, injecting drug use and their consequences
2. Explain the increasing trends of high risk and vulnerability to HIV/AIDS in South and South-East Asia and Latin America.
3. Identify vulnerable or high risk behaviours and the effects of substance abuse and IDUs on their lives
4. Understand ways of preventing the consequences of drug and substance use

Content Outline

1. HIV/AIDS, drugs and substance abuse
2. Threat of drugs and substance abuse to youth
3. Programmes for harm reduction
4. IDUs, their partners and safer sex practice
5. Illicit drugs use in different parts of the world

Procedure

1. Play the icebreaker ‘Blowing Condom.’ (see the Facilitator’s Note for instruction)
2. After completing the game and summarizing the outcomes, ask the participants to sit in a circle.
3. Describe briefly the purpose of the activity to the participants.
4. Explain that the use of drug/substance among youth is an emerging concern.
5. Divide the groups into two teams and allow them 15 minutes for group work.

6. Tell the participants to initiate group discussion on the following questions:
 - ▶ *Have you heard the term 'drug abuse'?*
 - ▶ *When did you first hear the term and from whom did you hear it?*
 - ▶ *If you think someone you know is abusing drugs, what will you do?*
6. Ask both group members to pick up a chart each and some markers. (30 minutes)
7. Instruct the groups to discuss the term 'drug' within their group and come up with:
 - ▶ A definition based on their common understanding
 - ▶ The status of drug/substance abuse among the youth in your country/region or locality
 - ▶ Link of drug/substance abuse to other health concerns among young people
 - ▶ After the participant presentations, you provide the definition of terms and the status of drug/substance use based on Resource Material 5.1
8. Instruct the participants to initiate discussion within the group on the following questions (30 minutes):
 - ▶ *Why do young people use drug?*
 - ▶ *What factors contribute to young people becoming IDUs?*
 - ▶ *How is HIV transmitted among IDUs and their sex partners?*
 - ▶ *What causes contribute to HIV among IDUs?*
 - ▶ *What is the role of peer pressure among young people for illicit drug use and IDUs?*
 - ▶ *What is the relationship between drug use, unprotected sex and use of needles and syringes among young people?*
 - ▶ *What are the types of programmes that foster harm reduction?*

Evaluation:

Ask the following questions (15 minutes):

1. What skills did you learn to protect yourself from the illicit use of drugs?
2. If you were to help someone from becoming a drug addict, what would you suggest?
3. What could be the role of peer educators in preventing illicit use of drugs/substance by youth?

Learning Outcomes:

1. Understanding of illicit drug use and related terms like IDU and harm reduction
2. Status of drug/substance abuse among the youth in your country/region or locality
3. Causes of drug and substance abuse
4. Peers' roles in prevention of drug use, IDU and HIV transmission
6. Programmes that foster harm reduction



Facilitator's Note:

1. Introduce the game 'Blowing Condom' as an icebreaker.
2. Give one condom to each participant.
3. Ask the participants to blow up the condom.
4. Announce that the one who makes the condom the biggest will get a prize and those who break the condom while blowing it will lose and be obliged to either dance or sing.
5. Give a prize to the one who blows the condom the biggest.

Activity 5.2

Beliefs and the Reality of Drugs

Approximate Time: 1 hour 45 minutes

Materials:

1. “Myth and Fact Statements” and information/answer key for myth and fact statements, flip chart paper, markers, cloth bag or a small box.
2. Prepare the myth and facts statements based on the reality in the locality, country, region

Objectives

After doing this activity, the participants should be able to:

1. Clarify the myths and facts about illicit drug and substance use and harm reduction
2. Identify the association between drugs, sex, sexual abuse and HIV/AIDS
3. Analyze the information they already have about drug and substance abuse and IDUs
4. Be acquainted with those factors that are protective for adolescent drug/substance use in different countries

Content Outline

1. Facts versus myths of drugs and substance abuse
2. Protective factors for avoiding adolescent drug/substance abuse

Procedure

1. Ask the participants to sit in a circle.
2. Describe briefly that they will be learning some facts about drugs through a game. (5 minutes)
3. Also share with them that those who answer correctly will score 10 points and those who fail to respond correctly will score 0 points. (10 minutes)
4. Any team who responds correctly to the passed question will get 20 bonus points on a correct answer.
5. Put a flip chart up to keep scores. Ask for a volunteer to help you, if required.
6. Allow the teams to discuss their answer within the team for 10 minutes or so.
7. After each round, encourage discussion by asking the teams to give reasons for their answers.
8. Initiate discussion among the participants using the following questions as guidelines in three groups. (40 minute)
 - ▶ *Did you learn anything new from this game? What?*
 - ▶ *Were you surprised or distressed by anything that you learned? What and why?*

- ▶ *Why do you think there are so many myths related to drug use?*
- ▶ *How do you feel about drug use? Why?*
- ▶ *Why is drug use among young people becoming a major cause for concern?*
- ▶ *Can you think of ways in which you can spread awareness about drug use? What can you do/*
- ▶ *If you have a friend who is using drugs, how will you help him/her?*

9. Ask the participants to discuss the types of life skills to strengthen protective factors in treatment and after care, and the types of programmes that foster harm reduction. Share in the plenary.

10. Ask the participants for presentation and provide them with the information from Resource Material 5.2. (10 minutes each)

Evaluation

Based on the plenary discussions

Learning Outcomes:

1. Increased awareness level and assessment of the level of knowledge and beliefs about drug use
2. Ability to distinguish between myths and facts regarding drugs
3. Awareness of life skills to strengthen protection against drug use

Facilitator’s Note:

1. In case the participants fail to give the correct answers on ‘Myth and Fact Statements,’ you have to provide the answer.
2. Encourage the participants to discuss by asking some question, for example:
 - ▶ Have you ever thought of experimenting with drugs?
 - ▶ Do you know of anyone who uses drugs?
 - ▶ Why do young people experiment with drugs?

Resource Material 5.1a

Some Concepts: HIV/AIDS and IDUs

Injecting Drug Use and HIV/AIDS:

The three epidemics – of opiate use, of heroin injecting, and of HIV infection among heroin injectors – can develop extremely quickly, and often unexpectedly.

1. How is HIV transmitted by injecting drug use?

When the blood of an HIV-infected drug user is transferred to a drug user who is not yet HIV infected, HIV can be transmitted through injection drug use. Needles and syringes are the primary drug injection equipment involved in transferring HIV-infected blood between drug injectors. Sharing and multiple use of syringe and needles lead the transfer of HIV-infected blood. Even a tiny amount of HIV-infected blood left in the syringe can be transmitted to the next user.

In recent years, youths have been the biggest population affected by HIV. Persons who inject drugs and share drug injection equipment are at high risk of acquiring HIV because HIV is transmitted very efficiently through such sharing. HIV transmission among IDUs to their sex and needle-sharing partners, and to their newborns, is a major factor in the continuing spread of HIV.

HIV transmission also is occurring among people who trade sex for non-injected drugs. Trading sex for drugs often is associated with unprotected sex and having multiple sex partners. Further, the use of non-injected drugs or alcohol can place a person at risk for HIV transmission in part because these substances lessen inhibitions and reduce reluctance to engage in unsafe sex.

The practice of trading sex for drugs has contributed not only to the spread of HIV infection, but also to large increases in rates of STIs. The IDUs are the largest group of potential HIV/AIDS carriers among the vulnerable groups in many parts of the world. Injecting drug use accounts for significant numbers of cumulative AIDS cases.

Infected blood can be drawn up into a syringe and then get injected along with the drug by the next user of the syringe. This is the easiest way to transmit HIV during drug use because infected blood goes directly into someone's bloodstream.

Enough needles and syringes are not available or are not affordable to IDUs, and this sharing causes HIV infection among IDUs to efficiently spread. Unprotected sexual activity with an HIV-positive partner is also a high-risk factor for IDUs. Male IDUs who have sex with men, women IDUs who trade sex for money and women with IDU partners are especially in danger of getting the HIV virus. Risk varies depending on the amount and frequency of drug use and of sexual relations. IDUs often struggle with multiple health risks due to social, economic and psychological factors.

The transmission of HIV among IDUs has been most pronounced in drug producing and transit countries in South-East Asia. Epidemics of HIV that can literally be called explosive have been documented among IDUs in Thailand, Myanmar, Malaysia, Viet Nam and northeast India. The prevalence of HIV infection among injecting drug users has often reached 60 to 90 percent within six months to a year from the appearance of the first case. In many countries, these explosive epidemics among IDUs then form epicentres for wider diffusion of the HIV epidemic to other parts of the community.

Several communities in Asia have had HIV among IDUs for some time, and are now in the grip of multiple ongoing epidemics:

- ▶ Of drug use and its consequences
- ▶ Of HIV infection among IDUs
- ▶ Of HIV transmitted from IDUs to their sexual partners and their children
- ▶ Of subsequent AIDS and of tuberculosis

The injecting of illicit drugs exists in 120 countries, and in at least 80 of these countries there are epidemics of HIV infection among IDUs. The majority of these infections result from sharing contaminated needles and syringes, which happens for many reasons. Such epidemics can occur with explosive rapidity, and, having occurred, can form a core group for further sexual and vertical transmission.

Injection and Infection: HIV infection spreads easily when people share equipment to use drugs. Sharing equipment also spreads Hepatitis B, Hepatitis C, and other serious diseases. For a lot of people, drugs and sex go together. Drug users might trade sex for drugs. Some people think that sexual activity is more enjoyable when they are using drugs. Drug use, including alcohol, increases the chance that people will not protect themselves during sexual activity. Someone who is trading sex for drugs might find it difficult to set limits on what they are willing to do. Anyone using drugs is less likely to remember about using protection, or to care about it.

It is therefore very important to include effective prevention measures against HIV transmission among IDUs in any comprehensive AIDS strategy. IDUs are a hidden and stigmatized group because their behaviour is illegal; often they engage in other risk behaviours for HIV such as commercial sex work or paid blood donation because of the cycle of poverty and the cost of the drugs. The strategies that have been demonstrated to be effective in both the developed and the developing world are those based on the principles of harm reduction. The primary aim of harm reduction is to reduce the harm associated with the injecting of drugs, especially the transmission of HIV and other blood borne viruses, without necessarily diminishing the amount of drug use. This is an approach entirely compatible with sensible demand and supply reduction approaches, and sees drug use and abuse of drugs as a public health issue. As with all effective community responses, it acknowledges the humanity and worth of the IDU, and creates a partnership with the IDU and his or her community to protect their common health.

As HIV transmission among IDUs can be extremely rapid, approaches to intervene and obstruct the spread of HIV infection have needed to be explored by many countries. What has emerged, both within the developed and developing world is the approach of "Harm Reduction." Harm Reduction can be viewed as the prevention of adverse consequences of illicit drug use without necessarily reducing their consumption. **Harm Reduction** is an alternative treatment approach which views the reduction of harm as a legitimate goal for substance users. It includes **substance abuse counseling**, as well as harm reduction training for therapists and counselors.

Harm reduction is a safety net for addicts who are either not ready or too frightened of withdrawal to attempt abstinence. The rehabilitation approach favours abstinence as the only goal of treatment. With the goal of progressively limiting the consequences, the harm reduction approach focuses on reducing the negative consequences that stem from injection drug use. Advocates of the harm-reduction approach recognize that while addicts may never achieve total abstinence, they may improve their health, and social functioning while in treatment, and reduce the cost to society from criminal behaviour. Methadone maintenance treatment (MMT) is the largest drug treatment modality for heroin addiction that has proven effective in reducing injection drug use, and it plays a special role within the harm reduction approach.



Needle Exchange Programmes: In many parts of the world, some agencies have started needle exchange programmes to give free, clean syringes to people so they won't need to share. These programmes are generally the recipients of criticism and objection from governments because some people think they promote drug use. Yet, while the connection between needle exchange programmes and the incidence of drug use remains controversial, the programmes do have a positive effect on rates of HIV infection, which have dropped among IDUs that participate in such programmes.

A broad range of programmes have been implemented to foster harm reduction principles and to prevent HIV infection among IDUs. These include:

- ▶ The provision of information programmes to inform IDUs of the risks of different drugs and their use
- ▶ Information on using drugs more safely, and reducing overdoses
- ▶ Establishment of drug treatment substitution programmes
- ▶ Provision of methadone as a substitute for heroin, offering medication to counteract a drug overdose
- ▶ Education and referral to drug treatment opportunities
- ▶ Programmes that permit drug users to exchange used syringes for new ones, or buy new syringes
- ▶ Outreach education using peer educators, often former IDUs, themselves
- ▶ Over-the-counter sales of injecting equipment
- ▶ Counselling and testing for HIV among IDUs
- ▶ Increased access to primary health care
- ▶ Removal of barriers to safer injecting, including laws and police practices
- ▶ Targeting special groups and circumstances

All these programmes aim to change behaviour and thereby reduce the risks of HIV infection among IDUs.

Peer Role in HIV Prevention among IDUs: Peers play crucial roles in influencing behaviours. Individuals generally exert pressure on their peers for different behaviours. Therefore, most of the risk behaviours such as IDUs, illicit use of drugs and unsafe sexual practices are the result of peer pressure. However, studies have shown that peers may effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies. Therefore, peers are often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours.

Peers, such as recovering IDUs, can be effective in motivating behavioural change. However, recovering IDUs used as peer educators need support to avoid relapse into drug use. IDUs are more likely to use condoms when members of their social network discuss general health concerns and condom use, and when they have broader financial support. Access to quality medical care and STD/HIV treatment can help promote safer behaviors. Community-based prevention programmes can be effective. These programmes address not just individual IDU needs, but the health and welfare of the entire community.





In the context of injecting drug use and HIV infection, the following points need to be highlighted:

- ▶ Illicit drugs are injected in many parts of the world
- ▶ Reuse of contaminated needles and syringes by different people is common in many settings where injecting drug use takes place
- ▶ HIV is efficiently transmitted by this sharing of injecting equipment
- ▶ The reasons for sharing are various – poverty, lack of availability or access to needle and syringes, cultural factors and ignorance
- ▶ Enforcement of illicit drugs prohibition promotes conditions for transmission of HIV among IDUs
- ▶ HIV spreads from IDUs to their sexual partners and children

The scale of HIV spread among IDUs, their sexual partners and their children depends on a wide variety of factors. These include the following:

- ▶ The drugs injected and the frequency of injecting
- ▶ The social organization of drug injecting, especially the existence of ‘shooting galleries’ or professional injectors
- ▶ Knowledge on the part of IDUs of HIV, hepatitis viruses and other infections which can be associated with unsterile injecting equipment
- ▶ The availability of sterile injecting equipment or of the means to sterilize equipment
- ▶ The availability and accessibility of drug treatment programmes
- ▶ The availability and accessibility of welfare and health programmes for IDUs

Research and education performed in collaboration with the affected community is the most effective. Peer education is the most effective form of education.

Behaviours that put IDUs at risk of HIV infection are not random; they result from the social, political and cultural context. IDUs in prisons or among ethnic minorities, sex workers and women are at an increased risk of HIV infection. The biggest barrier to reducing HIV transmission among IDUs is the failure to implement effective prevention programmes. Increasing access to quality drug treatment and sterile injection equipment would greatly affect this epidemic among IDUs. It is often erroneously assumed that IDUs are not comfortable discussing sexual issues. Prevention programmes for IDUs need to address sexual behaviour, as well as injecting behaviour. Handing out condoms is not enough; service providers need to initiate discussions about sex.

2. What are “drugs”?

The word ‘drug’ refers to any substance or product that affects the way people feel, think, see, taste, smell, hear, or behave. The World Health Organization (WHO) defines ‘drug’ as ‘any substance, solid, liquid or gas, that changes the function or structure of the body in some way.’

A drug can be a medicine, such as morphine, or it can be an industrial product, such as glue. Some drugs are legally available, such as approved medicines and cigarettes, while others are illegal, such as heroin and cocaine. Each country has its own laws regarding drugs and their legality. The use of drugs may have a little or a large effect on a person’s life and health. The extent of the effect depends on the person, the type of substance, the amount used, the method of using it, and the general situation of the person.

Drug use is a major factor in the spread of HIV infection. Shared equipment for using drugs can carry HIV and hepatitis, and drug use is linked with unsafe sexual activity. Drug use can also be

dangerous for people who are taking anti-HIV medications. Drug users are less likely to take all of their medications, and street drugs may have dangerous interactions with HIV medications.

3. Why do young people use drugs?

People, including young people, take drugs for their immediate and short-term effects. Usually many young people use drugs because they either add something to their lives or help them to feel that they have solved their problems, however fleeting this feeling might be. Drug use may also be influenced by a number of factors such as:

The individual: Adolescence is a time of immense physical and emotional change. Young people often feel awkward and self-conscious. They may feel caught between conformity and the urge to be different, or the urge to fit in with their peer group. Young people often do not have the skills necessary for dealing with stress and pressures of life, and drugs may be seen as a way of dealing with them.

Family and friends: Young people may learn about drugs and their uses from their family and friends. Often children living in families where smoking, drinking alcohol and taking prescription drugs or any other stimulants are considered a part of life and believing that drugs are normal. They also believe that drugs are helpful in releasing stress, worries etc. Friends and peers have a great influence on young people, and among them drug use may be considered normal and a part of growing up.

Society: Mixed messages from media, peers, parents, school and work often contradict or conflict with young people's experiences of themselves. Often young people receive messages that encourage and discourage drug use. Young people usually start using drugs as an experiment in social gathering, with friends and for recreational reasons.

Environmental factors: These include laws which control supply and availability of drugs, advertising/promotion of alcohol and drugs, and access.

4. What are the names and types of the commonly used drugs by young people?

The number of drugs that can be used is enormous. The generic name of a drug is standard and used throughout the world. However, most drugs are marketed under various trade names and also have many street names. *Trade names* usually begin with a capital letter. For example, a commonly used drug to reduce anxiety is *diazepam* (generic name) and is sold in some countries as Valium (trade name). Another example is *diacetylmorphine*, for which the generic name is heroin; it has the street names "brown sugar" in India and "smack" in the USA and Australia. It is also common for street names to change regularly. The three main types of drugs, classified by their effects on the central nervous system, are:

- ▶ Depressants
- ▶ Stimulants
- ▶ Hallucinogens

Depressants slow down, or depress, the central nervous system. They don't necessarily make the user feel depressed. Depressant drugs include:

- ▶ Alcohol
- ▶ Opiates and opioids: heroin, morphine codeine, methadone, and pethidine
- ▶ Cannabis: marijuana, hashish and hash oil
- ▶ Tranquillisers and hypnotics: Rohypnol, Valium, Serepax, Mogadon, and Euhypos
- ▶ Barbiturates: Seconal, Tuinal and Amytal
- ▶ Solvents and inhalants: petrol, glue, paint thinners and lighter fluid

In moderate doses, depressants can make users feel relaxed. Some depressants cause euphoria or a sense of calm and well-being. They may be used to wind down anxiety, stress or inhibition. Because they slow the nervous system, depressants affect coordination, concentration and judgment. In larger doses, depressants can cause unconsciousness by reducing breathing and heart rate. Speech may become slurred and movements sluggish or uncoordinated. Other effects of larger doses include nausea, vomiting, and in extreme cases, death. When taken in combination, depressants increase their effects and the danger of overdose.

Stimulants are used by millions of people every day. Coffee, tea and cola drinks contain caffeine, which is a mild stimulant. The nicotine in tobacco is also a stimulant, despite many smokers using it to relax. Other stimulant drugs such as ephedrine are used in medicines for bronchitis, hay fever and asthma. Stronger stimulant drugs include amphetamines, “speed,” and cocaine, which are illegal in most countries.

Hallucinogens distort perceptions of reality. These drugs include:

- ▶ LSD (lysergic acid diethylamide); trips acid microdots
- ▶ Magic mushrooms (psilocybin): gold tops, mashies.
- ▶ Mescaline (peyote cactus)
- ▶ Ecstasy: (MDMA/ methylenedioxymethamphetamine)
- ▶ Cannabis in stronger concentrations, such as in hashish and resin, can act as a hallucinogen, in addition to being a central nervous system depressant
- ▶ Ketamine, also known as K or Special K

Negative effects of hallucinogens can include panic, paranoia and loss of contact with reality. In extreme cases, this can result in dangerous behaviour like walking into traffic or jumping off a roof. Driving while under the influence of hallucinogens is extremely hazardous. It is common for users to take minor tranquilizers to help them come down from a hallucinogenic drug.

5. Commonly used drugs by young people:

Amphetamines belong to a group of drugs called psycho-stimulants, and chemically manufactured drugs that are powerful stimulants of the central nervous system. Most amphetamines are produced in illegal backyard laboratories and sold illegally. Amphetamines can be diluted in juice, snorted or injected into a vein. Due to the unknown strength of street amphetamines, some users have overdosed and died. With increasing doses, users often can be aggressive and potentially violent; withdrawal symptoms include fatigue, disturbed sleep, irritability, hunger and severe depression.

Methamphetamine is a stimulant drug that falls in the amphetamine family. The use of methamphetamine produces similar behavioural and physiological effects as cocaine and other stimulants. These effects include euphoria, increased alertness, the perception of improved self-esteem and self-confidence, impaired judgment, and impulsiveness. Acute and chronic use of methamphetamine typically results in nervousness, irritability, restlessness, and insomnia. Permanent neurological changes and deficits can result from chronic methamphetamine use.

Cocaine mainly comes as a white powder called cocaine hydrochloride. Cocaine in this form is usually snorted or injected. Effects of cocaine, which can last for minutes or hours, happen very quickly and can include an extreme feeling of well-being, increased heart rate, agitation, sexual stimulation, alertness, energy, unpredictability and aggressive behaviour. The inside of the nose can be severely damaged if you regularly inhale cocaine through the nose. Cocaine, or “coke,” is highly addictive and, as with other stimulants, reduces hunger, thirst and natural needs like rest, food and water. Death can occur as a result of overdose.



Ecstasy: The chemical methylenedioxymethamphetamine (MDMA) is a drug, which can cause users to see things that are not seen by other people. It produce a feeling of tranquillity, increased confidence and feeling close to people, which is why it's also known as "the love drug." Users can also have jaw clenching, teeth grinding, dry mouth and throat, nausea, loss of appetite, anxiety, paranoia and confusion.

Inhalants: Some drugs turn to gas in air and when the fumes are inhaled can cause the user to feel high. These are inhalants. Many household products are used as inhalants such as glue, aerosol spray cans, lighter fluid, paint thinner, chrome-based paint or petrol. The drug in some of these products can cause heart failure, particularly if the user is stressed or does heavy exercise. Some users have been known to pass out and suffocate in the plastic bag from which they inhale. Like most street drugs, inhalants are addictive although almost all who try inhalants only use them once or twice.

Cannabis: Also known as marijuana, this drug can have a slight effect on one person and a much greater effect on another person. The initial effect for a new marijuana smoker can be a strong rush. Some people say they feel nothing. For some people, cannabis use is a pleasant experience. For others, there are unpleasant side effects. There are negative health effects which result from continued use. The hemp plant, *Cannabis sativa*, grows throughout most of the world. The cannabis plant is prepared for consumption in various ways. Three common forms of cannabis are marijuana, hashish, and hashish oil. The term "marijuana" refers to the cannabis plant and to any part or extract of it that produces somatic or psychic changes. Drying the leaves and flowering tops of the plant produces the tobacco-like substance. When marijuana is smoked, the effects are felt within minutes, reach their peak in 10 to 30 minutes, and may linger for two or three hours.

6. Is there any association between drugs and sex, sexual exploitation, sexual abuse and HIV/AIDS?

The connections between drugs and sex, sexual exploitation and sexual abuse are well established. Due to this nexus, many young people find themselves vulnerable to HIV infection, as well. Some examples of this are:

- ▶ Some young people may run away from their home or village due to the drug use of family members and/or other adults who may become violent when intoxicated (some of this violence may be in the form of sexual abuse) or neglect their needs.
- ▶ Some young people are sold by their parents for money to buy drugs.
- ▶ Some young people who use drugs may engage in sex work for money to buy drugs.
- ▶ Some young people may get paid in drugs for sex work.
- ▶ Some pimps and brothel owners may give drugs to young people to get them to have sex (so they are less likely to refuse or to get them sexually aroused).
- ▶ Some pimps and brothel owners may give drugs to young people to keep them working (i.e. get them physically and psychologically dependent so that they stay 'on').
- ▶ Some pimps and brothel owners may give drugs to young people to make them semi-conscious when not working so they do not run away or leave.
- ▶ Some customers may give young people drugs and then have sex with them (e.g. as payment, to increase pleasure, for certain sexual acts, or to decrease the changes that the young persons could identify them later).



- ▶ Some young people are drugged so that they can be more easily involved in pornography (e.g. photo or videos) or perform sexual acts.
- ▶ Young people may take drugs so that they can cope with sex work – or certain sexual acts (so they will perform the acts or to reduce the pain of the acts).
- ▶ Some young people may take drugs so that they can cope with the effects of sex work (e.g. shame and guilt).
- ▶ Some young people may take drugs to make sex feel better.

