

## Session 1.1 – Introduction

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### **Aim**

To introduce the participants to each other and to the course programme

### **Outcome of this session**

By the end of this session participants will have:

- Been welcomed and introduced
- Discussed their expectations
- Reviewed the training objectives and the programme
- Discussed norms and logistics for the training

### **Key points**

1. Participants know each other by name
2. Participants expectations are discussed in relation to objectives of the training
3. Ground rules are established and tasks assigned

### **Materials and handouts**

1.1.1 Programme and objectives of the training

## Handout 1.1.1 Programme and objectives of the training Peer education and behaviour change communication

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Overview of workshop goal, objectives and methodology

### GOAL

To build capacity of trainers of peer educators in designing and delivering a peer education training programme and in developing strategies for behaviour change communication.

### OBJECTIVES

At the end of the training the participants are able to:

1. Guide different target groups to develop a peer education strategy based on a common understanding of the nature and purpose of peer education, its benefits and its limits
2. Use effective strategies to reach intended target groups and to select, motivate, train and supervise peer educators
3. Display non discriminatory values and attitudes related to STI/HIV/AIDS, drug use, commercial sex work, MSM and use the right language and (gender) sensitivity to discuss these issues
4. Use participatory techniques, group working skills and skills based education to work with peer educators
5. Develop peer education strategies as part of a wider programme (access to Sexual and Reproductive Health care, condom promotion, harm reduction) including linkages to referral stakeholders/institutions and information resources
6. Develop a strategy for behaviour change communication that is based on an assessment of the intended target audience

### METHODOLOGY

*Peer education is supposed to be strictly non-directive, aiming to promote the empowerment of target audiences through providing them with contexts in which they can generate their own solutions to the health risks at hand.*

The workshop will apply adult learning principles. It will use a variety of participatory methods and techniques that will draw upon the experience that each person brings to the workshop. These will include:

- individual and group work
- readings
- oral presentations with interactive discussion
- overhead projections, videos and handouts
- exercises in groups and in plenary

### TARGET GROUP

Trainers from consortium member NGOs

## **Participant notes: Day 1**

### **ADMISSION REQUIREMENTS**

- Member of the target group
- In accordance with the selection criteria proposed by the consortia and the TAMEER project

### **COURSE DURATION**

The course will take 5 days

### **RESOURCE REQUIREMENTS**

Human resources:

- Two facilitators
- Preparation and reporting time for at least one of the facilitators

Material resources:

- Participant files
- Facilitator files
- Flip chart stand, flip charts, pens of different colour
- Overhead projector
- Coloured cards
- Tape
- Rubber bands
- Stapler
- Paperclips
- Scissors
- Puncher

Physical resources:

- Venue
- Four tables for group work

Financial resources:

- Venue and equipment
- Accommodation and meals
- Materials
- Refreshments
- Cost of facilitators
- Cost of resource persons

## Participant notes: Day 1

### Programme

#### **DAY 1 –Development of common understanding**

TIME	TOPIC/activity	METHODOLOGY
09:00	<b>Session 1.1</b> Introduction Welcome Introduction of participants Expectations Objectives Programme overview Discuss possible gaps in expectations Daily 2 reporters Ground rules Practical information/administration	Plenary
10.30	<b>Session 1.2 Basic facts on HIV/AIDS</b>	Brainstorm Individual: self-administered questionnaire Reading and discussion in pairs
11.00	BREAK	
11.20	Basic facts (cont.)	Plenary wrap-up, question and answer
12.00	<b>Session 1.3 Understanding behaviour change</b>	Plenary and group work
13.00	LUNCH BREAK	
14:00	<b>Session 1.3 Continued</b>	
15:10	BREAK	
15:30	<b>Session 1. 4 Making it personal: Wildfire</b>	Simulation exercise
17:00	End of session	