7. Are there any symptoms for recognizing students/persons who may be using drugs?

Yes, it is possible to get an indication through some symptoms if a person is using drugs. One has to be careful in any enquiry, and drug use should not be presumed unless confirmed otherwise. The following symptoms are indicative of drug use and may not always be related to drug addiction:

Marked personality change: a placid, soft-spoken person suddenly becomes noisy and abusive

Mood swings: mood may swing from high to low and back again, seemingly, without reason

Change in physical appearance or well-being: a change in weight, sleep patterns, slurred speech, talkativeness, euphoria, nausea, and vomiting

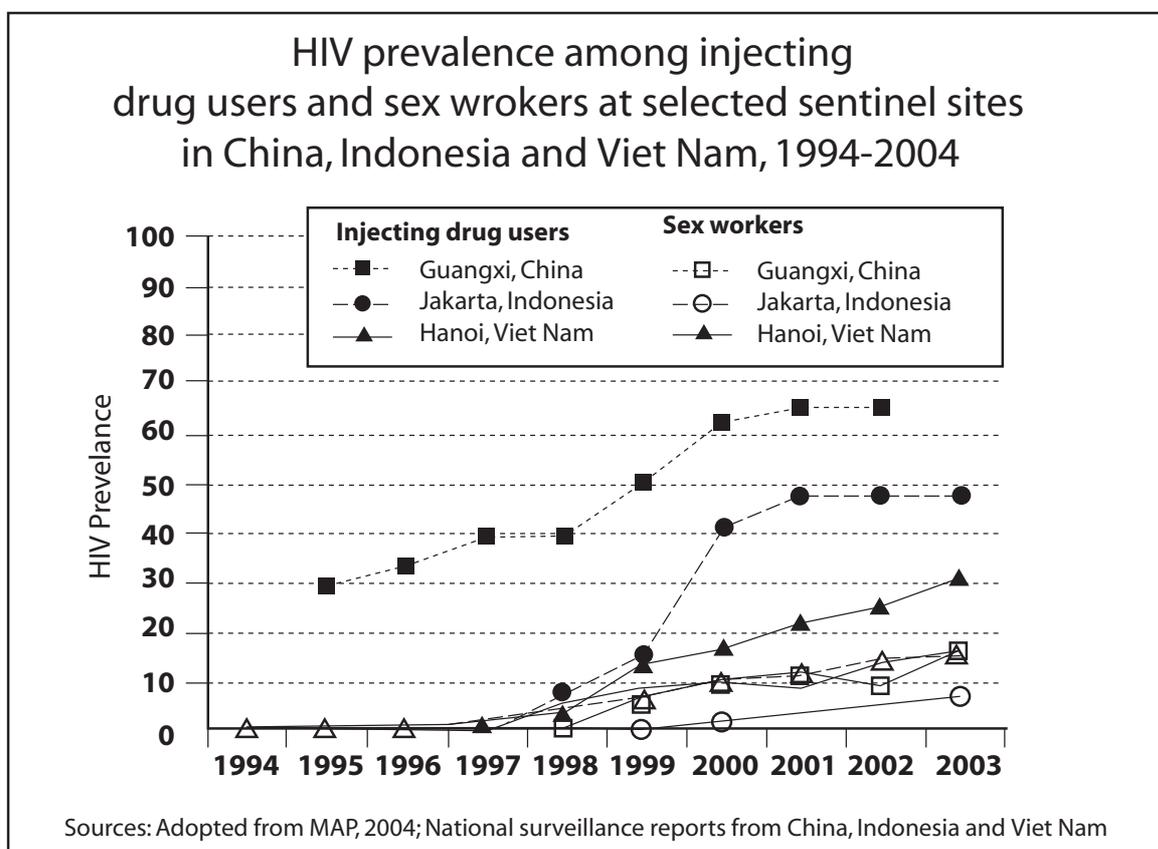
Change in school performance: for students, a significant deterioration in performance, especially when the student has been diligent, may be an indicator of difficulties; equally, a rapid change from poor performance to diligence may be important

An excessive need for or increased supply of money: buying drugs costs money, and the more drug dependent the person becomes, the greater their need for money to finance their 'habit'; money, however, is not the only transferable commodity for young people (for example, baseball caps, sports shoes and sex are commonly traded for alcohol and other drugs).



Resource Materials 5.1b: High Risk Behaviour and Sharp Rises in HIV

HIV prevalence is rising sharply in several places where it stayed low for many years. These rises are most dramatic among people whose behaviours carry a high risk of exposure to HIV—drug injectors, sex workers and their clients, and men who have sex with men. In **Indonesia, Nepal, Viet Nam** and parts of **China**, rapid, recent rises in HIV infection among drug injectors appear to have spurred subsequent rises in HIV infection among non-injectors who have sexual risk behaviours, “kick-starting” wider epidemics, as the figure below illustrates. Given the very large population numbers in these countries, continued HIV spread among those with risk behaviours and their sex partners will give rise to several million new infections. These countries stand at a cross-road; they dare not delay introducing effective responses.



On a vast archipelago such as **Indonesia**, where research has revealed ample opportunities for wider HIV transmission, the epidemic will assume diverse patterns. Risk behaviour among IDUs in Indonesia is very common. A recent survey in three cities found 88% of the injectors had used non-sterile needles or syringes in the preceding week, yet less than one third said they felt at high risk of HIV infection (Pisani et al., 2003). When IDUs are tested for HIV, very high infection levels are found. One in two injecting drug users in Indonesia’s capital, Jakarta, now test positive for HIV, while in far-flung cities such as Pontianak (in West Kalimantan province on the island of Borneo) more than 70% of drug injectors who request HIV tests are discovering that they are HIV-positive (MAP, 2004).

Conditions also favour HIV spread through sex work. In seven Indonesian cities, an average 42% of sex workers had either (or both) gonorrhoea or chlamydia in 2003. Condom use ranges from irregular to rare.



HIV behind bars

Prisons are playing a growing role in **Indonesia's** emerging epidemic. In Jakarta's jails, HIV prevalence started to rise in 1999, two years after it had taken off among drug injectors, reaching 25% in 2002. Some of the rise reflected the fact that injecting drug users were more likely to have been infected by the time they entered prison. But there is evidence that HIV transmission is occurring inside jails. Surveillance data from a West Java prison has shown HIV prevalence soaring from 1% in 1999 to 21%, then "falling" sharply to 5% in 2002. The 2002 "drop" was an illusion, though, reflecting a change in sampling: only newly-registered inmates were tested for HIV. When a random sample was used again in 2003, HIV prevalence was found to be 21%. This discrepancy suggests that HIV is being transmitted inside the prison, either through drug injection with contaminated needles or through unprotected anal sex between prisoners (MAP, 2004; data from Indonesian national surveillance).

A huge prevention opportunity beckons. Unlike their counterparts outside the prison walls, jailed drug injectors are not a "hard-to-reach population." HIV-prevention programmes are needed inside prisons, with reinforcement in preparation for prisoners' release. Jails can provide an entry point for treatment for both antiretroviral and drug substitution treatment. Referral systems between jail and services outside can help introduce essential health, prevention and care services to people who might otherwise potentially be hard to track down in the community after release.

Unsafe injecting drug use is the wellspring of **Nepal's** epidemic, too. Use of non-sterile injecting equipment is widespread and accounts for the high HIV prevalence—22% to 68% across the country in 2002—among male injectors, many of them younger than 25. Younger injectors appear more likely to report risky practices in parts of Nepal; in the east, for example, injectors under 25 were three times as likely to report using non-sterile equipment at last injection compared with older injectors (MAP, 2004). Nepal's epidemic also highlights the potential links between HIV infection and mobility. Injecting drug users from cities with low prevalence, but who had injected drugs elsewhere, have been found to be two to four times more likely to have acquired HIV than those who had remained in their home cities. Half of the sex workers surveyed in central Nepal who said they had worked in Mumbai (India) were HIV-infected, compared with 1.2% of those who had never been to India.

Risky business

Most new HIV infections in Asia occur when men buy sex—and large numbers of men do so. Household-based surveys in a number of Asian countries suggest that between 5% and 10% of men buy sex, which makes commercial sex a large and lucrative industry in Asia. Many sex workers—especially very young women from rural areas—are either coerced into the industry or join it under duress because they lack other employment opportunities. Studies among sex workers in **China**, for example, have found that young and ill-educated women from rural areas sell sex because they can not find other work. However, others sometimes opt for the profession instead of arduous, low-paying jobs. In **Viet Nam**, for example, sex workers have reported earning up to seven times the average income of other workers in the areas where they plied their trade. Their counterparts in **Nepal** have reported earning around 2200 rupees, or US \$30, a week, six times the average wage income (MAP, 2004).

The majority of the women who did not use condoms with their last client in places where condoms were easily available said it was because their clients refused to use them. Because many men are willing to pay more for sex without a condom, many women find it especially difficult to negotiate condom use. In **India**, one quarter of street-based sex workers said that if a client refused to use a condom, they simply

charged more money and went ahead with sex. Sex workers in China's Yunnan province have reported that they earn about 60% more for sex without a condom, while non-brothel-based sex workers in **Indonesia** charged around 20% more. In addition, some clients threaten or use violence when sex workers try to insist on condom use.

Who's doing the buying? In southern Viet Nam, sex workers reported that more than one third of their clients were businessmen or white-collar workers, while over half in five northern provinces were said to be government officials. Women selling sex in **Indonesia, Laos** and **Pakistan** also said that civil servants and businessmen were among their most frequent clients, while in **India**, over one-quarter were businessmen or service sector employees. Many of these men are married or in steady relationships. Those who have unprotected sex with sex workers are at risk, therefore, not just of contracting HIV, but of passing it on to their wives and girlfriends. Indeed, in a study in the southern Chinese city of Guangzhou, some 72% of women with sexually transmitted infections said they had only had sex with their husband or regular partner in the previous six months—a clear sign that they were put at risk by their partners' behaviour rather than their own. Expressed in these ways are deeper social inequalities, not least the imbalances in men and women's social power, and women's stunted earning and career opportunities in most countries of Asia (and, indeed, the world). Prevention efforts that neglect these wider dynamics are likely to achieve just short-lived success, if any.

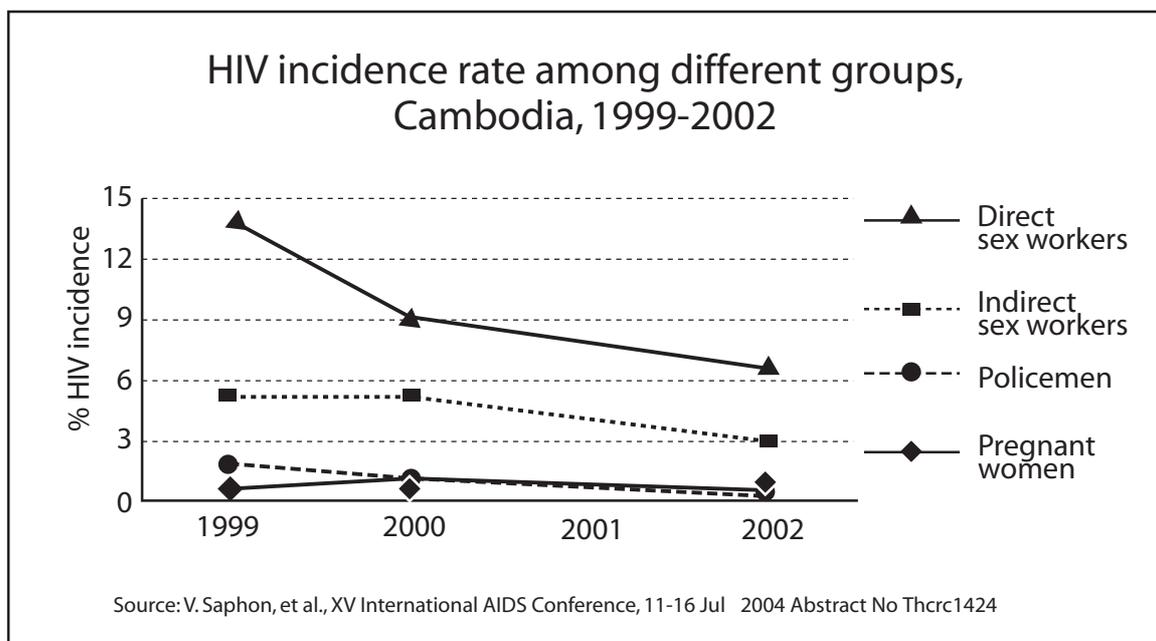
It's easy to forget, though, that not all sex workers are women. Asian men also buy sex from male and from transgender sex workers. For example, 48% of men who have sex with men in Lahore, Pakistan, and 20% in Sichuan, China, said they had paid for sex in the previous six months. Over one third of men in five cities in India who have sex with men, reported in 2002 having bought or sold sex in the previous month, while a 2001 study in the city of Chennai found that one in five men who have sex with men had exchanged money for sex at some point (Go et al., 2004). The high rates of commercial sex between men reported in surveys do not represent the habits of all men who have sex with men, but they highlight the forgotten population of male sex workers and the high risks of HIV infection they have. In one Bangkok study, for example, 32% of MSM reported selling sex were infected with HIV.

Widespread injecting drug use by sex workers makes **Viet Nam's** epidemic particularly explosive. In Ho Chi Minh City, 38% of almost 1000 sex workers included in one survey injected drugs—and fully 49% of those injecting sex workers were infected with HIV (compared with 8% of those who didn't use any drugs). In the northern port city of Haiphong, nearly 40% of all sex workers said they injected drugs, compared to one in six sex workers who did likewise in the capital, Hanoi. Drug-using sex workers are about half as likely to use condoms as those who do not use drugs, according to another study in Ho Chi Minh City. These trends probably explain a good deal of the steep rises in HIV prevalence detected in some of Viet Nam's cities, where the virus now appears to be spreading freely among groups that are at high risk of exposure to HIV. HIV prevalence of 8% was detected in a 2003 Ho Chi Minh city survey among MSM. Most new HIV infections in Asia occur when men buy sex—and large numbers of men appear to do so.

High prevalence and HIV spreading among wider population: In some areas, including parts of **India, Myanmar** and southwestern **China**, HIV has acquired a strong foothold among people who have been exposed to a high risk of infection for several years. Inadequate prevention efforts have allowed the virus to filter from people with the highest risk behaviours (such as non-sterile drug injection and unprotected commercial sex) to their regular sex partners, which accounts for rising HIV infection levels among women who report having only one sexual partner. **Myanmar**, which has one of the most serious epidemics in Asia, is an example. The situation varies across the country, but HIV has already become entrenched in

lower-risk populations in several parts of Myanmar. By 2003, 12 out of 29 sentinel sites for pregnant women were recording HIV prevalence above 2%. At Pyay and Hpa-an, respectively, 5% and 7.5% of pregnant women tested HIV-positive. About 2% of new military recruits tested HIV-positive at two sites in 2003 (Ministry of Health Myanmar, 2003). Exceptionally large proportions of IDUs have acquired HIV: in some places, 78% of drug injectors tested positive in 2003. Between 45% and 80% of drug injectors have tested positive for HIV infection in sentinel surveillance each year between 1992 and 2003. HIV among sex workers rose significantly from around 5% to 31% over the same period. Meanwhile, the proportion of male and female patients at STI clinics who tested positive for HIV rose to 6% and 9%, respectively, in 2003 (Ministry of Health Myanmar, 2003; MAP, 2004).

Strong prevention efforts that have shown results: Asian countries that have introduced large-scale prevention programmes addressing sexual transmission of HIV—notably **Cambodia** and **Thailand**—have seen significant reductions in risk behaviour, and have recorded declining levels of new HIV and other STIs. In Cambodia, fewer men are now visiting sex workers, and there has been a significant rise in condom use in commercial sex. The combined effect has been a steep drop in STIs and a steady decline in HIV prevalence. New testing technologies that allow researchers to estimate what proportion of infections were recently acquired show a significant drop in new HIV infections (or incidence), as shown in figure below.



While **Thailand** has actively worked to curb infection rates within the sex industry, an estimated one fifth of all new HIV infections are now occurring through unsafe injecting drug use, compared with about one twentieth a decade ago (Thai Working Group on HIV/AIDS Projections, 2001). Exceptionally high levels of HIV infection are being detected in parts of the country. In northern Thailand, 30% of drug injectors are infected with HIV, while median HIV prevalence as high as 51% has been found in other parts of the country. Yet, scant prevention resources are deployed on this front. The fact that injecting drug use is illegal should not block the path of effective action. A pragmatic approach—such as that adopted toward sex work in the 1990s—is much more likely to bring success. The same holds for MSM, among whom HIV prevalence as high as 17% has been detected (UNDP, 2004).

Very low HIV prevalence, big prevention opportunities: Several countries still have a rare opportunity to prevent a significant epidemic from taking hold at all. There, very low rates of HIV infection are being recorded, even in populations whose behaviours put them at great risk of HIV infection, as shown in the figure below. These countries still have an opportunity to deny the virus a firm foothold by providing prevention services to those most at risk of HIV infection.

HIV prevalence in populations at risk in various Asian countries, 2001-2003

	Bangladesh 2002	East Timor 2003	Mongolia 2003	PDR Lao 2001	Pakistan 2003	Philippines 2003	Sri Lanka 2003
Female sex workers	0-0.7%	3%	0	0-1.1%	0	<1%	0-0.2%
Men who have sex with men	0-0.2%	0.9%	-	-	-	0	-
High-risk men*	0	0	0	0	-	0	0
STI clinic clients	0	-	0	-	-	-	0-1%
Drug injectors	0-4	-	-	-	0	0	-

*Bangladesh: Truck drivers, launch workers, boyfriends of sex workers. East Timor: Taxi drivers and soldiers. Laos: Truck drivers. Philippines: Military recruits. Sri Lanka: Transport workers and male military.

Sources: Lao People's Democratic Republic National Committee for the Control of AIDS Bureau 2001; Philippines Department of Health 2002 and national surveillance reports; Bangladesh National AIDS/STD programme 2003; Pisani and DI:STI survey team 2004a

The AIDS picture in **Malaysia** is far from clear, mainly because it is derived largely from HIV and AIDS case reports that focus on IDUs. Such reports indicate that 55% of people detected with HIV between 1998 and 2001 were drug injectors. A study carried out in Penang has found that 17% of drug injectors who agreed to testing were HIV-positive (Navaratnam et al., 2003). It is possible, though, that other significant factors in the epidemic are being missed. For example, when surveillance was last conducted among sex workers in 1996, HIV prevalence was 6.3% in Kuala Lumpur and 10.2% in Selangor.

Resource Material 5.2

1. What are ‘life skills’ and how can life skills training help in reducing drug/substance abuse?

Life Skills Approach: A life skills approach may help to contribute to a reduction in the harm associated with issues such as HIV/AIDS and other STIs; alcohol, tobacco and other drug use; war and political instability; unemployment; sexual and other forms of exploitation; and discrimination in its many forms. The life skills approach refers to the interactive process of teaching and learning that focuses on acquiring knowledge, attitudes and skills which can support positive change in behaviors.

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of every day life (WHO 1994). Based on positive experiences with life skills approaches in substance/drug abuse prevention, life skills are a promising approach to strengthen protective factors in treatment and aftercare, including relapse prevention, as well.

Life skills applied to drug/substance abuse prevention are supposed to facilitate the practice and reinforcement of psychosocial skills that contribute to the promotion of personal and social development, such as self-awareness, empathy, communication skills, interpersonal skills, creative thinking, critical thinking, coping with emotions and coping with stress. In drug/substance abuse prevention, which should also be part of treatment programmes, this means imparting skills in drug/substance resistant/refusal and critical thinking, social competence and communication skills to explain and reinforce personal anti-drug commitments.

While people use alcohol or other drugs to cope with the stresses of their lives, it is very difficult to change their habit or behavior regarding substance use. Outreach and counseling should focus on helping them learn life skills that will help them cope so that they no longer need the substance. Life skills include: assertiveness, anger management, conflict resolution, time management and stress management. There are different ways to obtain these life skills.

2. Risk and protective factors for adolescent drug/substance use

Prevention programmes often are designed to enhance “protective factors” and to reduce “risk factors.” Risk factors are those that make drug use more likely. WHO analyzed research on risk and protective factors from more than 50 countries, and concluded the following for Asia (WHO 2001):

Risk factors for adolescent drug/substance abuse	Protective factors for adolescent drug/substance abuse
<ul style="list-style-type: none">▶ Conflict in the family▶ Friends who use drug/substance	<ul style="list-style-type: none">▶ A positive relationship with parents (family)▶ Parents provide structure and boundaries (family)▶ A positive school environment (community) having spiritual beliefs (individual)



At an individual level, life experiences play a more significant role in substance/drug abuse than genetic traits. Important factors are the level of support and care from a parent or other adult at an early age, and the quality of a child's school experience. In addition, general personal and social competence, such as feeling in control and feeling positive about the future, are important factors. Also personal beliefs play an important role. At the peer level, the selection of peers and nature of peer support is crucial.

Factors arising from the family level include a history of substance abuse or lack of effectiveness of family management, including communication and discipline, structure of coping strategies, the level of attachment between parents and children, nature of rule and parental expectations, and the strength of the extended family network. Adolescents who have a positive relationship with their parents and whose parents provide structure and boundaries are less likely to abuse drugs/substances. However, adolescents in families where there is conflict are more likely to abuse substance/drugs.

At the societal and community levels, factors include the prevailing social norms and attitudes towards substance/drug abuse, social competency skills, communication, and resistance skills.

At the school level, adolescents who have a positive relationship with teachers, who attend school regularly, and who do well in school are less likely to use substance/drugs. (Source: Global youth Network, 2002; WHO, 2001).

Other risk and protective factors include: friends' attitudes toward substance uses, friends' use of substances, perceptions of risks, delinquency, social support, participation in activities, exposure to anti-drug media messages, intensity of religious beliefs and observance, and exposure to prevention messages.

Fact and myth statements:

The facilitator can either provide a list of statements to identify facts and myths, or s/he can provide each statement written separately on cards to the participants and then have them identify the statement as fact or myth, and explain why.

The facilitator should provide the answer key only after all the participants have answered.



S.N.	Fact and myth statements
1.	You cannot become addicted to alcohol; it is not a drug.
2.	It is okay to use drugs for recreation.
3.	Driving after using marijuana is much safer than driving after drinking alcohol.
4.	Cigarette smoking is addictive.
5.	Many drug addicts say that smoking marijuana was their first step towards addiction to other serious drugs.
6.	People who become addicted to drugs have no will power.
7.	A change in weight, sleep patterns, slurred speech, talkativeness, euphoria, nausea, and vomiting of drug users.
8.	Drugs help a person to deal with his/her problems.
9.	Steroids should be used only with a prescription.
10.	One cannot become addicted to a drug prescribed by a doctor, such as painkillers and sleeping pills.
11.	Coffee and tea also contain stimulants/drugs.
12.	More young people use alcohol than any other addictive substance.
13.	Alcoholism is a disease.
14.	If you use drugs without injecting, you will not contract HIV.
15.	It is rare for a teenager to be an alcoholic.
16.	If I take brown sugar only once, I will not become addicted.
17.	Inhalants are basically harmless even though people make a big deal about them.
18.	Anyone using oral contraceptive (birth control pill) has to be careful about prescription medicine.
19.	Cigarette smoking can be harmful for the pregnant woman, but not for the child in her womb.
20.	Alcohol is a sexual stimulant.
21.	Marijuana is used legally to treat severe pain (in cancer and other chronic illnesses).
22.	Heroin is addictive, but not marijuana.
23.	Experimenting with drugs is a part of growing up.
24.	Addiction can lead to homelessness and loss of life.
25.	Taking amphetamines or methamphetamines only once is not addictive.
26.	Drugs like alcohol, marijuana and ecstasy wouldn't be a problem for young people if they were not addictive.
27.	HIV infection among young IDUs is on the rise.
28.	Heroin is addictive.

Answer key for the facilitator

S.N.	Answer key for the facilitator
1.	Myth: Alcohol is a drug like any other stimulant.
2.	Myth: Drug use for any reason can lead to addiction.
3.	Myth: Like alcohol, marijuana affects motor coordination, slows reflexes and affects perception (the way we see and interpret events around us). Any of these changes increases the likelihood of an accident while driving.
4.	Fact: Most people who smoke become addicted to nicotine.
5.	Fact: Usually people who become addicted to strong drugs say they feel that they can control their use, as they do with marijuana or amphetamines.
6.	Myth: Addiction is not only mental, but also physical, as well.
7.	Fact: This is one of the symptoms, but one has to be careful in any enquiry; drug use should not be presumed unless confirmed otherwise.
8.	Myth: Drugs help people forget about their problems or reduce the pain caused by problems; however, problems do not go away, and only increase.
9.	Fact: Steroids have very serious health consequences, such as liver disease, heart disease, sexual dysfunction and mood swings leading to aggressive or depressive behaviour; sharing needles for steroid use can transmit HIV, the virus that causes AIDS.
10.	Myth: Often people who take such prescription drugs become addicted to them.
11.	Fact: Coffee, tea and many soft drinks contain caffeine, which is a stimulant; caffeine is addictive (headaches are a common sign of withdrawal).
12.	Fact: Alcohol is the most frequently used substance among teenagers; approximately 50% of males and 20% of females begin drinking before 20 years of age.
13.	Fact: Alcoholism is a disease, just as diabetes or epilepsy are diseases; can respond to treatment, which includes eliminating all alcohol consumption.
14.	Myth: Drinking alcohol or using other drugs can inhibit your ability to use condoms correctly, or they may make us forget to use condoms at all.
15.	Myth: Approximately 30% of males and 20% of females use alcohol more than three times a week.
16.	Myth: Brown sugar is highly addictive and can lead to addiction after a single use.
17.	Myth: Using inhalants such as thinners, glue, and cleaning fluids can cause permanent damage to organs like the liver, brain or nerves; they are also extremely flammable and can cause serious injury if matches are lit nearby.
18.	Facts: Girls and women who are using oral contraceptives to prevent pregnancy need to tell their doctor if he/she prescribes antibiotics; some medications make oral contraceptives ineffective and pregnancy could result.

HIV/AIDS and Human Rights

Approximate Time: 3 hours 45 minutes

Module Message: HIV/AIDS and human rights are interrelated and interdependent. Human rights addresses the needs of AIDS care (by protecting the human rights of those infected and affected by HIV/AIDS) and HIV prevention (by working in the factors that lead towards HIV transmission). Stigmatisation and discrimination not only obstruct PLWHA' access to treatment, but also affect their employment, housing and other rights. Additionally, this contributes to others' vulnerability to infection.

Overview: The connection between HIV/AIDS and human rights is obvious. In this context, the realization of rights by people living with HIV would require non-discriminatory access within a supportive social environment. People affected by HIV may progress toward the realization of their rights and better health if the enabling conditions exist to alleviate the impacts of personal, societal, and programmatic issues on their lives. This requires policies and programmes designed to extend support and services to affected families and communities. Children orphaned by HIV/AIDS illustrate this need.