#### **DAY 2 – Building background knowledge on skills based peer education and behaviour change communication**

TIME	TOPIC/activity	METHODOLOGY
09:00	Recap of previous day Overview of today's programme	Plenary by rapporteurs Facilitator
09.15	<b>Session 2.1 What is peer education</b>	Plenary and group work
10.15	<b>Session 2.2 Steps in developing a peer education and behaviour change communication strategy</b>	Introduction to group work
11.00	TEA/COFFEE BREAK	
11.20	<b>Session 2.2 continued</b>	Group work and presentation of group work
13:00	LUNCH BREAK	
14.00	<b>Session 2.3</b> Presentation by resource	Plenary

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	person	
15:30	BREAK	
15.50	<b>Session 2.4 Setting aims and objectives of peer education and behaviour change communication</b>	Presentation and group work
17:00	End of session	

## **DAY 3 – Reaching target groups**

TIME	TOPIC/activity	METHODOLOGY
09:00	Recap of previous day Overview of today's programme	Plenary
09.15	<b>Session 3.1 Participatory methods</b> for assessment, peer education and behaviour change communication	Plenary and group work (role plays, exercises)
11:15	TEA/COFFEE BREAK	
11:35	<b>Session 3.1 continued</b>	Plenary and group work
12.00	<b>Session 3.2 Rapid situation assessment</b>	Plenary presentation
13.00	LUNCH BREAK	
14.00	<b>Session 3.2 continued</b>	Group work
15.30	BREAK	
15.50	<b>Session 3.3 Defining target groups and areas, segmenting.</b>	Group work and discussion
17:00	End of session	

## **DAY 4 – Guidelines for planning and implementing a programme**

TIME	TOPIC/activity	METHODOLOGY
09:00	Recap of previous day Overview of today's programme	Plenary
09.15	<b>Session 4.1 Selecting channels, methods and materials for communication</b>	Group work and discussion
11.00	BREAK	
11.20	<b>Session 4.2 Selection, training and motivation of peer educators</b>	Exercises, group work and discussion
13.00	LUNCH	
14.00	<b>Session 4.3</b> Presentation by resource person	Plenary
15.30	BREAK	
15.50	<b>Session 4.4 Developing linkages and partnerships/referral systems</b>	Group work and discussion

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17.00	End of session	
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### ***DAY 5 – Looking at the way forward***

09:00	Recap of previous day Overview of today's programme	Plenary
09.15	<b>Session 5.1 Monitoring of peer education programmes</b>	Group work and discussion
11.00	TEA/COFFEE BREAK	
11.20	<b>Session 5.2 Consolidating the group work results in one presentation on a strategy for the specific target group</b>	Group work
13.00	Lunch	
14:00	<b>Session 5.2 continued</b>	Presentation of group work
15.00	<b>Session 5.4 Evaluation</b>	Individual: self-administered evaluation form Plenary: reflect on expectations, objectives
16:00	Closure	

## Participant notes: Day 1

### Session 1.2 – Basic facts on HIV/AIDS

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#### **Aim**

To ensure that all participants have accurate up-to-date information about HIV/AIDS

#### **Learning objectives**

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

- Explain the facts about HIV and AIDS
- Describe the progressive stages from HIV infection to AIDS
- Discuss the relationships between STIs and HIV infection
- Discuss misconceptions about STI, HIV and AIDS

#### **Key points**

1. HIV can be transmitted in three ways
2. People infected with HIV can live productive lives and be healthy for a longer period of 7-9 years or over
3. STIs make people more vulnerable to HIV infection

#### **Materials and handouts**

- 1.2.1 Handout: Questionnaire on HIV/AIDS basic facts
- 1.2.2 Handout: Questionnaire information sheet
- 1.2.3 Fact sheets in the resource pack

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### 1.2.1 Handout: Questionnaire on HIV/AIDS basic facts

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This questionnaire covers basic facts about the HIV/AIDS epidemic. It has been drawn up to assist you in assessing and expanding your current knowledge and understanding of the global epidemic.