Vulnerability to HIV is the lack of an individual's and/or a community's power to minimize or modulate risk of exposure to HIV infection. Though HIV or the rights of individuals in the context of HIV/AIDS are not specifically mentioned in the international human rights treaties, all the international human rights mechanisms responsible for monitoring government action have expressed their commitment to exploring the implications of HIV/AIDS for governmental obligations.

Resolutions of the UN Commission on Human Rights and the 1998 International Guidelines on HIV/AIDS and Human Rights also provide advocates and policymakers with useful tools for helping to ensure increased attention to both HIV/AIDS and human rights. These days, there is increasing awareness with regard to the fundamental linkages between HIV/AIDS and human rights among people living with HIV/AIDS, their friends and relatives, their communities, national and international policy- and decision-makers, health professionals, and the public, at large. Despite bringing HIV/AIDS policies and programmes in line with international human rights law, most governments and policy makers fail to implement them.

HIV/AIDS and human rights are interrelated and interdependent. While the HIV/AIDS problem is a cause and outcome of human rights violations, it is only through the protection, promotion and respect of human rights that the prevention and control of HIV/AIDS will be successful. It is also through human rights that those infected or affected by the virus can live a life of dignity and



worth in society. Human rights addresses the needs of AIDS care (by protecting the human rights of those infected and affected by HIV/AIDS) and HIV prevention (by working on the factors that lead towards HIV transmission).

Early human rights responses to HIV/AIDS emerged to provide a remedy to the stigma and discrimination which accompanied the epidemic. Later, the development of human rights began to take place in the form of a human rights-public health nexus exemplified by the work of Jonathan Mann, and promoted as a model of public health and human rights (1997).

People vulnerable to or living with HIV/AIDS are often denied their basic human rights, such as the rights to non-discrimination, work and social security, health, equality between women and men, privacy, education and information, marriage and founding a family, liberty and freedom of movement. This human rights deficit has increased the spread of infection among marginalized groups and the impact on society. It has eroded the dignity of people living with HIV/AIDS, and their access to treatment. It has disempowered individuals and communities.

The relationship between HIV/AIDS and human rights appears in three areas:

Increased vulnerability: Certain groups are more vulnerable to contracting the HIV virus because they are unable to realise their civil, political, economic, social and cultural rights. Individuals who are denied the right to freedom of association and access to information may be precluded from discussing issues related to HIV/AIDS, participating in AIDS service organizations and self-help groups, and taking other preventive measures to protect themselves from HIV infection. Women, and particularly young women, are more vulnerable to infection if they lack access to information, education and services necessary to ensure sexual and reproductive health and prevention of infection. People living in poverty often are unable to access HIV care and treatment, including antiretroviral and other medications for opportunistic infections.

Discrimination and stigma: The rights of people living with HIV/AIDS often are violated because of their presumed or known HIV status, causing them to suffer both the burden of the infection and the consequential loss of other rights. Stigmatisation and discrimination may obstruct their access to treatment and may affect their employment, housing and other rights. This, in turn, contributes to the vulnerability of others to infection, since HIV-related stigma and discrimination discourages individuals infected with and affected by HIV from contacting health and social services. The result is that those most needing information, education and counselling will not benefit even where such services are available.

Impedes an effective response: Effective HIV prevention, treatment, support and care strategies are hampered in an environment where human rights are not respected.

Defining “stigma” and “discrimination”

In December 2003, UNAIDS posted a fact sheet on stigma and discrimination on their website which provides useful summary definition of both stigma and discrimination.

HIV/AIDS related '**stigma**' can be described as a 'process of devaluation' of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug use – two primary routes of transmission.

'**Discrimination**' follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging (or being perceived to belong) to a particular group.

Objectives:

After studying the module, the participants should be able to:

1. Understand the concept of human rights
2. Identify the relationship between HIV/AIDS and human rights
3. Understand how society stigmatizes people living with HIV/AIDS (PLWHA)
4. Understand how society discriminates PLWHA and its negative consequences
5. Find ways of ensuring human rights and minimizing discrimination and stigma

Content Outline:

1. HIV/AIDS, Stigma and Discrimination
2. HIV/AIDS and Human Rights

Learning Activities

1. Brainstorming on the concept of human rights and its relationship with HIV/AIDS
2. Discussion on the ways and means of minimizing stigma and discrimination towards PLWHA and those affected with HIV/AIDS

Evaluation:

Question–answer on the following questions:

1. What are different types of stigma and discrimination that are prevailing in local communities?
2. Why it is essential to control stigma and discrimination for prevention of HIV/AIDS infection?
3. Why it is necessary to ensure human rights of PLWHA and those affected with HIV?
4. What are discriminatory laws that obstruct the human right practices with respect to HIV/AIDS, PLWHA, sex and sexuality?

Facilitator's Note:

Follow to conduct icebreaker and warm-up game

ACTIVITY 6.1

Stigma and HIV/AIDS

Approximate time: 1 hour 30 minutes

Materials: Whiteboards, flip charts, cards, markers, sticking tape, Resource Materials, adequate numbers of condoms for icebreaker game

Objective: At the end of the activity, the participants will be able to:

1. Discuss stigma, discrimination and HIV/AIDS (the social dimension of the epidemic)
2. Define stigma and discrimination with respect to HIV/AIDS, PLWHA and sexual behaviours of the individual
3. Identify how society stigmatizes people living with HIV/AIDS (PLWHA)
4. Describe the consequences of stigma and discrimination

Content outline:

1. Concept of stigma and discrimination
2. Forms of HIV/AIDS-related stigma and discrimination

Procedure:

1. Conduct the game 'How Strong is Your Condom?' (See Facilitator's Note)
2. After completing the game, divide the participants into three - four groups.
3. Explain the group task and the procedure for presentation.
4. Ask them to:
 - ▶ define what they do mean by stigma and discrimination in the local, as well national, context of social, cultural and religious considerations, and reflect on the types of discrimination with respect to HIV/AIDS.
 - ▶ identify behaviours, attitudes, beliefs etc. that they think carry stigma, and note them in a chart for presentation. (40 minutes)
5. Ask the students to give their presentations. (10 minutes each)
6. After the presentations, distribute Resource Material 6.1.

Evaluation Following the presentation, ask the participants to write 2 to 3 points on stigma's impact on people affected by the disease, and on prevention and care activities.

Learning Outcome: Describe the consequences of stigma and discrimination, and the need and importance of diminishing stigma and discrimination for HIV/AIDS prevention.

Facilitator's Note

The facilitator should provide the following instruction to play the game 'How Strong is Your Condom?':

- ▶ Ask for two volunteers to participate in a role play.
- ▶ Give one condom to each of them.
- ▶ Ask one participant to pour oil into the first condom.
- ▶ Similarly, ask the other participant to fill the second condom with water.
- ▶ After some time, the condom with oil will burst, while the other one will be okay.
- ▶ Repeat the activity with more water in one condom and wait for some time.
- ▶ The condom with water will not burst.
- ▶ Ask the participants to discuss the game, and conclude the game clearly noting that oily matter should not be used as a lubricant for the condom. Use of oil with condoms is, thus, risky as regards approaches for safer sex.

ACTIVITY 6.2

Minimizing Stigma and Discrimination

Approximate Time: 1 hour 30 minutes

Materials: Charts, flip charts, markers, sticking tape

Introduction: To discuss the concept of human rights and its relationship to HIV/AIDS.

Objective: At the end of the activity, the participants should be:

1. Familiar with the concept of human rights
2. Acquainted with existing human rights laws
3. Able to identify the relationship between HIV/AIDS and human rights
4. Able to identify the negative consequences of human rights violation with respect to HIV/AIDS
5. Knowledgeable about how to ensure human rights and minimize discrimination/stigma

Content outline: Concept of human rights and its violation

HIV/AIDS and human rights

Procedure:

1. Divide the class into three small groups.
2. Ask them to discuss in the groups what is meant by human rights, and the cases of human rights violation, in general, and HIV/AIDS prevention, in particular. (20 minutes)
3. Ask the groups to prepare a role play. (10 minutes for preparation; 5 minutes for each group skit)
4. The role plays should be on one of the following:
 - ▶ *A doctor refusing to take care of a person living with HIV*
 - ▶ *A teacher asks an HIV-positive pupil to sit in one corner of the class room*
 - ▶ *After the death of a family member with AIDS, the family is socially boycotted*
6. After the presentations, ask the participants about what they observed, about the consequences of discrimination and about ways of diminishing discrimination.
7. Later, distribute the Resource Materials 8.2 to all participants and encourage group discussion about ways of ensuring human rights and minimizing discrimination/ stigma. (30 minutes)

8. Ask the participants to share with their friends the types of stigma and discrimination that they have experienced or heard about.

- Learning Outcome:**
1. Participants will be informed about the concept of human rights and about its relationship with HIV/AIDS.
 2. Participants will be informed about the consequences of human rights violations and issues related to HIV-infected and affected people.

Evaluation Ask each group to write some points on cards about measures for ensuring human rights and minimizing discrimination/stigma.

Facilitator's Note: Encourage the participants to do role plays that reflect on the real-life situations of the PLWHA in their community.

ACTIVITY 6.3

Learning How to Minimize Stigma and Discrimination of PLWHA

Approximate Time: 45 minutes

Materials: Charts, flip charts, markers and sticking tape

Objective: At the end of the activity, the participants should be able to:

1. Relate the experience with human rights issues
2. Find ways to diminish discrimination against PLWHA

Content outline: Violation of human rights

Procedure:

1. Divide the class into four small groups and ask each group to play a role of a PLWHA: a teacher, an employee at school, a woman whose husband died from AIDS and a school student whose father is HIV-positive.
2. Provide the guidelines for role play to all groups. (5 minutes)
3. You may use the following topic to start the dialogues:
 - ▶ *A teacher is HIV-positive*
 - ▶ *An employee at school is HIV-positive*
 - ▶ *A woman whose husband died from AIDS*
 - ▶ *A school student whose father is HIV-positive*
4. Allow 10 minutes to prepare how to play the role.
5. Ask them to select the actors for each group to perform the roles of a HIV outreach worker and the PLWHA described above. (5 minutes for each group)
6. Distribute a checklist for those who are observing the plays.
7. Explain the observation checklist.
8. After completion of the role plays, thank the actors.
9. Ask them to talk about the lessons of the exercise. (10 minutes)
10. Explain the overall conclusions from the exercise about forms of stigma/discrimination against PLWHA, including human rights violations, and ways to diminish them.
12. Conclude the session by noting that AIDS is everyone's concern and all should be involved.

Evaluation:

Divide the participants among groups for home assignment to write briefly one of the following:

- a. Stigma and discrimination against people and families affected by HIV/AIDS
- b. Care requirements of people and families affected by HIV/AIDS
- c. Services needed to support people affected by HIV/AIDS
- d. Persons who provide care to families and people affected by HIV/AIDS
- e. Services needed to support people affected by HIV/AIDS
- f. Role of the participants as an individual in supporting people and families affected by HIV/AIDS

Learning Outcome:

1. Empathy for PLWHA and their families as relates to the experiences of stigmatization and discrimination they face
2. Ability to relate human rights issues with HIV/AIDS

Facilitator's Note:

You should plan for **Activity 6.3** well in advance .

Resource Material 6.1

Stigma and HIV/AIDS

Stigma is a powerful tool of social control. Stigma can be used to marginalize, exclude and exercise power over individuals who show certain characteristics. While the societal rejection of certain social groups (e.g. homosexuals, injecting drug users, and sex workers) may predate HIV/AIDS, the HIV infection or AIDS condition has, in many cases, reinforced this stigma.

There are stigmas related to HIV/AIDS due to a number of reasons:

- ▶ HIV and AIDS are often seen as shameful.
- ▶ Infection is associated with minority groups or behaviours like homosexuality.
- ▶ HIV/AIDS may be linked to 'perversion' and those infected will be punished.
- ▶ HIV/AIDS is seen as the result of personal irresponsibility.

There are also HIV factors which contribute to HIV/AIDS-related stigma:

- ▶ HIV/AIDS is a life-threatening illness.
- ▶ People are scared of contracting HIV.
- ▶ Human behaviours such as sex between men and injecting drug-use are already stigmatized in most societies.
- ▶ People living with HIV/AIDS are often thought of as being responsible for becoming infected.
- ▶ Religious or moral beliefs that lead some people to believe that having HIV/AIDS is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

Together with the widespread belief that HIV/AIDS is shameful, the images such as HIV/AIDS as punishment (e.g. for immoral behaviours); as a crime (e.g. in relation to innocent and guilty victims); as war (e.g. in relation to a virus which need to be fought); as horror (e.g. in which infected people are demonized and feared); as other-ness (in which 'ready-made' - but inaccurate - explanations provide a powerful basis for both stigma and discrimination).

Forms of HIV/AIDS-related stigma and discrimination

Government level:

- ▶ Laws, rules and policies that increase the stigmatization of people living with HIV/AIDS
- ▶ Compulsory screening and testing, as well as limitations on international travel and migration
- ▶ Lack of rules and regulation to ensure their right to employment, education, privacy and confidentiality, as well as the right to access information, treatment and support
- ▶ Cover-up and hiding of cases, or failure to maintain reliable reporting systems by the governments and national authorities; such forms of denial fuel AIDS stigmas by making those individuals who are infected appear abnormal and exceptional

Local level:

- ▶ Stigma and discrimination can arise from community-level responses to HIV and AIDS.
- ▶ Attacks on men who are assumed gay have increased in many parts of the world.
- ▶ Women are quite often blamed for transmitting HIV and STI infections.
- ▶ In many developing countries, women are often economically, culturally and socially disadvantaged, and lack equal access to treatment, financial support and education.
- ▶ Not all family response is positive. Infected members of the family can find themselves stigmatized and discriminated against within the home.
- ▶ Pre-employment screening takes place in many industries, particularly in countries where the means for testing are available and affordable.
- ▶ Many reports reveal the extent to which people are stigmatized and discriminated against by their health care systems.

HIV-related stigma and discrimination remains an enormous barrier to effectively fighting the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly.

The facilitator should provide the following questions and discussion points to start the dialogues about stigma and discrimination.

1. What is stigma? Identify the behaviours, attitudes, beliefs etc. that you think carry stigma.

Discussion Points

- ▶ Stigma is associated with attributes and behaviours which are seen by many people to be contrary to prevailing norms or accepted ways of behaving in society (for example in many countries, sex is a stigmatized activity).
- ▶ AIDS was first associated with individuals and groups who already carried the burden of stigmatized practices and behaviours.
- ▶ Views and responses to the disease evolved from a complex environment of the existing views on homosexuality, illegal drug use, fear, and beliefs about the disease, in particular the fatal nature of AIDS.
- ▶ AIDS gave renewed life to the concept of disease as punishment, historically a widespread belief/explanation for why some people get sick and other remains well.

2. Ask participants to think about and discuss the effects of stigma.

Discussion Points

- ▶ Stigma creates BLAME by others of these people for the issue that stigmatizes them;
- ▶ Stigma leads to SHAME, on the part of the person or people stigmatized;
- ▶ Stigma leased to the perception that stigmatized people are DIFFERENT and not worthy of others.



3. Ask the participants to think about why AIDS is a stigmatized disease.

Discussion Points

- ▶ HIV/AIDS is the most stigmatized modern disease. HIV/AIDS carries stigmas because of the way it is transmitted and because of the perception about the people who are both infected and affected by it.
- ▶ HIV/AIDS is associated with SEX and SEXUALITY. These are often difficult subjects to talk about because they touch on intimate and personal behaviour. AIDS has become associated with homosexuality in some countries and also with sex work, both of which are the objects of stigma.
- ▶ HIV/AIDS raises deep-seated fears in many people of DEATH, which is also often not discussed in public.
- ▶ HIV/AIDS is also transmitted through the sharing of needles, which may involve injecting illegal or illicit DRUGS.

4. Ask participants to discuss the impact of stigma on people affected by the disease, and on prevention and care activities.

Discussion Points

- ▶ PLWHA and their families and partners are ISOLATED and shunned because of the stigma of the HIV/AIDS.
- ▶ PLWHA also experience DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS because the stigma of the infections leads other people to think about them and act towards them as though they have lost the qualities that make them worthy of respect and dignity.
- ▶ Stigma creates BARRIERS TO HIV/AIDS PREVENTION AND CARE by crating an environment in which it is difficult to talk openly about the ways in which HIV is transmitted and how to stop it being transmitted (for example, talking about condoms and sexual behaviours). Stigma also creates a false impression that only some people (those stigmatized, e.g., sex workers, injecting drug users or homosexual men) are at risk of being infected.



Resource Material 6.2

Minimizing Stigma and Discrimination

Introduction

Human rights are broadly concerned with defining the relationship between individuals and the state. International human rights law dictates that governments should not do things such as torture people, imprison them arbitrarily, or invade their privacy. Governments should, however, ensure that all people in a society have shelter, food, medical care, and basic education.

The catastrophic impacts of HIV/AIDS on the human resources and economies of many countries and the tremendous spread of HIV infection throughout the world have drawn attention to the enormity of human rights challenges at both national and global levels. It was only by the end of 1980s when recognition of the relationship between human rights and HIV/AIDS was made. The assurance of human rights is a governmental obligation towards its citizens; because these obligations include the protection of public health, they are relevant to the design, implementation, and evaluation of health policies and programmes.

The 1980s were extremely important in defining some of the connections between HIV/AIDS and human rights. Despite a long history of human rights, discrimination against women, men, and children infected with, affected by, and vulnerable to HIV has increased immensely throughout the world. It was only on December 10, 1948 when the Universal Declaration of Human Rights (UDHR) was adopted by the U.N. General Assembly. A number of international human rights treaties exist that further elaborate the rights set out in the UDHR, including:

- ▶ The International Covenant on Civil and Political Rights
- ▶ The Covenant on Economic, Social, and Cultural Rights
- ▶ The Convention on the Elimination of All Forms of Racial Discrimination
- ▶ The Convention on the Elimination of All Forms of Discrimination Against Women
- ▶ The Convention on the Rights of the Child

1. What does HIV/AIDS have to do with human rights?

Human rights are inextricably linked with the spread and impact of HIV/AIDS on individuals and communities around the world. A lack of respect for human rights fuels the spread and exacerbates the impact of the disease, while at the same time, HIV/AIDS undermines progress in the realization of human rights. This link is apparent in the disproportionate incidence and spread of the HIV infection among certain groups which, depending on the nature of the epidemic and the prevailing social, legal and economic conditions, include women and children, men who have sex with men, ethnic minorities and particularly those living in poverty. It is also apparent that the overwhelming burden of the epidemic today is borne by developing countries, where the effects of HIV/AIDS threatens to reverse vital achievements in human development. AIDS and poverty are now mutually reinforcing negative forces in many developing countries.

2. Minimizing stigma and discrimination associated with HIV/AIDS

HIV-infected people face stigma and discrimination at various levels in the family, at the workplace, in schools and hospitals, etc. This alone is not a disease of discrimination. Epilepsy, mental diseases, tuberculosis, leprosy and STIs all carry the burden of societal stigma. Such stigma is rooted in vast historical experience.

HIV/AIDS linkage with sexual relation and injecting drug is the primary cause of stigmatization. Based on prevalent ideology, people start believing that sufferers are only people who engage in “deviant” behaviour, and, thus, their “immorality” leads to such “punishment.”

Stigmatization has a very negative effect on victims lives, such as mental tension and inaccessibility to medical facilities. Stigma for HIV/AIDS results in discrimination. People who are infected with HIV are often not rented houses, not given services and not treated in hospitals; because of this, they may not be able to lead a normal life and face many problems.

Education on the basis of these questions can lessen discrimination. Media can play an important role in spreading positive messages. Laws that protect human rights can build an atmosphere where discrimination is less. In this way, PLWHA *can* become empowered.

3. What is a human rights approach to HIV/AIDS?

There is clear evidence that where individuals and communities are able to realize their rights – to education, free association, information and, most importantly, non-discrimination - the personal and societal impact of HIV and AIDS are reduced. The protection and promotion of human rights are therefore essential to preventing the spread of HIV and to mitigating the social and economic impact of the pandemic. The reasons for this are threefold. The promotion and protection of human rights reduces vulnerability to HIV infection by addressing its root causes; lessens the adverse impact on those infected and affected by HIV; and empowers individuals and communities to respond to the pandemic. An effective international response to the pandemic, therefore, must be grounded in respect for all civil, cultural, economic, political, and social rights, as well as the right to development in accordance with international human rights principles, norms and standards.

States’ obligations to promote and protect HIV/AIDS-related human rights are defined in existing international treaties. HIV/AIDS-related human rights include the right to life; the right to liberty and security of the person; the right to the highest attainable standard of mental and physical health; the right to non-discrimination, equal protection and equality before the law; the right to freedom of movement; the right to seek and enjoy asylum; the right to privacy; the right to freedom of expression and opinion and the right to freely receive and impart information; the right to freedom of association; the right to marry and found a family; the right to work; the right to equal access to education; the right to an adequate standard of living; the right to social security, assistance and welfare; the right to share in scientific advancement and its benefits; the right to participate in public and cultural life; and the right to be free from torture and other cruel, inhuman or degrading treatment or punishment.

The United Nations human rights instruments and mechanisms provide the normative legal framework, as well as the necessary tools for ensuring the implementation of HIV-related rights. Through their consideration of States reports, concluding observations and recommendations, and general comments, the UN treaty bodies provide States with direction and assistance in the implementation of HIV-related rights. The Special Procedures of the Commission on Human Rights, including special representatives, thematic and country rapporteurs, and working groups also are in a position to monitor respect for HIV-related rights.

Resource Materials 6. 3

Learning how to minimize Stigma and Discrimination of PLWHA

Role play 1: A teacher who is a PLWHA:

The main actor will be a teacher who is a PLWHA. He acquired the HIV virus from unsafe blood: The purpose of the role play will be to show how he got the HIV infection, and the problems he faced with his wife, family and community. The socio-economic and psychological problems and the problems while seeking services from local hospital and clinics should also be demonstrated.

Role play 2: A HIV-positive woman employee at school:

The main actor will be an employee in a local school. She acquired the HIV virus through unsafe sex in a brothel. She was given school job through the support of local NGOs working for HIV/AIDS prevention and care: The purpose of the role play will be to show how she was trafficked to a brothel and rescued later by a local NGO. The role play will also share information on the discrimination she faced at home; by the local community; by the students and teachers in school; and by the local tea-shop. The problems she faced while seeking services from local health workers and pharmacists should also be demonstrated.

Role play 3: A woman whose husband died due to AIDS:

The main actor will be a housewife whose husband died due to AIDS. Her husband was a factory worker in the countryside: Her husband used to consume alcohol regularly and visit sex workers occasionally. When he was tested HIV-positive, he was terminated from the job. Then he led a pitiful life for few years and died recently. She has been blamed by the local community for spreading HIV/AIDS. His wife has been boycotted several times from social functions. Nobody participated in the cremation of her husband. She was turned away from the hospital when the hospital staff knew the status of her husband. Their children were expelled from the school; she was banned from entering temples. The local human rights groups and NGOs help her to access health services and get her children re-admitted to school.

Role play 4: A school student whose father is HIV-positive:

The main actor will be a school student whose father is HIV-positive. The father of the student was a businessman. He got HIV when he had casual sex with female sex workers during his business travel: The purpose of the role play will be to give the participants the type of socio-economic and psychological problems the student felt when the HIV status of his father was known. The student was expelled from the school when the HIV status of his father was known. He, however, was readmitted to school because his father was a rich businessman and influenced the local community. However, the student faces a lot of problems while attending social functions, worship services, and treatment in the hospital.

19.	Myth: Smoking is equally harmful for the child in the womb.
20	Myth: Alcohol can actually depress a person's sexual response; the drug may lessen inhibition with a sexual partner, but it causes problems such as lack of erection, loss of sexual feeling or inability to have an orgasm, and may cause a person to do something sexually that he or she would not do when sober.
21.	True: In most instances, marijuana is against the law; persons who do receive permission are in the final stages of their lives.
22	Myth: Although research is ongoing, many experts believe that long-term use of marijuana is potentially dangerous and may lead to a decrease in motivation, memory loss, damage to coordination, impaired judgment, and damage to the reproductive system, throat, and lungs.
23.	Myth: Drugs are a matter of choice and have nothing to do with the growing-up process
24.	Fact: Most addicts lose their social and economic status, and in many cases lose their life to overdose and other complications.
25.	Myth: A person can become addicted after only one use.
26.	Myth: Drugs interrupt normal growth and development for youth, cause problems in relationships, and often result in unintended pregnancies of STD/HIV because their use can lead to risk-taking.
27.	Fact: Research shows that HIV infection rates are high and increasing among young IDUs.
28	Fact: A person can be addicted to heroin easily and it creates both a physical and psychological dependence.



MODULE SEVEN

Care and Support for People Living with HIV/AIDS (PLWHA)

Approximate Time: 4 hours 30 minutes

Module Message: Opportunities for positive living should be given to people living with HIV/AIDS. Community-based programmes should focus on delivering better care and support to them. Programmes should also be designed and developed to support orphans and other children in need of care.

Overview: People with HIV/AIDS can live healthy lives for longer if proper care and support is provided. The immune system can be strengthened by medical treatment, food, rest and exercise. One can cope much better if one is happy and feels productive. Emotional support and a positive attitude help to avoid depression. A lot can also be done to avoid the devastating effects that illness and death have on families and children.

Families and individuals usually cope with HIV/AIDS without much community support. In most cases, very few people know that someone is HIV-positive, and when they become ill their families and children bear the burden alone. Children and partners also have to deal with the grief of watching a loved one suffer and die. Most families who lose someone spend considerable time nursing the person.

Illness and death of a breadwinner usually increases poverty. Poor people do not have the resources to provide proper care for someone with HIV/AIDS. Many countries in Africa, Asia and South America have developed community-based programmes to deliver better care and support for people with HIV/AIDS.