- Please begin by reading through the questions and circling your response to each
- After completing the questionnaire, compare your answers with those of your neighbour and together check against the information sheet
- The topics covered in the questionnaire and information sheet will be discussed in the plenary session

***Please circle your answer***

1	Infected people can pass the virus on to others through their sexual or injecting drug use behaviour for the remainder of their lives	True	False	Don't know
2	Most infected people do not know they are infected	True	False	Don't know
3	25 to 40% of the children born to an infected woman will be infected (without preventive measures)	True	False	Don't know
4	You can tell when a person is infected by looking at her or him	True	False	Don't know
5	In the world there are more men than women infected with HIV	True	False	Don't know
6	Telling children about sex encourages them to try sex earlier than otherwise	True	False	Don't know
7	For most people, there is only a short time between infection and the onset of HIV-related illnesses and AIDS	True	False	Don't know
8	You always get infected with HIV if you have unprotected penetrative intercourse with an infected person	True	False	Don't know
9	Condoms are the only method available to prevent transmission of HIV during penetrative sex	True	False	Don't know
10	Mosquitoes transmit HIV	True	False	Don't know
11	In Pakistan in 2004 an estimated 80,000 people are infected with the HIV virus	True	False	Don't know
12	The sexual transmission of the virus is facilitated by the presence of sexually transmitted infections (STIs)	True	False	Don't know
13	With the appearance of HIV infection, the number of tuberculosis (TB) cases throughout the world has diminished	True	False	Don't know
14	Most of the opportunistic infections that occur in	True	False	Don't

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	people with HIV infection can be treated with effective drugs			know
15	Among the drugs used to treat persons infected with HIV, only the anti-retrovirals (ARV) can cure HIV infection	True	False	Don't know

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### 1.2.2 Handout: Questionnaire information sheet

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#### 1. True – once infected with HIV, a person is infectious to others for life

The virus can be transmitted in three ways:

1. Sexual transmission
  - Through unprotected penetrative sexual intercourse (oral, vaginal or anal)
2. Through blood and blood products
  - Blood transfusion with contaminated blood
  - Injecting drug use through contaminated needles
  - Other such as tattooing, medical or other instruments that are contaminated
3. From mother to child
  - During pregnancy
  - During delivery
  - During breastfeeding

Probability of HIV-1 infection per exposure

Mode of transmission	Infection per 1000 exposures
Female-to-male, unprotected vaginal sex	0.33 - 1
Male-to-female, unprotected vaginal sex	1 - 2
Anal sex	5 - 30
Exposure to contaminated blood products	900 - 1000
Contaminated needle	3
Mother-to-child	130 - 480

Source: World Bank, *Confronting AIDS*, 1997

The most common route, in 90% of new infections in adults, is through unprotected penetrative sexual intercourse. In Pakistan, sexual transmission (mainly heterosexual transmission) accounts for about 68% of the registered HIV cases (2002 country profile). HIV transmission becomes much more likely in the presence of STIs, especially those involving ulcers or discharge because there is more chance of broken skin or tissue allowing the virus to enter the body. The likelihood of transmission also increases with forced sex or with young girls, whose body is not yet fully developed, because this often involves damage to vaginal tissue.

HIV infection may be passed from a woman to her child before or during delivery or, during breast-feeding.

Shortly after infection, there is a short period (after 2 –6 weeks up to a few months) when a person is highly infectious. This period is called seroconversion and the body starts making antibodies. People may have flu-like symptoms, although this is not always the case. The likelihood of mother-

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to-child transmission increases when a mother becomes infected during pregnancy.

Following this period of acute infection, almost all people enter a period in which there are no signs or symptoms of HIV infection. This period is called asymptomatic HIV and may last from less than one year to 10-15 years or more. During this period, a person remains capable of transmitting the virus to others.

Once an infected person begins to experience HIV-related illnesses, called opportunistic infections, the likelihood of infecting others increases.

### **2. True – the overwhelming majority of the estimated 42 million people who are living with HIV/AIDS (UNAIDS, 2003) in the world do not know they are infected**

In many parts of the world, the facilities for voluntary and confidential testing (VCT) are not widely available or not available at all. People may suspect that they could be infected but, without testing centres, people have no way of knowing their infection status. Since knowledge of HIV infection status can be a factor in motivating people to change their behaviour, the establishment of such facilities is an important aspect of national HIV programs.

Even if testing is available, people often do not go for testing because of stigma and discrimination. For them there are more disadvantages than advantages to knowing their status. The advantages of being tested include: the ability to plan for the future and that of the children, setting aside fear and uncertainty and an incentive to prevent infection (if HIV negative) or re-infection (if HIV positive). For those who are infected, the knowledge gives the opportunity to make changes in lifestyle (avoid infecting others) and safeguard their health enabling them to live longer, healthier lives. It also allows access to social, spiritual and other support. For women, it gives them the chance to prevent transmission to a baby. Finally, knowing can ensure better medical treatment, including access to ARVs when needed. This may motivate people to get tested.

### **3. True – The risk of transmission of HIV from woman to child is about 33% during pregnancy or birth.**

HIV infection is passed from an infected woman to her child before or during birth or while breast-feeding. HIV is not transmitted by infected semen. The virus is more likely to be transmitted to the child during the initial period of acute infection of the mother and after the woman progresses to HIV-related illnesses. Antiretroviral therapy given to mothers at the onset of labour greatly reduces the chance of HIV transmission. In Namibia, VCT is offered at various centres around the country and if a woman is found HIV positive she is offered ARVs during childbirth as well as the child within 72 hours after birth. However, these prevention of mother-to-child transmission (PMTCT) programmes are not available everywhere.

The chance of transmission during breastfeeding is again about 33%. A solution to this transmission would be not to breastfeed, but there are social

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(stigma) and economic reasons that prevent mothers to give replacement feeding. If a mother decides to breastfeed, exclusive breastfeeding should be given and rapid weaning. With mixed feeding the baby's mouth or gut can easily become slightly damaged, allowing easier transmission of the virus.

Generally, breastfeeding is always greatly encouraged because it provides perfect nutrition and antibodies against infection, and helps to bond mother and baby. It avoids the cost and risk involved in replacement feeding using a bottle or a cup – risk of malnutrition if the replacement feed is diluted too much and risk of infection if the containers and water are not clean. In poor settings the chance of a baby dying from diarrhoea, malnutrition or dehydration may be higher than the chance of getting infected through breastfeeding.

### **4. False – you cannot tell by looking at an asymptomatic person that he or she is infected**

After the period of acute infection, there may be no observable signs of HIV infection for many years, perhaps a decade or more. When progression begins, trained personnel can clinically diagnose certain HIV-related conditions.

### **5. True – globally an estimated 35.7 million adults are living with HIV of which 17 million are women**

However, per region there are vast differences. In Pakistan, the male to female ratio is 7:1 (2002 country profile). For the region South and Southeast Asia, of the total adults infected end 2003, (6.300.000), an estimated 1.800.000 are women.

In Sub-Saharan Africa, women are infected at an earlier age than men, beginning in the early teens and rising steeply, peaking in the early to mid-twenties. Amongst men, infections peak five to ten years later. This age difference of becoming infected shows that young women are particularly vulnerable to HIV infection. This has physical reasons (genital tract not yet fully developed) and social reasons (not able to demand safer sexual behaviour). In Sub Saharan Africa, women are also infected more than men, the ratio in 2001 was 6 infected women (58%) for 5 infected men (42%).

### **6. False – talking to children about sex does not encourage promiscuity**

Although in many societies this belief prevents sex education from taking place in schools, evidence shows that such information in youth causes the rates of teenage pregnancies and sexually transmitted diseases to drop. Information and skill building permits adolescents to be better prepared and protect themselves and their partners when they start being sexually active. It also may give girls the skills to protect themselves better against rape or incest.

Research data and rates of teenage pregnancy and sexually transmitted disease from around the world, show that many children become sexually

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active in their mid teens. This is true irrespective of culture or religion, although children in urban areas often become sexually active at an earlier age than those in rural areas.