It is important to target PLWHA and their families for support. The families have to look after and support the person with HIV/AIDS, yet they also need emotional support, themselves. They must deal with prejudice from the community, and they often need information and training so that they can protect themselves and provide better care. Many of the things that should be done can also support people with illnesses other than HIV/AIDS. For example, home-based care should target all people who are bedridden. Programmes to support orphans should target all children in need. Poverty alleviation programmes should target all who need it.

Objectives:

After studying the module, the participants should be able to:

- ▶ Examine the concept of care and support in the context of HIV/AIDS
- ▶ Explain various forms of care and social support required to address the needs of HIV/AIDS patients and their families
- ▶ Explain the care needs of people infected and affected by HIV/AIDS
- ▶ Understand who should care and what qualities are necessary to care HIV/AIDS infected or affected people

Content Outline

1. Care and support issues of PLWHA, stigma and discrimination
2. Positive living for PLWHA

Learning Activities

1. Understanding the concept of care and support as it relates to human rights and its relationship with HIV/AIDS
2. Finding ways and means of providing care and support to PLWHA
3. Knowledge about positive living.

Evaluation:

Question–answer on the following questions:

1. What are the different problems faced by PLWHA and their families?
2. What are the roles of teachers in providing care and support to PLWHA and in creating conducive environments for positive living?
3. What are discriminatory laws that obstruct human rights practices with respect to HIV/AIDS, PLWHA, sex and sexuality?

Facilitator's Note:

Follow the Facilitator's Note to conduct icebreaker or warm-up game

ACTIVITY 7.1

Care and Support for People Living with HIV/AIDS (PLWHA)**Approximate Time:** 1 hour 30 minutes**Materials:** Presentation topics written on pieces of paper**Objective:** At the end of the activity, the participants will be able to:

1. Know about the issue of care and support for PLWHA and their families
2. Give the meaning of care and support to PLWHA
3. Describe ways of positive living
4. Explain the ways to care for PLWHA

Content Outline: Providing care and support of PLWHA and their families**Procedure:**

1. First, conduct the game 'Fish Bowl' as a warm-up exercise.
2. After completing the exercise, ask the participant to summarize the theme.
3. Divide participants into three groups and give them the tasks for discussion. (40 minutes)
4. The facilitator should suggest the following topics as references for discussion:
 - ▶ *The only earning member of the family, i.e. father, is suffering from AIDS and has lost his job*
 - ▶ *Ms Noi, daughter-in-law of a middle-class family, is tested HIV-positive during her second delivery*
 - ▶ *A 10-year-old child has acquired HIV after a blood transfusion*

Points for discussion

Identify:

- ▶ *Needs and problems of the people and families affected by HIV/AIDS*
- ▶ *Care requirements of people and families affected by HIV/AIDS*
- ▶ *Who should provide care to families and people affected by HIV/AIDS*
- ▶ *The right approach on quality care needed to support people and families affected by HIV/AIDS*
- ▶ *Existing care and support mechanisms and structures that can be offered*
- ▶ *Care and support service options that are not currently available, but that could be suggested*
- ▶ *The role of teachers and trained persons in the care and support of affected people and their families*

3. Provide Resource Materials 7.1 and 7.2 to the participants. Ask them to study them, and review the outcomes.
4. Ask each group to share their output on each task by summarizing and presenting in plenary. (*Discussion should touch on HIV testing facilities, traditional healers, psychological support and ongoing counselling, hospitals, DIC, legal aid service, home-based care, mental health services, spiritual support, lobbying, advocacy, PLWHA associations or groups.*) (30 minutes)
5. Summary and discussion

Evaluation:

The following questions should be asked:

1. What do you mean by living positively with HIV/AIDS?
2. What are the things that PLWHA should avoid?
3. What are the life skills that PLWHA should do to lead healthy lives?

Learning Outcomes: Knowledgeable about ways to help PLWHA and the concept of “positive life.”

Facilitator’s Note:

Follow the steps below to conduct the warm-up exercise, ‘Fish Bowl.’

- ▶ Divide the participants into two groups of equal size, forming an outer and an inner circle.
- ▶ Everyone should face towards the inside. Start some music, sing or clap, and the two circles move in opposite directions.
- ▶ After 10 seconds, stop the music and the people from the inner circle turn around face to face with a partner from the outer circle.
- ▶ They should then talk about a theme of the workshop.
- ▶ After several minutes, the music continues and the two circles move again.
- ▶ This can continue until you feel that all participants have listened to a number of participants. The technique is also useful for stimulating an exchange of thought before collecting the cards.

ACTIVITY 7.2

Understanding PLWHA Problems and Issues

Approximate Time: 3 hours

Materials Charts, flip charts, marker, sticking tape, video films

Preparation

1. Identify a place/institute or organization for contacting PLWHA.
2. Invite a PLWHA to attend class as a Resource Person (RP).
3. Collect films related to HIV/AIDS prevention or care of PLWHA

Objective: At the end of the activity, the participants will be able to:

1. Share experiences and feelings about how PLWHA are stigmatized and discriminated against
2. Relate the PLWHA experience to human rights issues
3. Identify ways to diminish discrimination against PLWHA

Content outline:

1. Acquaintance with real-life situation of PLWHA
2. Violation of human rights

Procedure: The facilitators will have two options for the activities:

Option 1:

1. Invite a PLWHA as a RP for plenary presentation to share his/her experience
2. Watch video films which present PLWHA's problems, stigma and discrimination issues, as well as ways to empower PLWHA. The videos should provide a realistic, factual presentation.

Option 2:

Visit with HIV or AIDS patients in coordination with NGOs or volunteer organizations working for HIV/AIDS prevention and care.

Suggested activities for Option 1:

1. Present a PLWHA as RP.
2. Express sincere appreciation for his/her valuable time as a resource person.
3. Note his/her biography and experience.



4. After the RP's presentation, ask him/her whether the participants could ask some questions focusing on various forms of stigma and discrimination, human rights issues related to HIV/AIDS, care and support of PLWHA, and ways to diminish discrimination. (15 minutes)
5. Summarize the major presentation outcomes in plenary. (10 minutes)
6. Present 1-2 short films. (1 hour 30 minutes)
7. Give a brief introduction for each film, title, purpose, production and theme.
8. Ask all participants to note:
 - What is the message?
 - What are the issues?
 - What are recommendations?
 - What are the lessons learnt?.
9. Initiate discussion (45 minutes)

Suggested Activities for Option 2: (3 hours)

1. Coordinate with a NGO or volunteer organization working for HIV/AIDS prevention and care.
2. Orient the participants about what to ask and what not to ask the PLWHA.
3. Visit the PLWHA.
4. Bring some gifts (food/fruits, medicines, clothes) with you.
5. Express your compassion to the PLWHA, share the purpose of your visit and ask some questions that guide you to collect information about:
 - ▶ *Individual, socio-economic, practical and emotional needs of the PLWHA and the families affected by HIV/AIDS*
 - ▶ *Care and support requirements of people and families affected by HIV/AIDS*
 - ▶ *Human rights violations of the individual and families affected by HIV/AIDS*
 - ▶ *Need for involvement of communities, families, NGOs and CBOs*
 - ▶ *Need for involvement of various governmental sectors, including health, education, agriculture, etc.*
6. Share impressions from the visit on the following day.

Evaluation Sharing from the participants

Learning Outcome:

1. Understanding of PLWHA experiences and feelings about stigmatization and discrimination.
2. Insight into how human rights issues are related to HIV/AIDS

Facilitator's Note: Plan for **Activity 7.2** well in advance.

Resource Material 7.1: *Care and Support*

It is a reality that society often discriminates against people who are infected with HIV/AIDS and their families. Infected and affected people need care and support at the spiritual, medical and psychological levels.

When a person develops AIDS, he has to be attended to both at home and in the hospital. Looking at the present scenario of the hospital, care and counselling has to be initiated from home. This is a very challenging task. Training of both family members and hospital personnel is required. Counselling is one of the most important issues of care and support. Teachers and NGOs can play an important role in this area.

Some guidelines for Teacher Trainers:

- ▶ To provide care and support for PLWHA, the following points need to be kept in mind:
- ▶ PLWHA should not be isolated
- ▶ PLWHA need emotional support; different people have different needs and so they must be treated differently
- ▶ PLWHA should be encouraged to take self-care
- ▶ If possible, keep PLWHA busy in various social activities, e.g. educating people in the community
- ▶ Providing emotional support does not mean talking on each and every issue; many times, the mere presence of a well-wisher is sufficient
- ▶ Don't feel hesitant to talk about the HIV/AIDS condition when the infected person is in a good mood

Care and Support Issues

	Social	Economic	Psychological	Health
1. Head of the family with five young children critically ill with AIDS				
2. Sex worker with AIDS				
3. A HIV-positive housewife with grown children				

Resource Material 7.2: *Understanding PLWHA Problems and Issues*

1. Living positively with HIV/AIDS

Positive living is an idea that can help a person with HIV/AIDS understand how to live life. Just because one has a diagnosis of HIV or AIDS, it does not mean that one should just give up on life and stop being close to people. A person may have years more to live, and it is up to him/her to live them well. If it is a family member who has HIV or AIDS, help them to think about positive living. Even people who don't have HIV or AIDS can try to live positively!

- ▶ It also means that in the home, you continue to play a role in the life of the family, including caring for others in the family, household responsibilities, socializing, eating, and decision-making to the best of your physical and mental ability.
- ▶ Positive living can be done by both PLWHA and their families – it is an opportunity for all people to learn more about living their lives more fully.
- ▶ Finding new ways to cope with new situations, including new diseases and changes in the body, is also important for positive living.
- ▶ Positive living does not mean that you are happy all the time; rather, it means that you have not given up on being happy.

A person with AIDS should try to keep the body strong. This means they should:

- ▶ Eat a good diet whenever possible, including food that is rich in proteins, vitamins, and carbohydrates. Nutritional deficiencies may adversely influence immune function. Good nutrition strengthens the body to fight against infection. Fresh food is preferred over canned and processed food. Fresh vegetables and fruits contain many vital vitamins and minerals. Food should be washed and properly cooked before consumption to avoid food related infections. Self-help groups can support members by providing healthy recipes.
- ▶ Stay as active as possible to keep fit and get regular sleep. Exercises help prevent depression and anxiety, and can add to a general feeling of wellbeing and contribute to general health and stamina.
- ▶ Continue to work, if possible.
- ▶ Socialize with friends and family.
- ▶ Be occupied with meaningful or, at least, distracting activities.
- ▶ Talk to someone about the diagnosis and illness.
- ▶ Use a condom during sexual intercourse.
- ▶ Seek medical attention for health problems and follow the advice for care, including counselling and social services. This includes preventive services by identifying potential and actual stress factors.
- ▶ If applicable, also seek information about preventive services such as immunization of children and infants with HIV/AIDS.



► Avoid:

1. Alcohol and cigarettes
2. Other infections, including further infection by HIV
3. Pregnancy, because it lowers the body's immunity and some report it can hasten the onset of AIDS for an HIV-positive woman and also because the baby may be infected
4. Isolating themselves

The best place for proper care of PLWHA is home because it is the place where most persons get love and emotional support. If PLWHA lead a healthy life, they can often delay progression of their disease. This is known as living positively. PLWHA need support to change their lifestyle and behaviour. This can also protect other people from getting an HIV infection. PLWHA can lead just as healthy a life as any other person. Some important points to live healthy and positively are:

1. Take care of oneself
2. Maintain self-esteem
3. Get appropriate information about HIV/AIDS
4. Do regular exercise
5. Take nutritious food
6. Keep busy
7. Get adequate rest and sleep
8. Spend time with family and friends
9. Seek medical care when ill
10. Be in contact with a counsellor
11. Plan for the future
12. Protect others from HIV infection

Emotional support for PLWHA

The stigma surrounding AIDS makes it a more difficult illness to live with for people with HIV/AIDS and for their families. Loneliness, anxiety and depression make people sicker and more vulnerable when their immune systems are weak. Families cannot support and care for someone who is ill if they, themselves, are depressed and scared.

Many projects concentrate on basic first aid for people who are already ill. It is important to also focus on emotional support for people who have HIV or who are not yet bedridden. It is often best for people to organize themselves into activist groups or support groups where they can share their experiences and feelings with other people in similar situations. Family members who are looking after people who are ill also need support and, where possible, support groups should be set up for children who are coping with death and dying.

Support groups: Support groups can be informal – you just need a group of people who share their problems and discuss ways of helping themselves and each other. Here are some ideas for organizing support groups. They are based on the experiences from many different countries. Support groups usually do the following types of things:

- Organize meetings where people with HIV/AIDS can get together and discuss their feelings, common problems and ways of coping.

- ▶ Teach people how to look after themselves and discuss symptoms, illnesses and treatment.
- ▶ Organize food and poverty relief to help people survive.
- ▶ Organize social events where people can be open about their status and relax with each other.
- ▶ Organize talks and presentations from experts.
- ▶ Set up an organization that works for people with HIV/AIDS and get people to join.

For families, support groups can be used to:

- ▶ Teach people about HIV/AIDS and how to care for someone when they get ill
- ▶ Talk about feelings and give families emotional support to help them cope
- ▶ Help families to get access to government grants and relief
- ▶ Put them in touch with services and projects that can help – like home-based care

Support groups are not the only way of organizing support. It is very important for people to get individual help with their problems and to feel that the community accepts and cares for them. Here are a few more examples of what can be done:

- ▶ **Counselling and advice** – make sure that counsellors are available at clinics and offices to give people emotional counselling and practical advice about their problems
- ▶ **Role models and public support** – local leaders like politicians, community leaders, sport stars, traditional leaders, business people, etc, should be open about HIV/AIDS, should mobilize people to volunteer to help in projects, and should publicly support any people who are open about being HIV-positive. This will help to make people with HIV/AIDS and their families feel that they are accepted and supported by their community.
- ▶ **Community support** – awareness campaigns and public events that mobilize the community to support HIV/AIDS projects are very important. When all people see HIV/AIDS as their problem, the people who are most affected will no longer feel alone and isolated.

2. Staying healthy – wellness programmes

Medical treatment is not the only way to stay healthy. If someone is HIV-positive, it is very important to keep the immune system as strong as possible. This will help fight diseases and infections. Food, exercise and lifestyle are all important.

Here are some of the things we should do:

- ▶ Educate people with HIV/AIDS and their families about healthy eating
- ▶ Start vegetable garden projects to help provide the right food types to people who cannot afford them
- ▶ Start food projects that collect food from supermarkets and farmers and distribute it to people who need it.

Keeping the body healthy: PLWHA need foods that are different from healthy people. HIV/AIDS and the medicines can make them lose a lot of weight, feel cold all the time and get serious stomach problems. This will make them weaker and more vulnerable to serious infections. Because they easily get infections, it is also very important to clean and cook food properly, and to drink only clean water.

**It is recommended to:**

- ▶ Drink two litres of water a day
- ▶ Drink sour milk, milk or yoghurt
- ▶ Eat beans, lentils, eggs or meat every day if you can – beans are just as good as meat if you put a tablespoon of uncooked sunflower oil with it before serving; all vegetables and fruits are very good
- ▶ For a healthy stomach, eat raw garlic, raw carrots or dried pumpkin seeds
- ▶ Eat a lot of grains and starch – maize, rice, sorghum, brown bread

Avoid

- ▶ Sugar: it is not favourable for the immune system and causes stomach problems
- ▶ Fried and spicy food: may cause stomach upsets – do not eat too much

Do:

- ▶ Keep yourself occupied and interested in things to avoid depression
- ▶ Try to exercise without straining yourself
- ▶ Get enough sleep and rest
- ▶ Find people you can talk to about your feelings

Do not:

- ▶ Smoke, drink or use addictive drugs
- ▶ Diet or lose too much weight

People who live in poverty will find it very hard to stay healthy. One has to make sure that poor people have access to food. It is very important that people with AIDS do not get too much stress and maintain psychological health. It helps to stay active and not become bed-ridden or depressed. Any kind of activity is good – limited exercise, gardening, social activities and sports' groups. People should obviously work for as long as possible since doing so will also help mental attitude. Emotional support is vital, and people who cannot talk to anyone else about their condition will very likely become ill more quickly.

3. Medical treatment, clinics and hospitals

When a person with HIV infection becomes ill, many common infections can kill easily because the immune system is weak. If someone has other diseases like TB or sexually transmitted infections, they also need treatment.

Tuberculosis: It is very important to treat TB since this is one of the main causes of death for people with AIDS. Most clinics and hospitals have got Directly Observed Treatment Short Course (DOTS) programmes that support patients to take their medication are quite well-developed. Home-based care should be linked with the DOTS programme.

Infections: People who get ill from AIDS should also be given broad-spectrum antibiotics to prevent things like lung infections that can easily kill people with weakened immune systems. Opportunistic infections, like thrush and gastro, should be treated. Any sexually transmitted infections should be treated.

Vitamins: Good nutrition is one of the most important ways of strengthening the immune system and can be supplemented with vitamins, where this is affordable.

Anti-retroviral therapy: The main goal of anti-retroviral therapy (ART) is to prolong life and improve the quality of life. Anti-retrovirals should be taken if they are available and affordable. It is very important to understand the side-effects and the correct way of taking anti-retroviral medication since it can also make people feel quite sick. When you take anti-retrovirals, you must be tested quite often to make sure that you are getting the right dosage.

In developed countries, anti-retrovirals have made a big contribution to fighting AIDS and preventing the spread of AIDS. More people come to be tested once there is some form of treatment available. If the anti-retrovirals work well, they will reduce the viral load. This means people have a smaller presence of the HIV virus in their blood, and it is less likely they will pass the virus on to others.

In Brazil, the government has made anti-retrovirals available to everyone who needs it. They produce generic versions of the medicines, and this makes it much cheaper. They also developed a support system so that people living with AIDS were trained and supported to take their medicine in the right dose. South Africa has set up successful antiretroviral treatment programmes in local townships, and they are using a similar approach to the Brazilian one.

The role of hospitals and clinics in treatment and care: Hospitals and clinics are the only places poor people can go for treatment. All medication is only available through hospitals or clinics. Testing is also coordinated through clinics.

When people get very ill with infections that can be treated, they should be hospitalized, if possible. If there is nothing the hospital can do for someone, it is often best for them to stay at home with the people they love. It is vital that hospitals and clinics work with home-base care and other community organizations to make sure that there is ongoing care for someone who is discharged from hospital.

Home-based care: People who are ill with AIDS need much more care than hospitals and clinics can provide. It is vital that health workers work with communities and families to make sure that people who are ill at home get proper care. This is where the idea of home-based care originates. At a community or district level, the hospital or clinic should be coordinating the treatment programme, providing the following to patients:

- ▶ Testing, diagnosis and counselling
- ▶ Treatment and medication
- ▶ Referral to support groups or other projects

Advantages of home-based and community care

- ▶ It frees up the number of hospital beds available for those who are very ill or suffering as a result of other diseases and accidents.
- ▶ It involves the community in directly taking responsibility for HIV/AIDS.
- ▶ It allows people who are ill to spend their days in familiar surroundings, and stops them from being isolated and lonely.
- ▶ It gives families access to support services as well as emotional support.
- ▶ It promotes a holistic approach to care, and does not only focus on narrow health needs.
- ▶ It is pro-active and helps keep people healthy longer.
- ▶ It involves the patients in their own care, and gives them more of a say about what should be done.

Many of the common diseases or conditions can easily be managed at home with the right training.

- ▶ It takes a big burden off the family, especially children.
- ▶ Home-based care focuses on the individual patient and her/his needs.
- ▶ It avoids unnecessary referrals or admissions to hospitals and institutions.
- ▶ It helps to co-ordinate different services in the community and get them all to people who need it through one volunteer.
- ▶ It helps to collect data and to record information about what is happening in the community.
- ▶ It makes sure that there is consistency of services and that everyone gets access to things like grants, projects and food parcels.

4. Involving people with HIV/AIDS

Home-based care volunteers can be drawn from any organisation within the community, and individuals should be encouraged to sign up. One of the most important groups for recruiting volunteers is People Living With HIV/AIDS. They are very well placed to play an important role in any of the following areas:

- ▶ Counselling people who have been diagnosed as HIV positive or who are being tested at hospitals and clinics.
- ▶ Forming and running support groups for people living with HIV/AIDS
- ▶ Volunteering for home-based care projects
- ▶ Educating the community by talking from their own experience
- ▶ Raising awareness at public events
- ▶ Speaking at awareness events
- ▶ Participating in special services, vigils, cultural events, etc.
- ▶ Helping children to cope with parents who are ill
- ▶ Training volunteers
- ▶ Representing the cause at HIV/AIDS-related functions

Causes of problems for PLWHA

1. Lack of knowledge

- ▶ lack of knowledge about care and treatment options for HIV and opportunistic infections
- ▶ limited access to information

2. Lack of skills

- ▶ limited opportunities for learning skills
- ▶ lack of opportunities for practising skills, e.g. condom use
- ▶ lack of practice in safer sex

3. Unhelpful attitudes and beliefs

- ▶ belief that women should not be independent or make their own decisions
- ▶ fear of being seen as different
- ▶ denial of HIV
- ▶ fear of people with HIV

4. belief that young people should not know about sex

5. Social and cultural pressures

- ▶ men expected to be decision-makers
- ▶ stigmatization of people with HIV
- ▶ discrimination and blame, e.g. against sex workers and gay men

6. Restrictive environment

- ▶ inappropriate policies, e.g. mandatory HIV testing
- ▶ uninformed and inaccurate media
- ▶ poverty and lack of resources
- ▶ limited access to medical care

Ways to make positive changes for PLWHA

1. Increasing knowledge

- ▶ how to prevent infection and re-infection
- ▶ treatment options
- ▶ safe injecting drug use
- ▶ how to care for ourselves e.g. how our bodies work, eating healthily
- ▶ reproductive health, e.g. healthy pregnancy, reducing risk of HIV transmission to babies, avoiding unwanted pregnancy

2. More skills

- ▶ leadership
- ▶ counselling
- ▶ income generation
- ▶ communication skills
- ▶ negotiating condom use
- ▶ using condoms properly
- ▶ explaining HIV to our children
- ▶ public speaking, negotiating and advocacy skills

3. Positive attitudes and beliefs

- ▶ believing men and women are equal
- ▶ wanting to make sex safer and enjoyable for people with HIV
- ▶ accepting people's right to different ways of life and sexuality



- ▶ caring for others
- ▶ understanding personal risk
- ▶ accepting young people's rights
- ▶ belief and confidence in yourself and your abilities
- ▶ feeling able to be different, e.g. postponing sex or marrying someone else with HIV

4. Helpful social and cultural influences

- ▶ challenging discrimination against same-sex relationships
- ▶ women have right to refuse sex or leave violent partners
- ▶ accepting abstinence, faithfulness, condom use as normal practice
- ▶ challenging traditions such as widow inheritance
- ▶ accepting rights of people living with HIV to sexual relationships
- ▶ include people living with HIV in making decisions
- ▶ less stigma about sex work
- ▶ men and women sharing sexual responsibility
- ▶ challenging early sexual activity

5. Supportive environment

Policy and laws/human rights

- ▶ legal access to condoms
- ▶ decriminalising sex work and same-sex relationships
- ▶ legal rights for women, e.g. property and safety
- ▶ legal rights for people with HIV, e.g. employment and housing

Access to materials and services

- ▶ access to health care for people with HIV
- ▶ safe blood supply
- ▶ health services for young people
- ▶ access to clean injecting equipment
- ▶ affordable condoms

Economic opportunities

- ▶ employment for people with HIV
- ▶ employment for women
- ▶ adequate income for men and women
- ▶ adequate social security for sick people

Open environment

- ▶ positive media images about people with HIV
- ▶ clear and frank messages about HIV
- ▶ condom advertising



POSITIVE LIVING: A CHECKLIST

- ▶ Freedom from stress
- ▶ Good nutrition
- ▶ Exercise
- ▶ Access to drugs, triple therapy, treatment of opportunistic infections,
- ▶ Access to information on HIV/AIDS
- ▶ Psychological and emotional support: how infected people and those who love them learn to live positively with this knowledge
- ▶ Support in (disclosing one's infection status) telling spouses, sexual partners, children, and important others
- ▶ Support to boost self-esteem
- ▶ Lessening of stigma and discrimination
- ▶ Creating a supportive environment at all levels
- ▶ Advocacy and policy – access to education, training, employment, etc.
- ▶ Support to plan one's own future
- ▶ Support in dealing with intimacy, entering or keeping relationships
- ▶ Spiritual support
- ▶ Income support and financial assistance
- ▶ Establishment of home/community care programmes linked to outpatient/inpatient services
- ▶ Domestic support: shopping, cleaning, cooking, child care, etc.
- ▶ Support for the carers, during the caring and after the death of the infected person(s)
- ▶ Survivor assistance programmes:
 - protection of property and other rights of survivors
 - emotional and psychological support of survivors
 - lessening of stigma and discrimination against survivors
- ▶ keep survivors as an integral part of the community to provide nurturing and socialization

MODULE EIGHT

Working Together in the Community to Combat HIV/AIDS

Approximate Time: 4 hours 15 minutes

Module Message: Community members and their network can play an important role in the design and implementation of a HIV/AIDS and sexual health programme. It also increases acceptability and, thereby, improves the programme, utilizes community resources and promotes services. Every member of a community has an important role and responsibility in coping with problems related to HIV/AIDS. In this connection, the educator needs to understand basic steps to consider in order to develop skills for encouraging community involvement.

Overview: Addressing the impact of the HIV/AIDS epidemic requires concerted community action. People need to understand their individual and collective roles and responsibilities in the effort against HIV/AIDS, including people living with HIV/AIDS (PLWHA) and their families. People working within the for community HIV/AIDS prevention and care also need communication skills. There are usually mixed reactions to the problems of people with HIV/AIDS. Understanding the circumstances of their lives, their needs and aspirations is the first step towards helping them.