### **7. False – progression from HIV infection to the onset of HIV-related illnesses and AIDS is relatively slow**

#### *Without anti-retroviral (ARV) therapy*

Data indicate that without ARV therapy, 10 years after infection occurred, an average of 50% will have developed AIDS and some will have died. 30% will have had some symptoms of progression and the remaining 20% will still be a-symptomatic. Many infected people continue to lead productive and healthy lives without illness for more than ten years. Progression from infection to HIV-related illness may be delayed through good nutrition, reduction of stress and anxiety, adequate rest and exercise and a positive outlook on life. Treatment of opportunistic infections associated with HIV infection, including thrush, skin diseases, TB, diarrhoea and fever, is critical in improving the quality of life, in reducing progression and in enabling people to remain economically productive and supportive of their families. Factors, which may hasten progression, include repeated exposure to HIV, recurrent sexually transmitted infections (STIs), drug use, excessive alcohol consumption and stress.

The time from the onset of AIDS to death has been found to be around 2 years although, with improvements in lifestyle and treatment, this period may be lengthened. Some people diagnosed with AIDS have continued to be well and productive for many years.

#### *With ARV therapy*

Certain anti-retroviral drugs, such as HAART (highly active anti retroviral treatment, are now available, although not everywhere. For those people with HIV that are eligible to HAART, this is likely to improve the quality of their lives or delay progression of infection. However, they do not cure infection. One problem with HAART in Namibia is, that at this moment it is only indicated for people with a CD4 count of less than 200. Often people who come for treatment after being tested already have a CD4 count below this. This means that their resistance has already been severely reduced and treatment may come too late for sustained recovery. In addition, HAART therapy is not readily available everywhere in Namibia because of the treatment condition that a person has to live within a 30 km radius from the health centre from where the drugs are being provided.

### **8. False – transmission does not occur on every occasion of unprotected sexual intercourse**

Transmission does not occur each time an infected person has unprotected penetrative intercourse (see also question 1). WHO estimates that, when the genital area is healthy in both partners, transmission occurs in less than one per cent of all cases of unprotected peno-vaginal intercourse; the risk of peno-anal intercourse is higher. When the genital tract is damaged or inflamed,

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such as in the case of untreated STI or forced sex, transmission may occur much more often. The presence of some genital conditions may increase the likelihood of transmission from less than 1% to 50% for an act of unprotected penetrative intercourse.

### 9. True – condoms are the only effective method to prevent transmission of HIV by penetrative sexual intercourse

Unprotected penetrative sexual intercourse is the major transmission mode in most population groups. The consistent and correct use of good quality male or female condoms is the only effective method to prevent HIV transmission during penetrative sexual intercourse (oral, vaginal or anal). However, this option neglects the fact that women often depend on men and are not in the position of negotiating or demanding condom use by their male partner(s); and that for many women sex is forced (and unprotected) at some point in their lives.

Alternatives to condom use include:

- The A: Sexual **A**bstinence, which of course also implies no risk. This is an option many people do not consider as contributing to good quality of life. However, for young people the delay of the start of sexual activity and abstinence is a good alternative. This option is said to have much contributed to the reduced prevalence in Uganda.
- The B: Partners may decide (and trust each other) to practice mutual monogamy (**B**e faithful). However, in order to be safe from the start, the latter requires that both partners are tested HIV-negative, while neither should have been exposed to HIV-infection during the three months prior to the HIV-test (the 'window period' during HIV-infection may not be detected by the test).
- Partners may practice non-penetrative sex.

Prevention for other modes of transmission:

*Injecting drug use:* transmission in drug injecting situations can be prevented by the use of new, sterile needles (e.g. through needle-exchange programmes), not sharing needles or through the cleaning of equipment with bleach.

*Contact with blood and blood products, organs and tissue.* In Namibia screening of blood, tissue and organs to be used for transfusion or transplantation have eliminated the possibility of HIV infection by these means in health care settings. The risk of transmission via contact with contaminated blood on medical instruments and clinical waste can be significantly lessened by infection control practices, including the effective disinfection of equipment, the careful use and disposal of sharp instruments and waste, and avoidance of blood contact with broken skin or mucous membranes

### 10. False – HIV is not passed from mosquitoes to people

When mosquitoes bite, they suck a person's blood into one part of their stomach. Then they inject saliva from another part of their stomach to replace the blood (this fluid is poisonous to humans and is what makes us itch).