Objectives: After learning this module, the participants should be able to:

1. Identify their own roles and responsibilities and that of various groups in the community towards prevention of HIV/AIDS and care/support for PLWHA
2. Understand the importance of working with stakeholders for community involvement in combating HIV/AIDS/STIs
3. Develop practical skills to approach community members
4. Choose appropriate action in coping with problems related to HIV/AIDS
5. Establish linkages with various agencies concerned with HIV/AIDS prevention and control

Content Outline:

1. Approaching the community
2. Roles and responsibilities of various groups in the community
3. Case studies
4. Agencies concerned with HIV/AIDS prevention and control

Learning Activities:

1. Panel discussion
2. Analysis of case studies
3. Interview

Evaluation:

Fill out the matrix based on Resource Materials 8.3 below by listing at least three major roles and responsibilities of community groups that are concerned with the prevention and control of HIV/AIDS.

Facilitator's Note:

Follow Facilitator's Note to conduct icebreaker or warm-up game



ACTIVITY 8.1

Approaching the Community

Approximate time: 1 hour 30 minutes

Materials: Chart papers, markers, handout

Preparation:

1. Prepare and send invitation letters
2. Assign a participant who will act as moderator to:
 - ▶ introduce the speakers
 - ▶ moderate the open forum
 - ▶ summarize the panel discussion

Objectives: After doing the activity, the participants should be able to:

1. Understand the basic steps to approach a community member with regard to working towards HIV/AIDS prevention
2. Develop practical skills for communicating with community groups

Content Outline:

1. Steps for approaching the community
2. Skills to communicate with community groups
3. Role play

Procedure:

1. Ask two volunteers from the group to come forward and do a role. One person will play the role of a community member and the other a teacher. (2 min)
2. Ask the participants: (20 minutes)
 - ▶ What did you hear/see?
 - ▶ What was the problem?
 - ▶ Do you know this problem from your own experiences?
3. Allow participants to share their feelings about communicating with others
4. Ask, 'Why does this happen?' 'What can we do to solve the problem?' **(The answer is to build good rapport with community people.)**
5. Let the participants express more ideas and note them on the chart paper.
6. Summarize by noting that nobody can start a programme without a good relationship with the community and, therefore, building good relations is very important.

7. Divide the participants into four groups and ask them to work on the following: (30 minutes)
 - Group 'A' Make a list of people who can help you in the community
 - Group 'B' Make a list of important things to do to establish contact and build good relations
 - Group 'C' Make a list of important points to be considered when meeting a woman, particularly in certain cultures
 - Group 'D' Make a list of important things that will help you develop successful community programmes

Move from one group to another to provide help, as needed.
8. Ask each group to give a brief presentation. (5 minutes each)
9. Allow the participants to comment and discuss. (10 minutes)
10. Summarize the outcomes of discussion.

- Learning Outcome:**
1. Knowledge of community groups and their respective roles/ responsibilities in helping PLWHA and their families
 2. Ability to summarize the collective role of the community in coping with HIV/AIDS

Evaluation: The participants should be evaluated on the basis of their discussion.

- Facilitators' Note:**
1. Encourage participants to share how they felt while approaching the community during the role play. The outcomes of discussion should be noted on the board or chart paper. By the end of the session, the facilitator must summarize the following:
 - ▶ *Rapport-building plays a crucial role in a programme's success.*
 - ▶ *Building relations is not a one-time event; it should be a continuous process.*
 - ▶ *There are key people who should be contacted in the beginning of any effort to seek community involvement.*
 2. Provide the following outline for the role play exercise.

Outline for Role Play:

(Two people - a community member and a school teacher)

One person is walking and suddenly a school teacher stops him/her and starts talking about HIV/AIDS. It is a fatal disease.... The person moves away without paying attention to the school teacher. (Role play not more than 2 minutes)



ACTIVITY 8.2

Strengthening Communication Skills

Approximate Time: 1 hour

Materials: Chart paper, markers, IEC materials on HIV/AIDS, Resource Material 8.2

Introduction: Communication problems often occur when discussing HIV/AIDS with people. Communication should be compatible with the audience, their age and their concerns.

Objectives: After doing the activity, the participants should be able to:

1. Demonstrate effective communication skills and IEC for HIV/AIDS prevention and care
2. Identify factors and situations that may influence what and how to communicate HIV/AIDS education to people

Content Outline:

1. Role plays of different situations
2. Appropriate ways of communication and use of IEC materials relating to HIV/AIDS

Procedure:

1. Conduct the game, 'I Am Joker Joni.' (see Facilitator's Note for instruction)
2. After completing the game, divide the class into 4-5 groups.
3. Ask each group to choose volunteers, as needed.
4. Provide them with the role play outline. (10 minutes for preparation)
5. Ask them to discuss the communication skills that would be needed for the role play (remind them of the previous session on rapport-building).
6. Assign actors to each role, and allow the performance. (5 minutes each)
7. Instruct selected participants to use the observation rating checklist. (see Resource Material 8.2)

Evaluation:

1. After the role play, discuss the feelings of the role players and outcomes of the discussion.
2. Ask one person from all remaining members of each group to provide feedback about the role play.

Learning Outcome: Understanding about how the role players are expected to cope when confronted with different situations and problems relating to HIV/AIDS

Facilitators' Note:

1. Use the following guideline to play the game, 'I Am Joker Joni':
 - ▶ All participants stand in a circle.
 - ▶ People introduce themselves with an adjective that tells something about them and that starts with the same letter as their name.
 - ▶ For example: "My name is Joker Joni, because I like to tell jokes."
 - ▶ After everybody's turn, ask for a volunteer to repeat all the names with their adjectives.
 - ▶ Ask the participants to call each other by the given name for at least the ongoing session. This will help people recall the name of their colleagues.
2. Inform the participants about the purpose of the role play. Its purpose is to enable the participants to reinforce and improve their communication skills. The lessons of this session:
 - ▶ Provide accurate information.
 - ▶ If you do not know something, be honest.
 - ▶ Use IEC materials; they help you to communicate the message effectively.
 - ▶ If the community is reluctant to accept your advice/approaches on certain issues like, for example, a condom demonstration, be sensitive to people's feelings but do not give up. In such a situation, you could conduct private instruction.
3. Make sure that feedback from the observation sheets includes good points as well as weaknesses.

ACTIVITY 8.3

Role and Responsibilities of Community Groups: Combating HIV/AIDS problems

Approximate Time: 45 minutes

Materials: Brochures of the the resource people's organizations

Preparation:

1. Prepare and send invitation letters
2. Assign a participant who will act as moderator to:
 - ▶ introduce the speakers
 - ▶ moderate the open forum
 - ▶ summarize the panel discussion

Objectives: After doing the activity, the participants should be able to:

1. List the roles and responsibilities of various groups in the community concerned with the problems of HIV/AIDS
2. Describe how these groups can help PLWHA and their families

Content Outline:

1. Identifying community groups' roles and responsibilities
2. Identifying actions for the community
3. Identifying forms of community assistance that could help PLWHA and their families

Procedure:

1. Invite persons representing 2-3 groups in the community to participate in a panel discussion, "The Roles and Responsibilities of Community Groups: Combatting HIV/AIDS."
2. Ask each representative to give a 10-minute presentation of his/her group's roles and responsibilities in relation to the theme.
3. In preparation for the panel discussion, assign class participants various responsibilities: introducing a resource person, keeping presentation notes, raising issues during the follow-up open forum, expressing thanks to the visitors for their time and valuable ideas, and finally, after the visitors depart, summarizing the outcomes of the discussion (one participant per visitor).
4. Introduce the speakers briefly.
5. Conduct an open forum after the presentations.
6. Ask those participants assigned to the task to summarize the outcomes of discussion.



- Evaluation:** Identify the roles of various agencies based on their presentations.
- Learning Outcome:**
1. Knowledge about community groups and their respective roles/responsibilities in helping PLWHA and their families
 2. Ability to summarize the collective role of the community in coping with HIV/AIDS
- Facilitator's Note:** Make sure that representatives of groups invited for the panel discussion include :
- ▶ Teachers
 - ▶ Healthcare givers
 - ▶ Religious leaders
 - ▶ PLWHA
 - ▶ Family member of PLWHA
 - ▶ Parent-Teachers Organization members
 - ▶ Youth leaders
 - ▶ NGOs/INGOs
 - ▶ Business sector representatives
 - ▶ Other community groups to invite: media practitioners and government leaders

ACTIVITY 8.4

Analysis of Case Studies

Approximate Time: 1 hour

Materials: Case studies

Objectives: After doing the activity, the participants should be able to:

1. Analyse different life situations involving persons with HIV/AIDS
2. Choose appropriate actions when confronted with problems relating to HIV/AIDS

Content Outline: Case studies (Resource Material 8.4)
Appropriate ways of coping with problems relating to HIV/AIDS

Procedure:

1. Divide the class into small groups of 4-5 members each.
2. Assign each group one case study to be presented in a role play showing how people usually react when they hear about a family member who is infected with HIV.
3. Assign actors for the role play.
Actor 1 is the person infected with HIV.
Actor 2 is the person told by Actor 1 about his/her infection.
Actor 3 is the person who will ask questions about the role play.
4. Instruct the groups to consider issues such as social stigma, discrimination, isolation, etc. which should be avoided.
5. After the role play, discuss the actors' feelings.

Evaluation: Based on observation of the role play

Learning Outcome: Describe how the role players are expected to cope when confronted with different situations and problems relating to HIV/AIDS.

Facilitator's Role: Make sure that the participants fully understand the purpose of the role play.

Resource Material: 8.1

Scenario for Role Play

Role Play 1

In the evening when you are returning home from the office, you happen to see Hemant having tea with his friend in a small tea stall. Hemant is your neighbor who works in a factory. His wife has informed you that he has changed a lot these days, and has begun to drink alcohol. Moreover, he visits sex workers with his friends. You want to give Hemant and his friend information about HIV/AIDS and STIs. How do you do it?

Role Play 2

Hisila is a young lady. She recently returned from her neighboring country. There is a rumor that she is back because she is HIV-infected. Now her family members are forcing her to leave home. All the members of her family are scared that she may transmit AIDS to other family members and also their relations with neighbor will deteriorate. How do you tackle the situation of this tension? What are different ways to communicate with them?

Role Play 2

You have planned to give HIV/AIDS education to a group of homemakers. They do not think that they are in risk of getting HIV/AIDS and STIs because they think this is the disease of men who travel frequently and of women who are engaged in selling sex. How do you approach them to introduce HIV/AIDS education?

Role Play 3

Sikandar is a secondary school student, and he comes to know that his close friend, Mahabir, uses illicit drugs and contacts sex workers. He knows other students (both boys and girls) from his school use drugs, as well. Sikandar's parents come to the school to complain that authorities are not being strict enough with their students. They demand HIV/AIDS and harm reduction education. As a school teacher, you want to implement effective awareness-raising and advocacy programmes. What do you plan to implement, and what message would you like to give to the parents?

Role Play 4

You are visiting a community for condom distribution as an outreach educator. During your visit, many women complain that they are not interested in using condoms during sex because they break. You want to organize a small meeting of women. While you demonstrate how to use the condom, some women refuse to stay. How do you get them to stay?

Resource Materials 8.2: Observation Check List

S.N.	Aspects of presentation	Rating of Role play			Remarks
		1	2	3	
1.	Voice				
2.	Charity of concept				
3.	Speed of speaking				
4.	Accuracy of information				
5.	Use of IEC materials				
6.	Listening to participants				
7.	Questioning of participants				
8.	Answers to queries				
9.	Involved all group members				
10.	Major points highlighted				
11.	Issues raised				
12.	Overall impression				

1 = Poor
2 = Average
3 = Good

Resource Material 8.3

Case Studies

Case 1

Imp is a sex worker. She prefers to use a condom and does so, except when clients refuse. Imp has recently tested HIV-positive, and has been forced to leave the apartment she is sharing with other sex workers. She hesitates to return to her home town, afraid of how her family and relatives will treat her.

Case 2

Nui was badly hurt in an automobile accident two years ago and received a series of blood transfusions while in hospital. Recently, Nui has not been feeling well and requested an HIV test from his doctor. He tested positive. Nui is now afraid that he might have infected his wife and 2-month-old son with HIV, and is unsure of what to do.

Cases 3

Deng is a young man from a small village who recently lost his mother and father in a fire. Soon after, he moved to Bangkok to work. He became very lonely and depressed, and began using heroin and opium. Deng recently learned that one of his close friends, with whom he has often shared needles, had tested positive for HIV. This frightened Deng and prompted him to go for a similar test. The test result was positive for HIV.

Case 4

Nissa used to work in a hotel visited by foreigners in a major city. She dated the same man for three years until about two years ago when they broke up. The man went abroad to study, which left her very lonely. After a while, she realized that she could receive a lot of attention from hotel guests by flirting with them. She had a few short-term intimate relations, and once had sex without a condom. Eventually Nissa got infected with HIV and developed AIDS. She asked one of her co-workers for help. Her co-worker, who disapproved of her intimacy with guests in the first place, told the hotel management about Nissa. She was consequently fired from her job.

Case 5

Krishna is a construction worker who was laid off when the project he was working on was discontinued due to an economic downturn. He was extremely worried about how he was going to provide for his family without a job. He was against the idea of using heroin, but learned through his friends that he could make enough money to support his family by selling it on the street. Krishna occasionally tried the drug and was often supplied with syringes by the people from whom he was buying the heroin. Two months ago Krishna tested HIV-positive. His wife eventually left him and returned with the children to her hometown. He has been unable to contact her since. Krishna increased his heroin use as he felt that it couldn't be worse than the fact that he was already infected. Besides, he enjoyed the temporary relief from his problems that the drug provided.

Case 6

Ravi is a secondary school student who learns that his classmate, Gopal, is HIV-positive. Ravi's parents refuse to send their son to school, and ask the principal not to allow Gopal to study with other students since he is HIV-positive.

Resource Materials: 8.4 Participant Note-taking Chart

Community Groups	Roles	Responsibilities
1. Students & teachers	1 2 3	1 2 3
2. Parents	1 2 3	1 2 3
3. Professionals	1 2 3	1 2 3
4. Religious community	1 2 3	1 2 3
5. Movie and entertainment industry	1 2 3	1 2 3
6. Persons with AIDS	1 2 3	1 2 3

N.B.: Other groups may be added to this tabulation.

1. Discuss with family members ways of helping persons dying of AIDS.
2. Identify at least 3 agencies providing services to PWLHA and their families.

Name of agency & address	Contact person	Services provided
1.		
2.		
3.		
4. Others (please specify)		

Integration of HIV/AIDS Prevention Education with School Curriculum

Approximate Time: 5 hours

Materials: Flip chart paper, pens, cards, masking tape, resource materials, handout

Module Message: As educators and parents, teachers can do much to save students and families from STIs and HIV infection. School children and teachers occupy a large section of the population in any country, and they are the ones who can be instrumental in creating mass awareness and education for HIV/AIDS prevention. There is a pressing need to educate teachers and implement HIV/AIDS education in schools. HIV/AIDS and sex education can be integrated into the school curriculum as a holistic approach to prevention, particularly for vulnerable young people. Through prevention education, we can equip them with knowledge, and help them to develop values, attitudes and skills to protect themselves.

Overview: The devastating toll in human death and suffering in sub-Saharan Africa has shown that HIV/AIDS has the potential to affect an entire education system on many levels: planning, demand and supply in education, resource mobilization, teacher training, curriculum design and implementation, and in regards to strategies that meet student needs and provide a support systems.

HIV/AIDS education generally plays a key role in establishing conditions that help students outside of the school to avoid high-risk situations. It also reduces vulnerability among a number of especially vulnerable groups: orphans, female sex workers, and street children. In this connection, the formal education system has a key role to play. Therefore, the integration of sex health and HIV/AIDS education into the curriculum for all educational levels is an urgent matter. Schools must ensure that every school member is adequately equipped with knowledge of relevant life skills to avoid HIV/AIDS infection. As educated members of a society, they should also be able to contribute to HIV/AIDS prevention by educating others throughout their communities.

The AIDS pandemic has been shown to have a negative impact on all aspects of human life and endeavour. Even while the search for appropriate drugs and vaccines continues, prevention education programmes are also being developed to promote awareness that this disease is indeed preventable. The programme in schools should focus on the capability of young people to make rational decisions for their own well-being and safety.

It is important to integrate HIV/AIDS facts and sex education with school curriculum because young people are particularly vulnerable at this stage of their life. Innovative teachers can explore the channel of students' knowledge on HIV/AIDS, and find various models of providing HIV/AIDS education to school

children. Teachers, therefore, must consider how students should be given HIV/AIDS and sex education. Innovative teachers can stimulate and challenge the active bodies and minds of their students. They are able to keep their students intellectually curious and productive. With the activities contained in this module, you will be asked to be creative in integrating HIV/AIDS facts and sex education concepts with standard school subjects.

Objectives:

After studying the module, teachers should be able to:

1. Explain the importance of HIV/AIDS prevention education through school-based programmes
2. Identify ways of providing HIV/AIDS and sex education, and understand the process of integrating HIV/AIDS/STI messages and sex education with school subjects
3. Find alternative ways of providing HIV/AIDS education to school children
4. Design and develop a matrix of HIV/AIDS/STI facts and sex education concepts that can be integrated with school subjects at appropriate levels
5. Develop skills in creative lesson planning by integrating HIV/AIDS/STI messages and sex education with related school subjects

Content Outline:

1. Importance of school-based HIV/AIDS and sex education
2. List of HIV/AIDS/STI facts and sex education concepts
3. Models of integrating HIV/AIDS/STI facts and sex education with standard school subjects
4. Alternative ways of providing HIV/AIDS education to school children
5. Creative lesson plan development

Learning Activities:

1. Brainstorming on ways to provide HIV/AIDS- and sex education
2. Using creative learning groups
3. Creating lesson plans that integrate HIV/AIDS/STI and sex education with school subjects

Evaluation:

1. Use an illustration to explain the process of integration.
2. Use a matrix to integrate HIV/AIDS/STI facts and sex education concepts with school subjects at relevant entry levels.
3. Suggest strategies for providing HIV/AIDS education.
4. List the advantages and disadvantage of integrating HIV/AIDS/STI prevention and sex education in the school curriculum.
5. Critique the written lesson plans integrating HIV/AIDS/STI prevention education with various school subjects.

Facilitator's Note:

Follow the Facilitator's Note to conduct the warm-up game.



ACTIVITY 9.1

HIV/AIDS and Sex Education

Educating School Children

Approximate Time: 2 hours

Materials: Flip chart paper, pens, cards, masking tape

Objectives: After this activity, the participants should be able to:

1. Share their perception on how students gain knowledge about HIV/AIDS and sex education
2. Explore how students can be educated about HIV/AIDS and STIs
3. Suggest models to provide knowledge and skills for HIV/AIDS prevention and sex education to students

Content Outline:

1. Study how students obtain knowledge about HIV/AIDS and sex
2. Examine existing practices in sensitizing students to HIV/AIDS/STI prevention and sex education

Procedure:

1. Distribute 2-3 colour cards to all participants and ask them to write down how students get information on HIV/AIDS and sex education.
2. Collect all cards and paste them in the chart paper. (5 minutes)
3. Discuss in plenary, and finalize a list of ways that students get HIV/AIDS messages. (15 minutes)
4. After finalizing a list of how students may access knowledge and information on HIV/AIDS, divide the participants into three groups and ask them to discuss: (30 minutes)
 - ▶ *Various types of facts and messages related to HIV/AIDS and sex education that should be given to students at various grades or age levels*
 - ▶ *Ways of providing HIV/AIDS and sex education*
 - ▶ *Ways to involve parents and community personnel for effective HIV/AIDS and sex education through school programmes*
5. Use Resource Material 9.2b to tabulate facts and messages that should be given to students by grade or age. (30 minutes for discussion)
6. Ask them to give a short presentation. (10 minutes for each group)

Evaluation: Based on presentation and discussion

Learning Outcome:

1. Knowledge about how students are accessing information about HIV/AIDS and sex education
2. Identification of the types of messages about HIV/AIDS to be given to various students

Facilitator's Note:

1. You should guide the group during discussion to ensure that the discussion reveals the following points:
 - ▶ Existing practices of providing HIV/AIDS and sex education to students
 - ▶ Need for providing HIV/AIDS and sex education through school programmes
 - ▶ Measures needed to educate school children about HIV/AIDS and sex

ACTIVITY 9.2

Creative Learning Groups

Approximate Time: 1 hour 30 minutes

Materials: Flip chart paper, pens, masking tape, Resource Material 9.2

Objectives: After this activity, participants should be able to:

1. Illustrate the process of integrating HIV/AIDS facts, sex education and concepts with a school subject
2. Design a matrix for integrating HIV/AIDS content and messages with various subjects in the school curriculum

Content Outline: Integration of HIV/AIDS/STI prevention and sex education with the curriculum:

- ▶ Integration
- ▶ Principles of learning
- ▶ School subjects
- ▶ Selection of content
- ▶ Why integrate
- ▶ Advantages and disadvantages of integration

Procedure:

1. Conduct the game, '7-Up.'
2. After completing the game, divide participants into 3 smaller groups and let them read Resource Material 9.2.
3. Ask Group I to illustrate the process of integrating HIV/AIDS facts and sex education concepts/messages with various school subjects. Ask them to list the fact, concepts/messages and school subjects. (20 minutes)
4. Let Group II work with Group I in preparing a matrix for the integration at different grade levels. Use the matrix by filling up the appropriate columns. (20 minutes)
5. Ask Group III to list the advantages and disadvantages of integrating HIV/AIDS prevention education with the standard school curriculum. (20 minutes)
6. Ask each group to present their creative work in plenary session. (5 minutes each)
7. Let the participants express their comments to enrich each presentation. (5 minutes)

Evaluation: Ask participants to summarize this activity in 2-3 sentences. (5 minutes)

Learning Outcome:

1. Illustration of the process of integration (Resource Material 9.2a)
2. Matrix for the integration of HIV/AIDS facts, concepts and messages with the school subjects and levels (Resource Material 9.2b)

Facilitator's Note:

1. Provide the following instructions for game, '7-Up':
 - ▶ Participants should stay in circle.
 - ▶ Every one should say one number (1, 2, 3, in order), but at the time of 7, the person should put his hand on his/her head and say 7-Up.
 - ▶ The next persons should go on saying 8, 9, 10 etc up to 16.
 - ▶ At the time of 17, the person concerned should put his/her hand on head and say "7-Up."
 - ▶ Continue this activity for some time.
 - ▶ At the numbers 7, 17, 27 etc the person should always put his/her hand on the head and say "7-Up."
 - ▶ The one who either misses the correct number or does not follow the special procedure will be out of the game.
2. You should ask the participants relate their group work with the outcomes of Activity 9.1

ACTIVITY 9.3

Writing Creative Lesson Plans

Approximate Time: 1 hour 30 minutes

Materials: Copies of Resource Material 9.3, “Outline for Group Presentation”

Objectives: After this activity, participants should be able to:

1. Write creative lesson plans integrating HIV/AIDS facts, concepts and messages with various school subjects
2. List (life) skills related to HIV/AIDS/STIs

Content Outline: Lesson plan format should include:

■ Motivation	■ Methods/Activities
■ Objectives	■ Evaluation
■ Content outline	■ Summary
■ Materials/Equipment	■ Assignment (Optional)

Procedure:

1. Let the participants read Resource Materials 9.3 and 9.3a, and pair off for further work.
2. Ask each pair to identify the HIV/AIDS facts, concepts or messages they plan to integrate with a specific school subject at a particular grade level. (10 minutes)
3. Divide the participants into three groups to prepare a lesson plan. (30 minutes)
4. Encourage them to discuss ways of improving their lesson plans. (15 minutes)
5. Ask each group to give a presentation (10 minutes each), and follow up with plenary discussion.
6. Ask a volunteer to summarize the results of this activity. (5 minutes)

Evaluation: Based on participants ability to:

1. Identify content and modalities for providing HIV/AIDS and sex education
2. List skills they obtained for providing HIV/AIDS and sex education to students
3. Identify ways of involving parents for effective programmes

Learning Outcome:

1. Understanding of the integration process.
2. Written creative lesson plans integrating HIV/AIDS facts, concepts and messages with school subjects
3. Completion of the matrix for the integration of HIV/AIDS facts, concepts and messages with school subjects and levels (Resource Material 9.2B)

Facilitator's Note:

1. Ensure that the participants study the given resource materials for review and discussion well.
2. Don't be rigid on the format of the lesson plan. Let the participants present their creative lesson plan in whatever way that works for them (so long as it is effective).

Resource Material 9.1

1. Even without organized HIV/AIDS and sex education programmes at school, students are exposed to HIV/AIDS and sex information. In some schools, students are given selected information about HIV/AIDS and sex education through health, physical education and science subjects. Besides, students are exposed to HIV/AIDS- and sex education through other non-formal programmes. They are as follows:
 - ▶ Community events such as street drama, cultural shows, and mass demonstration
 - ▶ “Day” events such as Condom Day (celebrated in Nepal) and World AIDS Day (celebrated throughout the world)
 - ▶ Outreach activities done by local NGOs as part of community HIV/AIDS prevention programmes
 - ▶ School peer education programmes implemented by NGOs and other programmes run for other target audiences, such as female sex workers and their clients
 - ▶ Extra-curricular activities such as poems and essay competitions
 - ▶ Joint school outreach and peer education programmes supported by NGOs
 - ▶ Mass media such as newspaper, radio, television, and cinema
2. School-based HIV/AIDS and sex education should involve parents and community groups to gain support. Without parental involvement, such programmes could be blamed for encouraging children to have sexual relationships.
3. Teachers should encourage peer education as part of a risk prevention and education programme.
4. Teachers should create open and accepting classroom environments.
5. Teachers should use the following methodology for HIV/AIDS- and sex education:
 - ▶ Discussion
 - ▶ Question-answer
 - ▶ Brainstorming
 - ▶ Role play
 - ▶ Group work
 - ▶ Story telling
6. The participation of parents and family members has an important role to play in the development of personal and ethical values in our students. Most parents recognize the threat posed by HIV/AIDS, and are in favour of school programmes. Some of them find it difficult to discuss sex with their children, and are happy if the school takes the responsibility.

Chart for Activity 9.2

Grade	Approximate Age	Types of HIV/AIDS/STI Facts/Concepts/ Messages and Sex Education to be given	Approaches- Extracurricular/ Integrated with certain specific subject/Peer education

Resource Material 9.2

Integration of HIV/AIDS prevention education with school curriculum

Introduction

Learning from experience promotes behavioural change and responses which will enable the individual to face certain situations in later life better. Education includes teaching students to recognize and understand social norms, and to distinguish those that are potentially harmful from those that can secure their health and well-being. We want to teach students to take the right decisions and actions when confronted with situations that render them vulnerable to HIV infection.

Integration

Integration is one strategy for providing learning experiences on the prevention and control of HIV/AIDS in the school setting. It is the process of placing facts, concepts and messages in the context of other subjects. It focuses on stimulating the learners to actively participate in acquiring knowledge; developing attitudes and values; and sharpening their skills for purposes of health promotion and/or disease prevention.

Principles of Learning

The following principles of learning apply to prevention in health education:

- ▶ Setting the stage of readiness for learning is important.
- ▶ Motivation is a prerequisite to learning.
- ▶ Responses must be immediately reinforced in the form of feedback.
- ▶ Learners' responses vary with how they perceive the situation.
- ▶ Learners' ability to internalize the process is influenced by heredity, background and certain forces in the environment.
- ▶ Students learn by imitation.
- ▶ Students learn from peers.

Effective Placement Within the Curriculum

There are three primary ways to implement HIV/AIDS skills-based health education in schools:

- ▶ **Core health education subject:** HIV/AIDS skills-based health education can be a core (or separate) subject in the broader school curriculum. This is a good long-term option, and requires a strong commitment from policy makers, school directors and teachers over time.
- ▶ **Carrier subject:** HIV/AIDS skills-based health education is sometimes placed in the context of related health and social issues within an existing, so called "carrier" subject that is relevant to subjects such as science, civic education, social studies or population studies. This is a good long-term solution, but has the risk of diluting the message.



- ▶ **Infusion across many subjects:** The HIV/AIDS topic can be included in all or many existing subjects by regular classroom teachers. This approach is not recommended as it does not yield good results on its own.
- ▶ **Combination of approaches:** Another option is the combined use of a carrier subject in the short term with instruction as a separate subject in the long term. This is a very long-term option.

Whichever option is chosen, it is important to understand that the efforts to influence behaviours in the context of school-based priority health, education, and development issues is a significant long-term commitment. Skills-based health education works best to affect behaviour where reinforcing strategies are in place.

School Subjects

Students should be exposed to various learning experiences in order to become responsible and productive members of society. Ideally, they should come from schools with a well-integrated curriculum which is balanced, refined and includes several instructional areas or school subjects that deal with relevant problems and issues confronting the community. Examples of school subjects where HIV/AIDS facts, concepts and messages can be incorporated are:

- | | |
|------------------|----------------------|
| ■ Science | ■ Biology |
| ■ Reading | ■ Economics |
| ■ Health | ■ Geography |
| ■ Mathematics | ■ Arts |
| ■ Social Studies | ■ Physical Education |
| | ■ Language |

Selection of Content

Guidelines in the selection of HIV/AIDS facts, concepts and messages that may be included in the content of school subjects:

- ▶ Consider the objectives of the subjects that you want to integrate
- ▶ Suit content to the learning readiness of the students
- ▶ Organize content according to the logical arrangement of the subject
- ▶ Allot time so that it sustains learner interest

Why Integrate?

Many schools claim that the curriculum is already burdened with so many subjects. Actually, integration can facilitate optimum use of time allotted for existing subjects as a holistic approach to learning.

Innovative teachers look for new ideas to motivate their students to discover ideas and concepts. They encourage creative thinking in identifying problems/issues, and in finding ways to resolve them. In this case, teachers should be able to show the interrelatedness of subject matter areas.

In many classes today, there is mutual trust, respect and acceptance in student-teacher relationships. Students have the opportunity to discuss and ask questions. Teachers welcome students' attempts to think creatively. Thus, HIV/AIDS/STI facts and sex education concepts/messages can be easily integrated. Students can ask personal questions about HIV/AIDS without fear of being embarrassed or ridiculed.

Toward this end, teachers of various subjects can come together and determine HIV/AIDS/STI facts, concepts or messages which can be integrated with each school subject. In this activity, the teachers can also identify gaps in their teaching. They can eliminate unnecessary duplications and reinforce essential ones. To accelerate this process, a person should be assigned the task of integration from its initial stage of planning to its implementation, monitoring and evaluation.

As in any activity, integration has many advantages and disadvantages. Some advantages are:

- ▶ HIV/AIDS prevention education can be included in the school curriculum by adding the appropriate facts, concepts and messages to existing subjects.
- ▶ Instructional materials can be developed and teachers can be trained to use them.
- ▶ Short-term training programmes can be conducted to train teachers on using the instructional materials effectively.
- ▶ Administrators and supervisors can also be oriented to the programme so that they can include HIV/AIDS prevention education in their responsibility for monitoring and evaluation.

Some disadvantages of integration are:

- ▶ Since existing school subjects are already very crowded with their own content and activities, there may not be sufficient time for HIV/AIDS prevention education.
- ▶ There may be resistance from teachers and administrators, themselves, to talk about HIV/AIDS/STI or issues related to sex.
- ▶ Possibilities of misinforming due to a lack of appropriate teaching materials may increase.
- ▶ There may be resistance from parents and the community.

Mention other advantages or disadvantages as you deem fit.

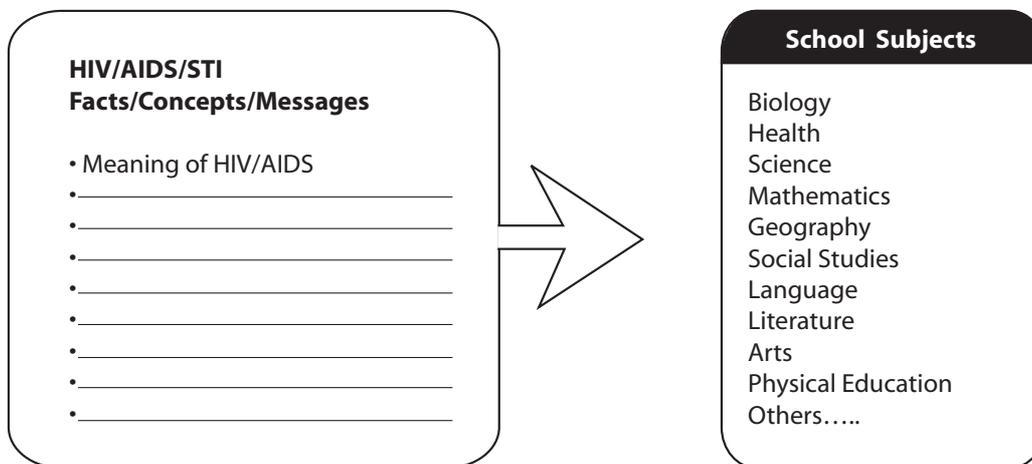
Proposed Goals of HIV/AIDS Prevention Education

These goals can be used as a guidepost in determining what contents to integrate into the various school subjects:

- ▶ Develop life skills that are necessary for dealing adequately with the daily problems of living
- ▶ Encourage independence but recognize that limitations are inevitable
- ▶ Consider the complex environmental forces that can affect normal growth and development of learners
- ▶ Enhance skills necessary for overcoming problems of self-expression
- ▶ Emphasize healthy behaviour and lifestyle

Resource Material 9.2a

Modality for integrating HIV/AIDS Facts/Concepts with the School Subjects



Resource Material 9.2b

Matrix for the Integration of HIV/AIDS Facts/Concepts/Messages with School Subjects and Levels				
HIV/AIDS/STI Facts/Concepts/Messages	School Subjects	Level		
		1 EP	2 L	3 SE

Legend 1–Early Primary; 2–Late primary; 3–Secondary Education

Resource Material 9.3

How to Write Creative Lesson Plans

Lesson Plan _____

Prepared by _____ City/province _____

Subject Area _____ Date _____

Grade Level _____

- I. Motivation
- II. Objectives
- III. Content Outline
- IV. Materials/Equipment Needed
- V. Methods/ Activities
- VI. Evaluation
- VII. Assignment (optional)

GUIDELINES:

I. *Review how to formulate goals and objectives.*

Goals are:

1. Broad statements of intent
2. Desired long-term outcomes of instruction
3. Expressed in non-behavioural terms
 - ▶ Know-Understand
 - ▶ Realize
 - ▶ Appreciate
 - ▶ Believe
 - ▶ Enjoy

Objectives are:

1. Precise statements of intent
2. Desired short-term outcomes of instruction, such as draw, discuss, predict, etc.
3. Expressions of exactly what behaviour can be observed
4. Descriptions that use action verbs (ie, "choose," "describe")
5. Precise expressions of what the learners can do if they master the lesson



Three (3) Components of Behavioural Objectives with Example

1. Condition: "Given a list of 35 chemical element,.
2. Behaviour: *you should be able to write the valences*
3. Criterion: *of all the chemicals correctly."*

Effective Action Verbs

1. Accept, listen, respond to
2. Comply with, follow, volunteer
3. Support, relinquish
4. Theorize, formulate, balance, examine
5. Revise, require, argue, resist, manage, resolve

Why Design Behavioural Objectives for the Learner?

1. To show them exactly what they are expected to do
 2. To show them what they have achieved
 3. To show them what they have yet to master
 4. To build their self-confidence
 5. To show them the interrelationship of the learning materials, activities, and evaluation
 6. To show them where they will be when they complete the lesson
- II. *Be sure that there is a "perfect fit" in your **objectives with the content, methods, media and evaluation**. In other words, they should be congruent to each other.*
- III. *Use participatory methods of teaching/learning.*

PARTICIPATORY METHODS OF TEACHING/LEARNING

All training methods in which the participants learn by active interaction with others are called Participatory Learning Methods. In the Training Modules you will find many different examples of Participatory Learning Methods, which can be divided into 3 types: small group activities; role plays; and games/simulations. Listed here are some of the advantages and disadvantages of participatory methods of learning, as well as some helpful hints for the facilitator in conducting these methods.

Advantages

1. **Active** involvement of many group members i.e., promote critical thinking and **learning through experience**
2. **Meaningful** participation in a low-risk, non-threatening environment
3. **Personal interaction** between participants
4. Opportunities for participants to **teach/learn from each other**
5. **Interesting** and **enjoyable** way to learn
6. **Understanding** other views

Disadvantages of Participatory Methods of Teaching/Learning include:

1. **High time consumption**
2. **Focus can be lost easily**

3. **Frustration** if instructions are not clear
4. **Unintended results** that do not reflect learning objectives

Tips for Successful Participatory Teaching/Learning:

1. **Don't be afraid of a little noise** – it is often a sign of involvement
2. As much as possible, **don't try to constrain activities to a strict time frame**
3. **Enjoy yourself** - your enthusiasm will be contagious

Resource Material 9.4

HIV/AIDS: Prevention Education in Schools: A lesson plan in health education

Health Area: **Communicable disease prevention and control**

Grade Level: Grade VI

I. Objectives: After participating in this lesson, the students should be able to:

1. Define HIV, AIDS and STI
2. Discuss the progression of HIV infection to AIDS
3. Discuss ways by which HIV is/is not transmitted
4. Choose behaviours that will reduce one's risk of HIV infection
5. Demonstrate their resistance skills against HIV/AIDS/STI

II. Content: AIDS

Concept: Practicing healthy behaviours reduces one's risk of HIV infection.

Any person, regardless of gender, age, race or sexual orientation, can become infected with HIV by engaging in specific risk behaviours. It is important to know how to avoid the infection. Students should take on the responsibility of making decisions and upholding values that can protect them in situations that could lead to acquiring AIDS.

III. Materials/equipments

- | | |
|----------------------|---|
| ■ Overhead projector | ■ Blackboard/whiteboard |
| ■ Transparencies | ■ Coloured paper cut into different sizes and shapes |
| ■ TV and VHS | ■ Film on "The Immune System and How AIDS Affects It" |
| ■ Sheets of paper | ■ Pentel pen |
| ■ Chalk | ■ Masking tape |

IV. Methodology

A. Video Showing *

In this film, Sam Goodbody is the principal character. He explains how HIV affects the immune system, the ways by which one can contract the virus and how infection can be avoided. He focuses on risk behaviours that might lead to AIDS, and admonishes the viewers to avoid these risk behaviours in order to protect themselves from AIDS. The following questions are written on the board before the video showing. The students will be asked to answer these questions based on the video.

1. What does HIV mean? What does AIDS mean?
2. How does HIV infection progress into AIDS?
3. How is HIV transmitted? How it is NOT transmitted?
4. How will you reduce your risk of being infected with HIV?

B. Small Group Discussion

1. After the video showing, divide the class into 4 small groups.
2. Ask each small group to choose a leader and a recorder. Explain their roles and that of the members.
3. Assign each small group one guide question to be discussed and answered based on the video.
4. Allow each group to discuss and answer the question for 5 minutes.
5. Ask each group leader to present the answer and summary of their discussion to the class using the transparencies and other visual aids prepared earlier by the teacher and students. Let the students ask questions after each presentation.
6. After all the 4 groups have presented their answers, ask each student to give one message which he/she will share with their friends.

C. Choose and Plate

1. Cut two coloured papers into pieces (3 X 4 inches) and distribute them to the students.
2. Ask learners to write how HIV can be transmitted on one of the pieces of paper, and on the other piece of paper they should write how it cannot be transmitted.
3. Ask each student to paste each coloured paper under the appropriate column:
 - A. HIV can be transmitted
 - B. HIV can not be transmitted
4. Let the students review their work for duplications and make corrections if necessary.
5. Ask one or two students to summarize their work.

* Any appropriate audio-visual material can be used.

D. Patchwork Jacket for Protection

1. Give each student coloured pieces of paper cut in different sizes and shapes.
2. Ask them to think of responsible and healthy behaviour that will protect them from getting infected with HIV.
3. Let them pin or attach the coloured papers to a jacket displayed in front of the class.
4. Let them pin or attach the coloured papers to a jacket displayed in front of the class.
5. Discuss the importance or significance of the jacket. "The jacket is a protection against HIV infection." "The patchwork is composed of prevention measures against HIV infection."

V. Evaluation: Agree/disagree: Ask students to respond to the following statements by:

1. Standing up, if they agree with the statement
2. Remaining seated, if they disagree with the statement; if they disagree, they are to state the reasons why.

Statements:

1. AIDS is transmitted by mosquito bites.
2. HIV infection always develops into AIDS.
3. There is no cure or vaccine against AIDS.
4. It is easy to detect a person infected with HIV.
5. HIV stands for human immunodeficiency virus.
6. Getting a tattoo constitutes a risk of getting HIV.
7. People can get AIDS by swimming in a public pool.
8. AIDS stands for advanced immunodeficiency symptoms.
9. A baby born of a mother with AIDS can be infected with HIV.
10. You can be infected with HIV if you hug someone who has AIDS.
11. HIV is a pathogen that destroys infection-fighting T Cells in the body.
12. Staying away from illegal drugs will reduce your risk of getting infected with HIV.
13. Getting blood transfusion from unknown sources will increase risk of getting HIV.

VI. Assignment: Write 5 review questions and answers in preparation for your Second Periodic Exam. Submit your review questions after class.

MODULE TEN

Learner-Centred Strategies and Life Skills Techniques

Approximate Time: 2 hours 45 minutes

Materials: Handout, resource materials, flip chart

Module Message: HIV/AIDS prevention programmes that teach balanced knowledge, attitudes and skills related to HIV transmission have proven more effective in actually changing behaviour. The use of learner-centred strategies, life skills techniques and appropriate media allow students to participate actively. In this module, the teachers will prepare and demonstrate sample instructional strategies which are learner-centred and enhance students' life skills.

Overview: These days, educators are arguing for more learner-centred models of schooling to address the growing problems of dropout and low level of academic achievement. Learner-centred psychological principles provide a framework for developing and incorporating the components of new designs for schooling. In this connection, it is important for teachers to consider psychological principles that pertain to the learner and the learning process, such as the nature and goal of the learning process; construction of knowledge; strategic thinking; context of learning; motivational and emotional influences on learning; intrinsic and extrinsic motivation to learn; reinforcement; developmental influences on learning; social influences on learning; individual differences in learning; learning and diversity; and assessment and feedback. We learn by listening (11%) and seeing (83%). We remember what we: read (10%); hear (20%); see (20%); see and hear (50%); say (70%); and say and do (90%). Therefore, learner-centred strategies are vital in instructional procedure.

Creative teachers invest time and effort in choosing their methodology and strategies. Instructional activities that are participatory are the most useful. Each lesson uses more than one activity to match a variety of student abilities and interests. In recent times, Life Skills Education (LSE) has become a key strategy in the prevention and management of HIV/AIDS. Experiences throughout the world have shown that the spread and impact of HIV and AIDS can be affected by HIV/AIDS prevention education. Skills-based programmes have proven more effective in delaying the age of first sexual intercourse, and increasing safe sex behaviour among sexually active youth (e.g., increasing use of condoms, reducing number of sexual partners). In countries of Eastern and Southern Africa (ESAR), where the pandemic has reached dangerous levels, attempts have been made to include LSE in the school curricula and link it to HIV/AIDS prevention in the education sector. Out-of school programmes on HIV/AIDS prevention, with LSE as a major focus, are essential. School curricula must respond to learners' needs for knowledge, attitudes and life skills to avoid high-risk sexual behaviour and manage the HIV/AIDS pandemic.

- Objectives:** After studying the module, the teachers should be able to:
1. Explain the learner-centred concept
 2. Compare traditional *versus* learner-centred instruction
 3. Demonstrate sample teaching strategies and media for use in HIV/AIDS prevention education
 4. Give examples of life skills in HIV/ADS prevention and sex education
- Content Outline:**
1. Learner-centred concept
 2. Traditional *versus* learner-centred instruction
 3. Life skill techniques
 4. Instructional media
- Learning Activities:**
1. Group-to-group exchange
 2. Workshop on the preparation of sample pre-test and post-test, learner-centred strategies, life skill techniques and use of instructional media in HIV/AIDS prevention education
 3. Demonstration on the use of the sample activities:
 - ▶ Learner-centred strategies
 - ▶ Life skill techniques
- Evaluation:**
1. The participants will be evaluated on the basis of specific knowledge and skills:
 - ▶ *What knowledge, skills, and new idea/concept did you learn from this activity? Write them on the cards.*
 - ▶ *What suggestions can you give to make students participate actively in the lesson?*
 - ▶ *Go through the answer cards from question (1), select cards and ask the participants to explain.*
 2. While giving presentations, each group will be evaluated on the basis of feedback from the other groups. The participants will use two tools (Appendix A and B) during their group work and presentation.
- Facilitator's Note:**
1. Provide the following instruction to conduct the icebreaker or game.
 2. Make sure that instructional activities are interesting and feasible, and:
 - ▶ Emphasize positive attitudes, values, interpersonal relations, behavioural changes, and total personality development
 - ▶ Help students resolve their concerns and problems on the issues at hand
 - ▶ Promote active and participatory learning, relating knowledge with healthy lifestyle and responsible behaviour
 - ▶ Encourage students to use life skills in avoiding HIV/AIDS risk
 - ▶ Promote learning by doing, learning how to learn and enhancing life skills with constructive feelings and actions



APPENDIX A

Media Selection Checklist

Direction: Read each item carefully and check your answer in the appropriate column.

Aspects	Yes	No	Not sure
<p>I. Content</p> <ol style="list-style-type: none"> 1. Is it accurate and up-to-date? 2. Is it appropriate to the grade level of your students? 3. Is it concise and clear? 4. Is it free from prejudices and discrimination? 5. Others, specify? <p>II. Instructional Design</p> <ol style="list-style-type: none"> 1. Are the objectives clearly stated? 2. Are the media format and strategies appropriate to the grade level of student, objectives and content? 3. Are the directions to the students clearly stated? 4. Are there provisions for assessments? 5. Others, specify? <p>III. Technical Aspects</p> <ol style="list-style-type: none"> 1. Are the objectives clearly stated? 2. Are the media format and strategies appropriate to the grade level of student, objectives and content? 3. Do the students and teachers possess skills to use the media? 4. Is the time required for the media compatible with the teaching/ learning time available? 5. Others, specify? <p>IV. Packaging</p> <ol style="list-style-type: none"> 1. Are they easy to handle, store and identify? 2. Is the packaging durable enough for use and storage? 3. Is it affordable in relation to the potential benefits? 4. Is it cost-effective compared to other comparable media? 5. Others, specify? 			

APPENDIX B

Observation Checklist

Name of Demonstration Teacher _____

Grade Level _____ Duration _____

Date _____

Instructions Please put a ? under the “Yes,” “Partly” or “No” column.

Questions	Yes	Partly	No
I. <ol style="list-style-type: none"> 1. Did the objectives include development of Critical thinking and ability to make Responsible decisions? 2. Were the objectives attained? II. Instructional Activity <ol style="list-style-type: none"> 1. Was the instructional activity interesting? 2. Was there maximum student participation? 3. Was the activity appropriate to the age and level of student competency? 4. Did the activity lead to the attainment of the objective/s? 			
III. Give your comments and suggestions to improve the activity:			

ACTIVITY 10.1

Group-to-Group Exchange

Approximate Time: 45 minutes

Materials: Pentel, pens, flipchart paper, masking tape, string, Resource Materials 10.1

Introduction: Teaching is less about content and more about the learning process. Group-to-group exchange is an example of cooperative learning whereby there is commonality and complementation of roles among members.

Objectives: After participants in this activity, the teachers should be able to:

1. Explain the learner-centred concept
2. Compare traditional and learner-centred instructions
3. Review the different examples of learner-centred strategies and life skill techniques
4. State the basic issues and advantages of using well chosen media

Content Outline:

1. Learner-centred concept
2. Traditional and learner-centred instructions
3. Learner-centred strategies
 - ▶ Pre-test and post-test
 - ▶ Cooperative learning
 - ▶ Peer teaching and learning
 - ▶ Case method
 - ▶ Decision stories
 - ▶ Crossword puzzles
 - ▶ Games
4. Life skills techniques
 - ▶ Enhancing self-esteem
 - ▶ Responsible decision making
 - ▶ Reinforcing resistance skills
5. Instructional media

Procedure:

Prior to the activity:

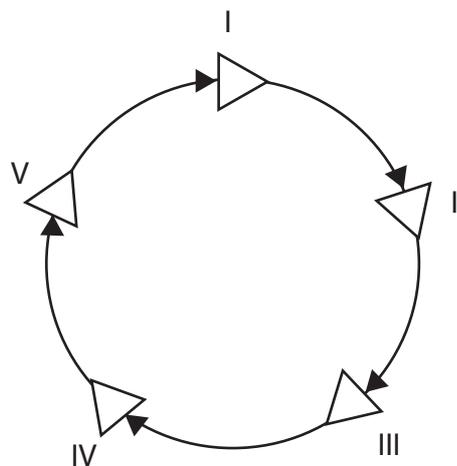
1. Ask the participants to form five small groups.
2. Ask each group to study a specific topic from Resource Material 10.1. “The Use of Learner-Centred Strategies, Life Skills Techniques and Media in HIV/AIDS Prevention Education.”
3. Remind them to bring all the materials needed for their presentation (see Materials above).

On the day of the activity:

1. Let each of the 5 groups review their previously assigned topics from Resource Material 10.1. (5 minutes)

Groups	Assigned topic to read
I	Learner-centred concept
II	Traditional <i>versus</i> learner-centred instruction
III	Learner-centred strategies
IV	Life skill technique
V	Instructional media

2. Let each group prepare their presentation using creative techniques such as flashing key words, drama, poster, chart, stick drawings, mnemonics, etc. (10 minutes)
3. Ask the groups to select one member to do the presentation.
4. The presentation from group-to-group can follow this sequence. (25 minutes)



Sequence of presentation

5. Encourage question-and-answer interactions.
6. Solicit comments and suggestions. (5 minutes)
7. Ask one or two volunteers to summarize this activity.

- Learning Outcomes:**
1. Illustration of the learner-centred concept
 2. Ability to select appropriate instructional media and use the media selection checklist
 3. Skills in giving model presentation on sample teaching strategies and media for use in HIV/AIDS prevention education

Evaluation:

Based on the learning experience from the presentation process:

1. Ask the teachers to complete any of the following verbally:
 - ▶ I now realize that _____
 - ▶ I now support _____
 - ▶ I would like to _____
 - ▶ I would re-evaluate my _____
 - ▶ I was surprised _____
2. Ask the teachers to explain briefly at least two new ideas or concepts that they have learned from each of these topics:
 - ▶ Learner-centred strategies
 - ▶ Life skills techniques
 - ▶ Instructional media
3. Ask the teachers which idea/concept interested them most? Why?

ACTIVITY 10.2

Preparing Instructional Activities and Media for HIV/AIDS Prevention Education

Approximate Time: 2 hours

Preparation: Two days before this workshop, assign partners to write sample teaching/learning strategies and to bring the materials needed for the instructional media: Resource Material 10.2 “Sample Teaching-Learning Activities,” 10.2a “Selection of Teaching Activities,” 10.2b “Selecting Teaching Strategies,” and 10.2c “Instructional Media.”