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Mosquitoes cannot inject blood, only saliva. Malaria is transmitted through saliva, not blood, and therefore can be passed by mosquitoes.

### **11. True – although official figures of reported HIV infected people are much lower**

The National AIDS Programme (NACP) reports 2.197 HIV positive cases including 246 with AIDS. But these are people who have been tested and reported. This is far below the estimated figure that is put at approximately 80,000 by NACP. This relatively low number of reported infections may be the result of actual low level of infections, widespread under-reporting of cases due to inadequacies in the surveillance system and limited individual-level care-seeking for possible HIV infection due to ignorance and/or stigma.

### **12. True – the likelihood of transmission of the virus during unprotected penetrative intercourse is significantly increased by the presence of genital lesions, scarification, inflammation or infections (such as caused by STIs)**

Genital damage may be the result of poor hygiene, infections of the genital-urinary tract, sexually transmitted infections (STIs), trauma from (forced or consensual) sexual activity, childbirth and abortion, and traditional practices such as female genital mutilation (FGM) and dry sex. The presence of some genital conditions may increase the likelihood of transmission from less than 1% to 50% for an act of unprotected penetrative intercourse.

### **13. False – according to UNAIDS, tuberculosis (TB), which is the second most deadly infectious disease, is also increasing, mostly due to the HIV epidemic**

TB is the leading cause of death in people with AIDS in Africa. Tuberculosis is of particular concern because it may be easily passed to healthy HIV negative and even more to HIV positive people if their specific immunity to the tubercle bacillus is weak. In Malawi, Uganda and Zimbabwe between 45% and 65% of TB patients are HIV positive. Also in Namibia this percentage is high. The most effective treatment for TB is directly observed treatment, short course (DOTS) as TB drugs need to be taken for 6 to 8 months, long after symptoms have disappeared. Direct observation of the patient taking the drugs is recommended for at least the first two months with regular monitoring after that. If the treatment is stopped early, the disease recurs, often in a form more resistant to treatment. In all public health services in countries with HIV and TB epidemics, as in Namibia, the responses should be closely linked and complimentary – yet this is often not the case.

### **14. True – there is effective treatment for most opportunistic infections**

In most cases, there are effective drugs for treating opportunistic infections (OI). However, effective intervention against OI not only requires the appropriate drug for a given medical condition. It also requires the infrastructure necessary to diagnose the condition, monitor the intervention

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and counsel the patients. Many people with HIV can greatly benefit from taking antibiotics and other prophylaxis.

### **15. False – anti-retroviral (ARV) therapy does not cure HIV infection**

Even though taking anti-retrovirals regularly makes it possible to reduce the quantity of virus in the organism and, consequently, to delay the development of infection, we cannot speak of curing. It is also important to know that, once started by those eligible for treatment, ARV-therapy is life-long and that adherence to the drug regimen is essential. Within a few weeks of stopping treatment, viral loads increase again. Non-adherence is an important factor contributing to the development of drug-resistance virus strains which needs to be prevented for public health reasons. ARVs are toxic drugs, building up poisons in the body that can cause a wide range of side effects. Therefore patient monitoring is important for side effects and benefits of the drugs, and for patient compliance.

ARV therapy is not easily available everywhere, and moreover, to take the drugs a good health and nutritional status is required. ARV therapy therefore must be arranged as part of a holistic program, comprising the treatment of opportunistic infections encountered during HIV infection, good nutrition, food security, behaviour change interventions, mental and social support and living positively.

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### Session 1.3 – Understanding behaviour change

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#### **Aim**

To increase understanding about factors that determine behaviour change and the process of behaviour change as it takes place in individuals and groups.

#### **Learning objectives**

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

- Analyse the steps in individual behaviour change and adjust their messages and approaches accordingly.
- Analyse the factors that enable behaviour change, those that hinder behaviour change and the skills and services needed to facilitate behaviour change

#### **Key points**

1. Behaviour change communication has to be based on an assessment of knowledge, attitude, practices and skills of the target group and has to take into account the social environment as well as the skills to change and sustain new behaviour.