Objectives: After this activity, participants should be able to:

1. Critique examples of instructional activities
2. Prepare sample teaching/learning activities that are learner-centred and enhance life skills
3. Show examples of instructional media
4. Demonstrate some teaching/learning strategies

Content Outline:

1. Sample teaching-learning activities:
 - ▶ Learner-centred
 - ▶ Life skills
2. Use of teaching strategies
3. Selection of teaching strategies
4. Instructional media
5. Observation checklist (Appendix B, Activity 10.1 Module 10)

Procedure:

1. Conduct the game, ‘Common Link’ (see Facilitator’s Note).
2. Assign partners to critique the samples of teaching/learning activities in Resource Materials 10.2 and 10.2a. (10 minutes)
3. Let participants improve the materials, as they deem fit. (5 minutes)
4. Ask them to prepare their own sample teaching/learning activities and to choose the instructional media needed for their purpose. (30 minutes). Refer to Resource Material 10.2B.
5. Let the participants critique each other’s work. Each partner should revise their work based on comments and suggestions from the other pairs. (5 minutes)
6. Ask them to demonstrate the sample teaching/learning activities that they have prepared. (40 minutes) Refer to the Observation Checklist (Appendix B: Learning Activity 1 Module 10).

Evaluation:

Ask selected participants to summarize the workshop and demonstration teaching by completing at least one of the following phrases: (5 minutes)

- ▶ I learned that I _____
- ▶ I am proud that I _____
- ▶ I feel that I _____
- ▶ I wonder _____
- ▶ I hope _____

Learning Outcome:

1. A collection of teaching/learning activities that are learner-centred and enhance life skills
2. A selection of instructional media for use in HIV/AIDS prevention education

Facilitator's Note:

1. Provide the following instruction to conduct "Common Link":
 - ▶ Divide the group into teams of three or four.
 - ▶ Each team has to come up with 5-10 different traits that are common to all members in the team — brown hair, wearing T-shirts, wearing glasses, having Tika on forehead, etc.
 - ▶ After five minutes or so, the teams share their common traits with the group.
 - ▶ Points are scored for each trait that isn't also on someone else's list.
 - ▶ So if two teams listed that everyone in the team wore glasses, neither team would get a point for that trait.
 - ▶ The team with the most points wins, but so does everyone else, as you've all discovered some pretty interesting things about one another!

Sample teaching/learning materials to be used as part of Activity 10.1 by the participants:

1. Title:

Feelings Toward the HIV-Infected Person

Objectives:

The students should be able to:

- ▶ Clarify their feelings/attitudes about AIDS-related issues
- ▶ Empathize with people living with HIV/AIDS

Procedure:

- 1.1. Introduce the lesson by writing "Case Study: A Classmate with AIDS" on the board:

You have learned that Joey, your classmate, has AIDS. Although AIDS is not transmitted by casual contact, a group of parents demanded that this student should be prevented from attending classes. Many of your classmates are avoiding and rejecting Joey. These classmates are your friends and expect you to support them.

1.2. To facilitate the discussion, you may consider the following questions and possible consequences of their actions:

- ▶ Would you join your classmates in avoiding or rejecting Joey?
Consequences:
- ▶ Would you refuse to join your classmates?
Consequences:
- ▶ Do nothing and be neutral.
Consequences:
- ▶ Would you attempt to change your classmate's action?
Consequences:

1.3. Ask students individually: What would you do?

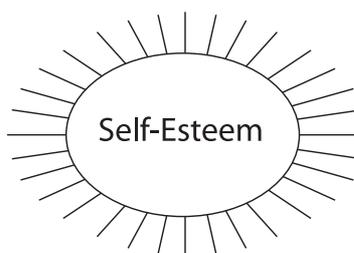
- ▶ Are you willing to accept the consequences?
- ▶ Would you be willing to publicly take a stand?

2. Title: Self-esteem and AIDS Prevention

Objectives: The students should be able to:

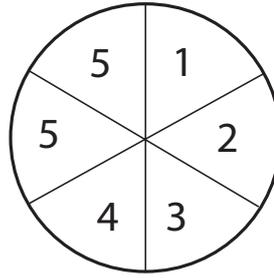
- ▶ Define self-esteem
- ▶ Relate self-esteem with responsible sexual behaviour
- ▶ Discuss the role of self-esteem and responsible behaviour in AIDS prevention

Procedure 1. Write the word "self-esteem" on the board. Encircle the words and put spokes around the figure.



- ▶ Ask students to write on each spoke, a word or words that they associate with self-esteem.
- ▶ Ask the students to choose phrases to define the term, such as:
 - positive opinion of oneself
 - self-respect, self image, feelings of worthiness
 - belief in oneself and liking oneself
- ▶ What factors enhance positive self-esteem? What could be some reasons for lack of self-esteem?
- ▶ Summarize this activity by defining self-esteem and enhancing self-esteem.

2. Ask each student to draw a big circle to fill one piece of chart paper and divide the circle into 6 equal parts.



3. Number each part 1-6 and ask them to answer the following:
- ▶ Three words which describe your best qualities, character or behaviour
 - ▶ One value in life which you do not wish to change
 - ▶ Your most valuable possession
 - ▶ Your greatest personal achievement in life
 - ▶ Name three persons who are very important to you
 - ▶ One thing that will help you succeed in life
4. Let them select a partner to discuss their work.
5. At the end of this activity, ask students how they felt about themselves.
6. Summarize this activity by relating self-esteem and responsible sexual behaviour to HIV/AIDS prevention.
7. Next, have the participants trace their hand showing their 5 fingers on a sheet of paper.



8. Give the following instructions:
- ▶ Let each participant write 5 good qualities about themselves on the fingers.
 - ▶ Discuss these qualities and how they can enhance self-esteem.
 - ▶ Explain how self-esteem influences one's attitude towards unhealthy and irresponsible behaviour.



Resource Material 10.1

Use of Learner-centred Strategies, Life Skills Techniques and Media in HIV/AIDS Prevention Education

1. Learner-centred Concept

In learner-centred classrooms:

- ▶ Teachers help students build on their prior knowledge.
- ▶ Teachers help learners connect what they know to new knowledge.
- ▶ Social and cooperative skills are developed.
- ▶ Activities are designed to help students use the thinking and learning strategies needed to succeed in school and in real life.
- ▶ Students learn to work in teams, to share, debate and synthesize.
- ▶ Students become active participants in learning and are, thus, empowered to make choices and progress at their own pace.

2. Learner-centred Strategies

Some examples of learner-centred strategies are pre-test and post-test, cooperative learning, peer teaching and learning, case method, decision stories, crossword puzzles, and games.

- ▶ **Pre-test and post-test.** Pre-test and post-test are the same tests. These enable students to confirm or correct their responses based on what they have learned from the programme.
- ▶ **Cooperative learning.** This includes the creation of a single product, requires students to help each other, practice social skills and promote positive interdependence within the activity. Cooperative learning is the foundation of many activities in learner-centred classrooms.

Teachers foster interdependence by assigning roles, holding the group accountable for each person's learning, requiring one creative product, and promoting group identity and standards. Students are motivated, focused and successful.

- ▶ **Peer teaching and learning.** An example of this is the "learning pair" in which student pairs alternately ask and answer questions on commonly read materials. This approach provides an opportunity for the learner to interact with a peer in order to work out a better understanding of the subject matter in a congenial manner.
- ▶ **Case study.** Cases are usually real-life situations that are synthesized to represent a particular principle or type of problem. In a case report, discussion should focus on asking questions, clarifying issues, challenging conclusions, encouraging analysis and testing the validity of the solutions or generalizations.

Points to consider:

- What is the problem?
- What causes the problem?
- What evidence will support or discount why the problem exists?
- What conclusions and recommendations can be derived from the study?

- ▶ **Decision stories.** These are open-ended vignettes that describe an issue or problem. They ask students to suggest a decision and corresponding action. The stories should reflect real-life situations and should be appropriate to the age of the students. For the activity to be effective, the story should have varied courses of action. A good decision story should encourage students to sort out opinions, values and feelings. It should require students to think, analyze and try out solutions.

Guidelines in preparing decision stories:

- Make the stories short between 50 to 150 words. Establish realism and identify the character/s.
 - Focus on the main issue, supported by facts and events.
 - Provide for varied courses of action.
 - Give a descriptive title.
 - Ask a focus question at the end to support a particular course of action.
 - Pool ideas based on the focus question.
- ▶ **Crossword puzzles.** These are useful in building vocabulary and reinforcing concepts. They can be made by the teachers and students. Some commercial materials are also available.
- ▶ **Games.** Games are fun and, at the same time, train students to follow rules and provide useful experience in socialization. Keep games from becoming too competitive.

3. Comparison of traditional and learner-centred instruction

Component of Instruction	Traditional	Learner-centred
1. Setting goals	Based on textbooks	Based on needs assessment
2. Objectives	Based on teacher performance	Based on student performance
3. Students are informed of objectives	Students are not told about the objectives	Students are told about the objectives to guide learning
4. Expected achievement	Based on the normal Curve	Based on criterion reference
5. Mastery	Few students master Most of the objectives	Most students master most of the objectives
6. Grading	Based on comparison with other students	Planned for students who need help
7. Remediation	Often not planned	Planned for students who need help
8. Instructional strategies	Based on teacher preference and Familiarity	Selected to attain the objectives; use of various strategies
9. Evaluation	Norm-referenced	Criterion-referenced; assess student mastery of objectives
10. Revision of instruction and materials	Based on availability of new material	Based on evaluation data and occurs regularly

4. Which skills are life skills?



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- ◀ An adolescent boy points to text during an information session on HIV/AIDS awareness and prevention. Cairo, Egypt.

There is no definitive list of life skills. The list below includes the psychosocial and interpersonal skills generally considered important. The choice of, and emphasis on, different skills will vary according to the topic and local conditions (e.g., decision-making may feature strongly in HIV/AIDS prevention, whereas conflict management may be more prominent in a peace education programme). Though the list suggests these categories are distinct from each other, many skills are used simultaneously in practice. For example, decision-making often involves critical thinking (“What are my options?”) and values clarification (“What is important to me?”). Ultimately, the interplay between the skills is what produces powerful behavioural outcomes, especially where this approach is supported by other strategies such as media, policies and health services.

Interpersonal Communication Skills

- ▶ Verbal/nonverbal communication
- ▶ Active listening
- ▶ Expressing feelings; giving feedback (without blaming) and receiving feedback

Negotiation/refusal skills

- ▶ Negotiation and conflict management
- ▶ Assertiveness skills
- ▶ Refusal skills

Empathy

- ▶ Ability to listen and understand another’s needs and circumstances, and express that understanding

Cooperation and Teamwork

- ▶ Expressing respect for others’ contributions and different styles
- ▶ Assessing one’s own abilities and contributing to the group

Advocacy Skills

- ▶ Influencing skills and persuasion
- ▶ Networking and motivation skills

Decision-making/Problem Solving Skills

- ▶ Information gathering skills
- ▶ Evaluating future consequences of present actions for self and others
- ▶ Determining alternative solutions to problems
- ▶ Analysis skills regarding the influence of values and attitudes of self and others on motivation

Critical Thinking Skills

- ▶ Analyzing peer and media influences
- ▶ Analyzing attitudes, values, social norms and beliefs and factors affecting these
- ▶ Identifying relevant information and information sources

Skills for Increasing Self-Control

- ▶ Self esteem/confidence building skills
- ▶ Self-awareness skills, including: awareness of rights, influences, values, attitudes, strengths and weaknesses
- ▶ Goal-setting skills
- ▶ Self evaluation/Self assessment/Self-monitoring skills

Skills for Managing Feelings

- ▶ Anger management
- ▶ Dealing with grief and anxiety
- ▶ Coping skills for dealing with loss, abuse, trauma

Skills for Managing Stress

- ▶ Time management
- ▶ Positive thinking
- ▶ Relaxation techniques

(Source: unicef.org)

5. Life Skills Techniques

Life skills are those which enable an individual to cope with challenges and threats in the environment, thereby ensuring self-preservation and well-being.

Examples of life skills are:

- ▶ Enhancing self-esteem
- ▶ Reinforcing resistance skills or saying “No”
- ▶ Using responsible decision-making skills

Self-esteem. To have self-esteem is to accept oneself, to be able to admit one’s shortcomings and take responsibility for one’s actions. Self-esteem can be reinforced by parents, teachers and friends. The individual with high self-esteem is most likely to avoid situations that will put him/her at risk for HIV infection.

Some positive “image building statements” to enhance self-esteem:

- ▶ I am ok.
- ▶ I like myself.
- ▶ I am creative.
- ▶ I can learn from others.
- ▶ I can start each day with a smile.

Reinforcing resistance skill or saying “No”. Decisions about sex are a very personal and sensitive matter. Saying “No” in an unwanted situation requires skill. Examples of what one might say:

- ▶ “I like you a lot, but I’m just not ready for sex.”
- ▶ “I don’t believe in having sex before marriage. I want to wait.”
- ▶ “I enjoy being with you, but I’m not old enough for this.”

- ▶ “I don’t have to give you a reason for not refusing. It’s just my decision.”
- ▶ On the other hand, sharing thoughts, beliefs, feelings, and most of all, mutual respect, is what make a relationship wholesome and lasting.

Ways of practising resistance skills:

- ▶ Using assertive behaviour
- ▶ Using nonverbal behaviour that matches verbal behaviour
- ▶ Influencing others to choose responsible behaviour
- ▶ Avoiding situations where there will be pressure to make harmful decisions
- ▶ Resisting pressure to engage in illegal or unlawful behaviour

Responsible decision-making skill. Responsible decision-making skill can be developed by following these steps:

- ▶ Clearly describe the situation or problem
- ▶ List possible actions that can be taken based on the situation/problem
- ▶ Share the list of possible actions with responsible adults
- ▶ Carefully evaluate each action: a responsible action is one that is healthful, safe, legal, and respectful to self and others; consistent with guidelines of parents and teachers; and compatible with good character
- ▶ Decide which action is responsible and appropriate
- ▶ Act in a responsible way and evaluate the results

6. Instructional Media

Instructional media are the physical means by which instruction is delivered to the students. It includes all the traditional means of delivering instruction: chalkboard, books, maps, charts, newspapers and TV broadcasts, slides and films, computers and interactive videos. Examples of visual materials are diagrams, charts, maps, graphs, photographs and cartoons.

Effective instructional media:

- ▶ provide a concrete basis for conceptual thinking
- ▶ have a high degree of interest for the learners
- ▶ help make learning more permanent
- ▶ contribute to growth of meaning and vocabulary
- ▶ make the learner respond actively

Some basic questions in choosing instructional media:

- ▶ Is the media readily available?
- ▶ Is it practical to use?
- ▶ Is it appropriate to student’s characteristics?
- ▶ Is it the best means of presenting a particular instructional activity?

Resource Material 10.2a

Points to Consider in Selecting Teaching/Learning Activities

- ▶ Characteristics of the students
- ▶ Skills of the teacher
- ▶ Content of the lesson
- ▶ Available time to deliver the lesson
- ▶ Available facilities in the school
- ▶ Knowledge, attitudes and skills to develop
- ▶ Methods that are interesting to the students
- ▶ Methods related to the objective(s) and assessment

Tips for Teaching HIV/AIDS Prevention Education

- ▶ Change attitudes and behaviour, and develop communication and interpersonal skills, rather than focusing on disease aetiology.
- ▶ Use strategies to help students cope with stress and fears about AIDS.
- ▶ Use situations to emphasize what to do, which actions to take and the benefits of doing so, as well as the consequences of failing to do so.
- ▶ Deliver clear and consistent health messages through a variety of communication channels.
- ▶ Keep an open mind and continue to explore issues meaningful to the students.
- ▶ Promote creative and collaborative learning by asking students to process new information.
- ▶ Ask students which part of the lesson affected them and why.
- ▶ Ask students which information they will discuss with their friends.

Resource Material 10.2b

Criteria in Selecting Teaching Strategies

- ▶ Select strategies that contribute to total learning. Some strategies lend themselves to acquiring knowledge, while others are better suited to attributes and decision-making. Any strategy selected should actively involve the students.
- ▶ Use more than one strategy to teach complex or difficult concepts. Besides, students learn in a variety of ways and by different means.
- ▶ Begin with a simple strategy and move to more complex ones, as the students become better able to deal with more complex ones. As the students become better able to deal with more difficult concepts, more complex strategies can be used that will require self-discovery or analysis of materials.
- ▶ Instructional aids should be included whenever possible. They are excellent for reinforcing learning.

Resource Material 10.2c

Criteria in Choosing and Using Media

1. Do they give a true picture of the ideas they represent?
2. Do they contribute to the meaning of the topic under study?
3. Is the media appropriate to the age, intelligence and experience of the learner?
4. Do they make the learners become better thinkers and critically minded?
5. Is the material worth the time, expense and effort involved?

Resource Material 10.3

Skills-based Health Education in the Context of HIV/AIDS and STI Prevention

1. Why Skills-based Health Education?

The application of skills-based health education - in particular, life skills - to areas such as HIV/AIDS prevention, reproductive health, early pregnancy prevention, violence, tobacco and substance abuse is becoming increasingly widespread. In areas such as these, individual behaviour, social and peer pressure, cultural norms and abusive relationships may all contribute to the health and lifestyle problems of children and adolescents. There is now increasing evidence that in tackling these issues and health problems, *a skills-based approach to health education works*, and is more effective than teaching knowledge alone.

There are numerous studies indicating that providing information about issues such as sex, STIs and HIV (transmission, risk factors, how to avoid infection) is necessary, but not sufficient, to lead to healthy behavioural change (Hubley, 2000). Programmes that provide accurate information, to counteract the myths and misinformation, frequently report improvements in knowledge and attitudes, but this is poorly correlated with behavioural change related to risk-taking and desirable behavioural outcomes (Gatawa 1995, UNAIDS 1997a). Skills-based health education can be effective in the more difficult task of achieving and sustaining behaviour change.

HIV/AIDS – A Critical Need for Skills-based Health Education

HIV/AIDS is an area where the scale and impact of the problem is such that the urgency of implementing preventative measures, including skills based health education, is critical. Skills based health education programmes are being increasingly adopted as means of reaching children and young people to help halt the spread of this crippling epidemic. Studies from African countries show that children between the ages of 5 and 14 have the lowest prevalence of HIV infection. Below the age of 5 they are susceptible to mother-to-child transmission and, after they become sexually active, the rate of infection increases rapidly – especially for girls (Kelly, 2000). Children aged 5-14 need to be reached at this critical stage in their lives and to open the 'window of hope' in stopping the spread of HIV/AIDS.

2. Skills-based Health Education Does Change Behaviour

There is now strong evidence from an increasing number of studies that skills based health education, applied in an appropriate context, changes behaviour – including behaviour in sensitive and difficult areas where knowledge-based health education has failed.

3. Context for Implementing Skills-based Health Education with HIV/AIDS Prevention

Although there is strong evidence that skills-based HIV/AIDS prevention is effective when properly applied and supported, implementing this approach and achieving this success on a larger, countywide scale is one of the greatest challenges to be faced. To be effective, HIV/AIDS prevention programmes must address the following areas:

- ▶ **Reassure stakeholders that these messages are beneficial:** Talking and teaching about reproductive health and HIV/AIDS issues does not result in earlier initiation of sex or promiscuity. The evidence suggests that well implemented skills-based programmes, conducted in an atmosphere of free discussion of all the issues, is likely to lead to young people delaying the initiation of intercourse and reducing the frequency of intercourse and number of sexual partners (Kirby *et al.* 1994, UNAIDS 1997a).
- ▶ **Provide support to teachers:** The lack of support for implementation of new programmes is one of the most important factors affecting success. For most teachers, both the content and methods of HIV/AIDS prevention programmes are new and perhaps sensitive, and yet the approach has great potential to assist teachers both in their work and also their personal lives since HIV/AIDS is, of course, also affecting teachers. Sufficient support, training, practice and time needs to be available to teachers, in both pre- and in-service training sessions and workshops, to facilitate reflection and development of their own attitudes, and to motivate them to apply their new knowledge and skills, rather than continue with the more didactic, traditional teaching methods, which are often focused on information alone (Gatawa 1995, Gachuhi 1999). In addition, sufficient time and an appropriate place must also be given in the curriculum so that *all students* have access to HIV/AIDS prevention.
- ▶ **Start early:** As well as targeting adolescents, programmes need to be targeted at children at an early age, with developmentally appropriate messages, before they leave school (Gachuhi 1999, Partnership for Child Development 1998). Because younger children are generally not sexually active, these programmes will address the building blocks for healthy living and avoiding risk, rather than the very specific issues related to sexual relationships and HIV/AIDS which are progressively introduced to programmes for older ages. However, the large number and diverse age range of children within primary schools is an enduring challenge, especially when addressing sensitive issues (Partnership for Child Development 1998). Active and self-directed learning methods which are commonly used in skills-based health education can be helpful in overcoming these classroom management issues to some extent.
- ▶ **Provide a supportive environment:** Schools need to have strong policies and a healthy supportive environment in terms of behaviour of students towards each other, teachers and school personnel. Sexual abuse can occur in schools, with both boys and girls reporting abuse by school staff (Kinsman *et al.* 1999, Lowensen *et al.* 1996). Programmes need to address this potential problem by training and supporting teachers so that they can become role models rather than neutral or adverse figures in relation to sexual behaviour.



- ▶ **Respond to local needs:** Many of the models for HIV/AIDS prevention have been developed in western, developed countries. The available evidence from developing countries, although more limited in scope than the studies from non-developing countries, supports skills-based health education for HIV/AIDS and reproductive health (Hubley, 2000). The main issue is that wherever programmes are to be implemented, they must be shaped to meet the local socio-cultural norms, values and religious beliefs, and need to include ongoing monitoring (Kirby et al 1994, UNAIDS 1999, Kinsman *et al.* 1999).

4. Elements of a Skill-based Health Education for HIV/AIDS Prevention

Reviews of school-based HIV/AIDS prevention programmes (23 studies in the USA: Kirby *et al.* 1994), 37 other countries (reported by UNAIDS, 1999) and 53 studies in USA, Europe and elsewhere (UNAIDS, 1997a) have identified the following common characteristics of successful programmes:

- ▶ Focus on a few *specific behavioural goals*, (such as delaying initiation of intercourse or using protection), which requires knowledge, attitude and skill objectives
- ▶ Provision of *basic, accurate information* that is relevant to behaviour change, especially the risks of unprotected intercourse and methods of avoiding unprotected intercourse
- ▶ Reinforcement of *clear and appropriate values* to strengthen individual values and group norms against unprotected sex
- ▶ Modelling and practice in *communication and negotiation skills* particularly, as well as other related “life skills”
- ▶ Use of *Social Learning theories* as a foundation for programme development
- ▶ Addressing *social influences* on sexual behaviours, including the important role of media and peers
- ▶ Use of *participatory activities* (games, role playing, group discussions etc.) to achieve the objectives of personalising information, exploring attitudes and values, and practising skills
- ▶ *Extensive training* for teachers/implementers to allow them to master the basic information about HIV/AIDS and to become confident with life skills training methods
- ▶ *Support* for reproductive health and HIV/STIs prevention programmes by school authorities, decision- and policy makers, as well as the wider community
- ▶ *Evaluation* (e.g. of outcomes, design, implementation, sustainability, school, student and community support) so that programmes can be improved and successful practices encouraged
- ▶ Age-appropriateness, targeting students in different age groups and developmental stages with appropriate messages that are relevant to young people; for example, one goal of targeting younger students who are not yet sexually active might be to delay the initiation of intercourse, whereas for sexually active students the emphasis might be to reduce the number of sexual partners and use condoms
- ▶ *Gender sensitive*, for both boys and girls

5. The Way Forward

Skills-based health education, promoted in a supportive framework such as that offered by the FRESH schools initiative, offers an effective approach to equipping children and young people with the knowledge, attitudes and skills that they need to help them avoid risk-taking behaviour and adopt healthier lifestyles. The scope of skills-based health education means that it can be applied to a wide range of areas, especially STIs and HIV/AIDS prevention, but also including violence; substance abuse; early pregnancy; water and sanitation-related diseases; and all areas where knowledge, attitudes and skills play a critical role in combating disease and promoting a healthy lifestyle for children and young people growing up in the 21st Century.

MODULE ELEVEN

Assessment Tools for Use in HIV/AIDS Prevention Education

Approximate Time: 5 hours 30 minutes

Module Message: Assessment tools are used in making students take the responsibility for their own learning. Designing assessment tools based on clearly defined objectives is a skill required from an effective teacher. In this activity, the teacher participants will identify indicators for student assessment, review criterion-referenced testing; tools for testing knowledge, attitudes and skills; purposes of testing; principles and rules for constructing tests; and pre-testing and post-testing.

Overview: Skills-based HIV/AIDS/STIs education requires that teachers continually evaluate their efforts through its effects on the students. Unlike in other subjects, HIV/AIDS/STI education requires students' knowledge, skills and attitudes be measured in slightly different ways because the purpose of this education is to help children avoid HIV/STIs infection and develop life skills. Evaluations require assessments tools for process indicators and outcome indicators. Teachers must consider the major indicators at programme-, teacher- and student levels.

A successful teacher should first develop a list of indicators for use at various levels and develop appropriate tools for assessment. Overall questions are crucial for assessing the students' HIV/AIDS/STIs knowledge, skills and attitudes.

Assessment tools refer to the different ways students can demonstrate that they have mastered the objectives. These include tests and other subjective instruments. Tests often refer to objective and essay tests. Other tools are rating scales, checklists, and questionnaires. Assessment tools are designed based on clearly stated objectives. To construct valid assessment tools, certain principles and rules must be observed.

In HIV/AIDS Prevention Education, assessment should not be limited to knowledge or cognitive domain, but must also be concerned with the formation of attitudes, values and life skills among the students. Therefore, the choice and use of the most appropriate tool for a particular grade level or group of learners is important.

The purpose of this module, however, is to help the participant school teachers: revisit their knowledge and skills in test construction; develop self-assessment tools the students can use in assessing their knowledge, attitudes and skills; and assess the strengths and weaknesses of the different types of tools.

Though students' assessment in school plays a role in their grades and promotion, their assessment of knowledge, skills and attitude on HIV/AIDS/STIs should be done on a continuous basis. For teachers, it is more appropriate

to assess without giving marks. Perhaps your purpose is to establish baseline data as in the case of a pre-test. You also want to help the students in their subsequent learning, and to tell them what they have already learned. After this module, you should be able to make different types of assessment tools.

Objectives:

After studying the module, the teachers should be able to:

1. Explain the importance of students' assessment in HIV/AIDS STIs prevention education
2. Describe the importance of criterion-referenced tests
3. Identify indicators that should be considered while testing on aspects of HIV/AIDS/STIs prevention
4. Follow the principles and rules for assessment tools construction, and for assessment of students
5. Design model tests for HIV/AIDS prevention education
6. Review various assessment tools for testing knowledge, attitudes and skills
7. Write sample tests on HIV/AIDS prevention education

Content Outline:

1. Indicators for student's assessment on HIV/AIDS/STIs education
2. Criterion-referenced tests
3. Steps in designing good tests
4. Kinds of assessment tools
5. Principles and rules for assessment tools construction

Evaluation:

Based on your learning experience in designing assessment tools, write two paragraphs. Start with any one of the following introductory phrases:

1. I am beginning to wonder...
2. I was surprised...
3. I now believe...
4. I have become more skilful at...
5. I am pleased that I...

Learning Activities:

1. Brainstorming on identifying indicators
2. Panel discussion: "Assessment Tools for Use in HIV/AIDS Prevention Education"
3. Workshop: "Designing Assessment Tools for HIV/AIDS Prevention Education"



Facilitator's Notes:

1. Provide the following instructions to conduct the icebreaker, "Rock, Paper, Scissors":
 - ▶ Divide the participants into two groups.
 - ▶ Inform them that each group should work in confidence.
 - ▶ Within each group, individual members are free to select one out of three word names - Rock, Paper, or Scissors - but the group should come to consensus.
 - ▶ When each member makes a decision, ask the group leader to write everyone's choices on a piece of paper.
 - ▶ Have both groups come to the front of the classroom and alternately announce one choice.
 - ▶ Groups will be scored on the following basis:
 - i. If one group says "scissors" and the other "stone," the stone group scores 1 point.
 - ii. If one group says "scissors" and the other "paper," the scissors group scores 1 point.
 - iii. If one group says "paper" and the other "stone," the paper group scores 1 point.
 - iv. If both groups say the same thing, the game will be a draw, and neither group will score.
 - v. You can repeat this activity for some time and decide a winner.
 - vi. The winning group should receive a prize.
2. While carrying out this module, the facilitators should pay attention to the following:
 - ▶ Assessment tools may be objective or subjective depending on design and purpose.
 - ▶ There are several assessment tools for testing knowledge, attitudes and skills, such as multiple choice tests, checklists, observation forms and performance guides.
 - ▶ Certain principles and rules determine proper assessment tool construction.
 - ▶ A valid test is one that measures what is stated in the objectives.
 - ▶ Assessment should be used to follow-up progress in the attainment of the objectives.
 - ▶ Similar tests can not be used for students of all grades.

ACTIVITY 11.1

Indicators for Assessing Students Outcomes in HIV/AIDS Prevention Education

Approximate Time: 1 hour 30 minutes

Materials: Chart paper, markers, glue stick

Preparation: Guidelines for discussion (see Resource Material 11.1 Appendix A)

Introduction: Designing assessment tools based on clearly defined objectives is a skill that is required of an effective teacher. In this activity, the teachers will review criterion-referenced testing; tools for testing knowledge, attitudes and skills; purposes of testing; principles and rules for constructing tests; and both pre- and post-testing.

Objectives: After this activity, the teachers should be able to:

1. Prepare a list of indicators to assess the students knowledge, skills and attitudes in relation to HIV/AIDS prevention education
2. Describe why it is important to identify the indicators before developing assessment tools

Content Outline:

1. Individual assignment and brainstorming for identifying student assessment indicators

Procedure:

1. Distribute 2-3 cards to all participants and ask: (10 minutes)
 - ▶ *What specific knowledge, skills and behaviours should be assessed on to ensure effectiveness of HIV/AIDS/STIs prevention and sex education?*
2. Collect the cards, read each point loud and clear, and ask whether they agree or not. Ask participants to explain, if necessary. (30 minutes)
3. Remove unnecessary cards from the chart paper.
4. Divide the participants into three groups and distribute the outline given in **Resource Material 11.1 Appendix A**. Ask them to briefly discuss whether they would like to revise the points suggested for assessing testing students. (30 minutes)
5. Summarize the outcomes of discussion and presentation. (15 minutes)

Evaluation: Ask the participants to write about what they achieved from the activity on identifying the student assessment indicators. (5 minutes)

Learning Outcomes: A list of indicators (knowledge, skills, behaviours and attitudes) to be covered in student assessment

Facilitator's Note: Develop a list of indicators on your own to test participants' knowledge, (life skills), values and attitude after this activity

ACTIVITY 11.2

Developing Assessment Tools for Use in HIV/AIDS Prevention Education

Approximate Time: 1 hour

Materials: Resource Materials 11.1 “Assessment Tools for Use in HIV/AIDS Prevention Education,” 11.1a “Steps in Designing Good Tests,” 11.1b “Advantages and Disadvantages of Using Specific Assessment Tools”; handout from the resource person

Preparation:

1. Invite 2-3 resource people who are experts on the subject matter to be panelists. Invite them several days before the panel discussion.
2. Ask participants to prepare questions that they may want to ask regarding assessment tools and tests. (Do this several days before the panel discussion.)
3. Submit these questions to the resource people to guide them during the discussion.
4. Among the teacher participants, ask for three volunteers to form a second panel that will ask questions and raise issues during the discussion. However, other participants in the audience may also ask questions whenever they wish.
5. Let another volunteer serve as moderator.
6. Arrange the training room with the two panels in front.

Objectives: After this activity, participants should be able to:

1. Describe the principles and rules for test construction
2. Explain the use of criterion-referenced tests
3. Prepare a list of various assessment tools used for testing
4. Describe the strengths and weakness of each type of tool
5. Design a good test on HIV/AIDS prevention education

Content Outline:

1. Presentation and discussion led by the resource people on “The Principles and Rules for Test Construction”
2. Criterion-referenced testing
3. Tools for assessing knowledge, attitudes and skills
4. Design a good test on HIV/AIDS prevention education

Procedure:

1. Make sure that you are now prepared for the panel discussion.
2. Ask the resource people and the participants who will ask the questions to sit at their respective panel tables.
3. Ask the moderator to sit between the two panels.
- 4.. Start the discussion by asking the moderator to briefly introduce the members of both panels. (30 minutes)
5. Let the resource people speak, followed by questions from the panel of teachers, then from the audience. (15 minutes)
6. Let the moderator facilitate the open forum.
7. Ask the moderator to summarize the result of the discussions and thank all who contributed to the success of this activity. (10 minutes)

Evaluation:

Based on the learning experience from the panel activity, ask the participants to explain briefly the highlights of the discussion by starting with any one of the following: (5 minutes)

1. I now believe...
2. I was surprised...
3. I am pleased...
4. I have become more skilful at
5. I am beginning to wonder

Learning Outcomes:

Preparation of assessment tools for testing knowledge, attitudes, and skills separately, and assessment tools to assess knowledge, attitudes and skills together

ACTIVITY 11.3

Developing Assessment Tools for Use in HIV/AIDS Prevention Education

Approximate Time: 3 hours

1. Preparation of: 11.1 “Assessment Tools for Use in HIV/AIDS Prevention Education,” 11.1a “Steps in Designing Good Tests,” 11.1b “Advantages and Disadvantages of Using Specific Assessment Tools,” 11.1c “Rules for Test Construction” and 11.2 “Teacher’s Creative Resource Book on HIV/AIDS Prevention Education” (Sample Cover).
2. Ask participants to bring the outcomes of Activity 11.2

Objectives: After this activity, participants should be able to:

1. Critique the assessment tools they have previously prepared in their lesson plan
2. Design assessment tools for school-based HIV/AIDS prevention education

Content Outline:

1. Brainstorming on the strengths and weaknesses of their existing practices on tools development
2. Principles and rules for assessment tool construction
3. Application of knowledge and skills on preparing assessment tools for testing knowledge, attitudes and skills
4. Development of tools to assess different aspects of students’ knowledge, skills and attitude on HIV/AIDS/STIs
5. Criteria for assessing good testing items

Procedure:

1. First, divide the participants into three groups and discuss the basis for the following questions: (30 minutes)
 - ▶ *What testing tools did participants use in school to assess HIV/AIDS/STIs knowledge and skills?*
 - ▶ *What aspects of assessment did they stress ?*
 - ▶ *What steps did they follow when developing the tools?*
 - ▶ *How did they interpret the assessment results?*
 - ▶ *What are the strengths and weaknesses of their existing assessment practices?*
2. Ask each group to give a brief presentation on the outcomes of its discussion. (10 minutes each)
3. Divide the participants into the six groups noted below and ask them to develop tools for student testing of HIV/AIDS/STIs knowledge, skills, attitudes and behaviours. (40 minutes)



- Group 'A'** Pre-test/post-test
- Group 'B'** Objective tests: multiple choice, fill in or completion, matching and true false
- Group 'C'** Short answer and essay questions
- Group 'D'** Observation, rating scale and checklist
- Group 'E'** Anecdote and questionnaire
- Group 'F'** Group for discussion, brainstorming and case studies

4. Have each group give a short presentation. (10 minutes each)
5. Allow for discussion and make points to revise the tools they prepared. (20 minutes)

Evaluation:

Ask selected participants to summarize the presentations and outcomes of discussion.

1. A collection of assessment tools such as multiple choice test, true/false, fill-in, matching, short answer, essay, checklist, rating scale, questionnaire, etc. for use in HIV/AIDS Prevention Education.
2. A collection of lesson plans with their revised assessment tools/tests.
3. Make a **Teacher's Creative Resource Book on HIV/AIDS Prevention Education**. This is a collection of articles; lesson plans; teaching methods and techniques; assessment tools; journal articles, notes, etc.

Facilitator's Notes:

1. If there are not enough participants to form groups, you may ask to do the work on a team of two persons. The tools to be developed should be a sample specific to assessing students' HIV/AIDS/STIs knowledge, skills and attitudes.
2. Provide the following clear instruction to the participants:
 - ▶ *The assessment tool should clearly state its (1) purpose; (2) area/s covered; and (3) weight of each item.*
 - ▶ *The tool should give clear and simple directions.*
 - ▶ *Each item is based on clearly stated objectives.*
 - ▶ *The items should not confuse or trick the students.*
 - ▶ *Each item should not be too long, which can confuse the students.*
 - ▶ *Each item is free from technical errors and irrelevant clues.*
 - ▶ *Each item is free from racial, ethnic and sexual bias.*

Resource Material 11.1

Assessment Tools for Use in HIV/AIDS Prevention Education

Introduction:

Students are usually afraid of tests. Assuming that the test items are, nonetheless, based on the lesson at hand and that the purpose of the exercise is well understood by the learners, the choice of an assessment tool and the manner in which it is designed is critical to the teaching-learning process. Following are some guidelines on the use of assessment tools, in general. Reference to HIV/AIDS prevention education is included in the resource material.

Criterion-reference testing:

A recent approach to assessing and testing is to design tools that are based on clearly stated knowledge and skill objectives. The tests are made to measure the ability of the students to attain the objective. This type of test is called objective-referenced or criterion-referenced test. It is based on the individual student's achievement vis-à-vis an external parameter, rather than the relative distribution of scores of other students (norm-referenced measurement).

Both criterion-referenced and norm-referenced tests may appear similar in content as “multiple-choice” or “true and false” types, but the main difference lies in the interpretation of results.

Here, the ability of the learner is measured in terms of the attainment of the objectives; that is, the test items should match the objectives. The learner is aware of what is important to study because there is congruence between instructional objective and assessment of instruction. Thus, the methods of assessment and the tools used serve many functions, such as to measure and diagnose, and for feedback and remediation.

Examples of assessment tools for knowledge objectives are:

- Multiple choices
- Fill-in
- Short answers
- True-false
- Matching
- Essay

Examples of assessment tools for attitude objectives are:

- Interviews
- Observations
- Rating scale
- Surveys
- Anecdotes
- Inventories

Examples of assessment tools for skills are:

- Problem solving
- Checklist
- Rating scale
- Observation
- Discussion
- Questionnaire

Examples of assessment tools to assess knowledge, attitudes and skills are:

- Projects
- Case studies
- Portfolio
- Assessment



Purposes of assessment:

- ▶ To assess the effectiveness of the learning activities
- ▶ To motivate the students
- ▶ To ascertain the quality and speed of student progress
- ▶ To grade student performance
- ▶ To identify the value and relevance of the content to the behaviour change of the students
- ▶ To undertake necessary remedial measures

Principles of constructing assessment tools:

The objective must convey very clearly what is to be measured and indicate how the measurement is to bring about learning. Tests are used to determine whether learning occurred.

Some principles to be followed in assessment tool construction:

- ▶ The tool should constitute a fair representative sample of the lesson.
- ▶ The tool should clearly state the purpose of the test, areas covered, and weight of each item.
- ▶ The test items should be clear and ambiguity should be avoided.
- ▶ The test items should not “trick” or confuse the students.
- ▶ The tool should give very clear directions and instructions.

Please refer to **Resource Material 11.1a** on the “Advantages and Disadvantages of Using Specific Assessment Tools” and **Resource Material 11.1b** on “Rules for Test Construction.”

Testing knowledge:

Acquisition of knowledge is the basis for learning the other levels of the cognitive domain. The six levels are knowledge, comprehension, application, analysis, synthesis and evaluation. The action verb used in the objective indicates the possible test item to write. Here are some examples:

Objectives	Tests
■ To identify _____	Multiple choice, list
■ To list _____	Fill in the blank, enumerate
■ To describe _____	Essay
■ To solve _____	Compute for the answer
■ To construct _____	Rating scale, checklist
■ To predict _____	Multiple choice, essay

Observing and testing attitudes:

Feelings, values and beliefs are difficult to assess because of their personal nature. One can only make inferences from the students’ words and actions. However, the responses of the students may not reflect their true feelings, and the outcome of instruction may come much later than the time the subject or topic is completed. Some uses of attitude assessment:

- ▶ Attitude outcomes measure how much attitudinal change has occurred after instruction.
- ▶ Instruction is determined by asking students what they like or do not like, and by soliciting suggestions for improvement.

Attitude assessment is very relevant in HIV/AIDS prevention education. It tells how people feel about each other, places things or ideas. Attitudes involve feelings. Values and appreciation are not easily measured by objective tests. Other common assessment tools are attitude scale observations, anecdotal record, questionnaire, checklist, survey, rating scale and interview guide.

Attitude scales require students to choose between alternatives on a continuum. Examples are the forced-choice scale, such as yes/no or agree/disagree. This scale provides only two options about each statement.

Likert scale provides a range of choices about an attitude issue. For example:

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. Relatives should take care of their AIDS patient.					
2. I am afraid I will contract AIDS later in life.					

Scoring is done depending on how the statements are formulated. The continuum of responses may be given weights from one to five, with the lowest score for “Strongly Agree” statements. If the student checks “Strongly Agree” on Item 1 above, the score will be fine. The scoring is reversed for negative statements such as Item 2, thus, the “Strongly Disagree” response gets a score of five. Attitude scales should not be used for grading purposes, because the scales can further bias the responses of the students.

Observation may be used to supplement attitude scales. Observation is an excellent way of assessing behaviour. It can provide important clues about attitudes.

Anecdotal recordkeeping goes hand-in-hand with observation. Both observation and anecdotal recordkeeping are subjective techniques.

Checklists can be useful in evaluating student behaviour and learning activities. The checklist allows the teacher to note quickly and effectively whether the characteristic is present.

Portfolio Assessment is like a file cabinet which has different files in each drawer. Each file contains evidence of learning: one drawer for written work, one for media, another one for projects, art work, etc. Teaching students how to organize their work is a thinking skill. The portfolio is a day-to-day, week-by-week collection of students’ best work in the subject.

Testing skills and behaviour:

To assess skills and behaviour, we have to observe students’ actions and how they carry out a particular task. The standards of performance are based on the instructional objective and activities. The student has the opportunity to practise and apply the skills by demonstrating learning

Pre-testing and post-testing:

Pre-testing and post-testing are used to assess learners' entry knowledge, attitude or skills on a subject or unit of study.

- 1) to assess a learner's level of ability in the subject or topic
- 2) to determine which competencies in the subject or topic the learner has already mastered
- 3) to know how much improvement has occurred after instruction is completed

Benefits of pre- and post-testing are:

- ▶ Alerting the students to what they do and do not know about the topic
- ▶ Indicating the remedial work to be done before the start of instruction
- ▶ Motivating students to study what they do not know
- ▶ Providing baseline data for determining behavioural change by comparing the pre- and post-tests
- ▶ Giving the teacher the opportunity to modify the lesson and start at the point of student readiness
- ▶ Taking time away from instruction
- ▶ Motivating learners to concentrate too much on what they do not know and neglect the other topics
- ▶ Creating negative feelings among students who get very low scores; to avoid this situation, be sure that they understand the purpose of the pre-test and that it will not affect their grades

Summary:

1. Assessment tools may be objective or subjective depending on their design and purpose.
2. Objective tests are limited primarily to testing recall.
3. A valid test is one that measures what is stated in the objective.
4. Assessment should be used for positive reasons.
5. Assessment tools should be associated with objective achievement.
6. Combinations of assessment techniques give a better indication of the learner's performance and level of achievement vis-à-vis the expected results of the teaching-learning process.

Resource Material 11.1a

1. Prepare the table of specifications based on the instructional objectives.
2. Draft the test items.
3. Decide on the length of the test
4. Select and edit the test items
5. Arrange the items in the order of difficulty from easy to the most difficult.
6. Prepare the instruction of the test and answer key.
7. Duplicate the test.

Resource Material 11.1b

Advantages and Disadvantages of Using Specific Assessment Tools

True/False Test: It consists of statements that are either true or false. Students must decide about each item and answer accordingly.

Advantages

1. It can sample a wide range of subject matter.
2. It is easy to score, and the score is objective.
3. It can be used in quizzes, lesson review and end-of-the-lesson testing.
4. It can be useful when there are only two positions in an issue.

Disadvantages

1. It encourages guessing.
2. It is often difficult to construct completely true or false statements.
3. It is difficult to avoid clues, ambiguities or details.
4. Minor details are given much credit as items.

Multiple Choice Questions (MCQ) Test: This test provides an opportunity to develop thought-provoking questions. It provides wide coverage of instructional materials. It is considered the best short-answer test.

Advantages

1. The items can be constructed to measure recall.
2. The items can be written to measure inference, judgment and discrimination.
3. It can cover the instructional material extensively.
4. It can be scored objectively and rapidly.

Disadvantages

1. The construction of the test is time-consuming.
2. Factually-based items can stress memorization.
3. More than one response may be nearly correct.
4. Alternative and plausible answers are often difficult to make.
5. The format does not allow students to express their own thoughts.

Matching Test: This test is a form of multiple-choice test, except that the numbers of choices are many.

**Advantages**

1. It is adaptable to many topics.
2. It can be developed fairly quickly.
3. The format uses space economically.
4. It is easy to score.

Disadvantages

1. It tests only factual information.
2. It permits guessing.
3. It is likely to include clues to the correct answers.
4. It increases difficulty as the number of items to be matched increases.

Completion Test: This type of test measures the student's ability to select a word or phrase that is consistent in logic and style to the statement.

Advantages

1. It is easy to construct.
2. It minimizes guessing because the answer must come from the student.
3. It has a wide use in testing situations, diagrams or charts.
4. It allows for objective scoring.

Disadvantages

1. It stresses factual information.
2. It may give premium to rote memory rather than real understanding.
3. Alternative answers provided by students maybe very close to the correct answer, making scoring problematic.
4. Clues can allow students to guess the answer.

Essay Test. The use of this test allows the student to organize information in a systematic way. It also gives the teacher an insight into the students' understanding of the lesson.

Advantages

1. Originality and creativity of the students are encouraged.
2. It stimulates students to organize their thinking.
3. The chance of cheating is minimized.
4. Guessing is reduced to a minimum.
5. It can provide answers that reflect students' attitudes, values and skills.

Disadvantages

1. Scoring can be subjective.
2. Scoring is time consuming.
3. Students with poor writing skills are at a disadvantage.
4. It can sample only a limited amount of the materials covered.

Resource Material 11.1c

Rules for Writing Test Items

General Rules

- Be careful not to provide clues to the correct answer.
- Avoid dependent items where one item clues the answer in another item.
- Avoid negatives.
- Avoid unnecessary difficulty, such as use of obscure vocabulary.
- Avoid direct quotations.
- Do not call for trivial, obvious, ambiguous, or meaningless answers.
- Each item should have only one correct answer.
- Use illustrations appropriately and accurately and make them clear.
- Follow the rules of grammar and syntax.
- Avoid items that give away the answer.
- Avoid complex sentence structure.

Multiple-Choice Items

- Make the stem a direct question
- Ask one definite question.
- Avoid making alternatives obviously different.
- Present alternatives in logical order.
- Avoid making correct alternatives systematically different.
- Present alternatives in logical order.
- Make response alternatives mutually exclusive and of a similar length.
- Make response alternatives plausible but not equally plausible.
- Use “None of the Above” seldom and with caution.
- Make options and the stem grammatically parallel and consistent.
- Present the term in the stem and definitions as options when testing knowledge of terminology.
- Avoid requiring personal opinion unless on attitude survey.
- Avoid redundancy in alternatives by stating once in the stem.
- Use “all of the above” option when there are several correct answers, not a best answer.
- Put as much of the problem as possible into the stem.



Matching Items

- Use response categories that are related but mutually exclusive.
- Keep the number of stimuli small and have the number of responses exceed stimuli by 2 or 3.
- Present response in logical order (e.g., alphabetically, chronologically).
- Explain the basis for matching; give clear directions.
- Avoid “perfect” matching by including one or more implausible responses.
- Use longer phrases in the response list, shorter in the stimuli list.
- Identify stimuli with numbers and responses with letters.
- Keep everything relating to an item on a single page.
- Make stimuli and response columns similar in level of difficulty.
- Avoid using complete sentences in stimuli column; use phrases or words instead.

True/False, Constant Alternative Items

- Be sure the item is definitely true or false.
- Avoid determiners such as “always,” “often.”
- Use approximately the same number of words in each statement.
- Avoid quotations or stereotypes.
- Don’t present items in a pattern.
- Use quantitative language when possible.
- Place crucial elements at the end of the sentence.
- Instead of “true/false,” you can use “yes/no,” “right/wrong,” “correct/incorrect,” “same/opposite.”
- Phrase items unambiguously.

Short Answer, Completion, or Supply Items

- Word items specifically and clearly.
- Put the blank towards the end of the sentence.
- Use only one blank in a sentence.
- Avoid quoted or stereotyped statements.
- Require short, definite, explicit answers.
- Provide the terms and require the definition rather than vice versa.
- Specify the terms in which the response is the given, e.g., word, phrase, sentence inches, feet.
- Use direct questions rather than incomplete declarative sentences.

Essay Items

Focus the type of response you wish the student to make.

Clarify limits and purposes of questions.

Avoid optional questions.

Word question so experts can agree on correct response.

Use more than one essay question.

Set up a systematic scoring procedure.

Application or Problem Solving Items

Use new or novel test materials.

Use introductory materials followed by item dependent on that material.

Call for identifying or producing examples.

Call for identifying or producing examples.

Test ability to use materials.

Use pictures or diagrams for testing.

Use reading material for testing.

Allow for creativity.

Resource Material 11.2

(Sample Cover)

UNESCO

**Creative Teacher
Resource Book on
HIV/AIDS
Prevention
Education**

Name of Teacher _____

School _____

APPENDIX A

- How effective was the delivery of curricula?
- Did all students take part in the course effectively?
- Have students' knowledge, attitudes and skills change as intended?
- Was the instructional method learner-centred and effective for students? What were the reasons?
- To what extent have teachers been satisfied with the ways they are delivering knowledge, attitudes and skills?
- Did the students actively participate in the design, delivery and evaluation of the programme?
- Were the students satisfied?
- Did the learning outcomes of students improve as a result of the school-based HIV/AIDS/STIS instruction?

Taking Action: A Lessons Learned Checklist

In conclusion, here is a checklist of actions that participants should now be empowered to take through their completion of this teacher training programme:

- Communicating methods to reduce the risk of acquiring HIV/AIDS and STIs
- Identifying behaviours and attitudes that help reduce HIV/AIDS/STIS infection
- Explaining the ways that HIV/AIDS/STIs is not transmitted
- Demonstrating how to use condoms, and explaining the importance of doing so
- Describing HIV/AIDS/STIs impact at the individual, family, community and national levels
- Identifying programmes available at community and national level that care for PLWHA
- Explaining how knowledge, behaviours, and life skills on reproductive health help prevent risk behaviours
- Explaining the consequences of various risk behaviours/early pregnancy/other...
- Supporting students who intend to “wait” to have sex until marriage – self protecting behaviour
- Helping students share their feelings and experiences with peers, family, school
- Encouraging students to share feelings towards those affected/infected by HIV/AIDS
- Soliciting student beliefs about how to reduce their risk of HIV/AIDS and STIs
- Developing students’ ability to apply life skills to hypothetical or practice situations related to HIV/AIDS/STI risk and discrimination (e.g., through unfinished sentences, scenarios, short answers, story telling, ranking, role play, etc.)
- Building students’ confidence to apply the skills to real life situations
- Ensuring through correct instruction that students can communicate well with peers, teachers, parents, others; refuse undesired sex; resist pressure to use drugs; refuse unprotected sex; insist on/negotiating protected sex; identify personal risk level; act on human rights issues, such as acting against discrimination; identify consequences of decisions and actions; weigh up pros and cons of decisions about early pregnancy or other risk situations; demonstrate correct condom use in hypothetical situations; seek a trusted person for help; and, if needed, identify and utilize health services

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