#### **Materials and handouts**

Handout: Stages of behaviour change

Handout: Factors that determine behaviour change

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### Handout 1.3.1 Stages in Behaviour change

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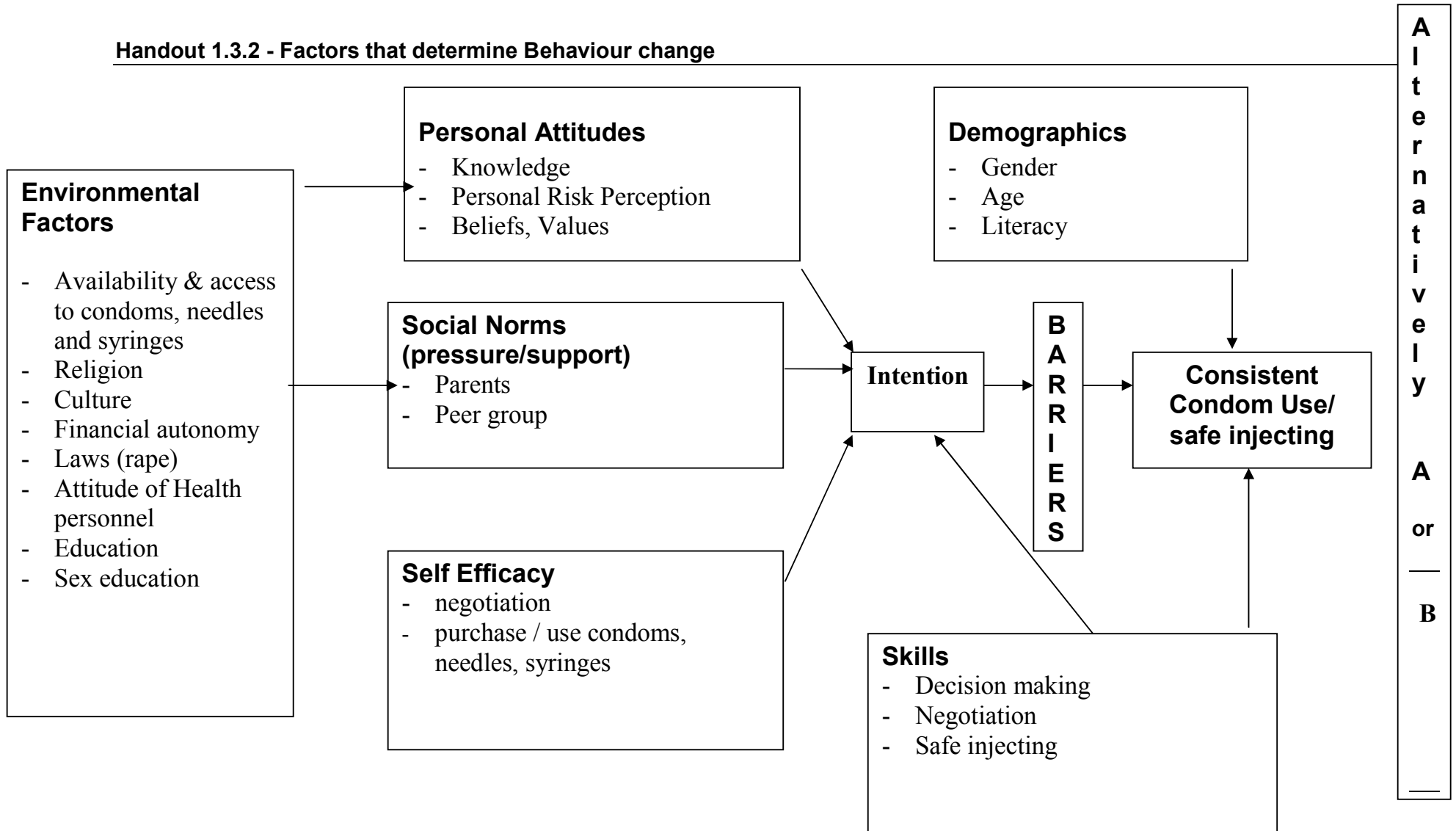
#### The process of individual behaviour change

What are the peer education/BCC activities that need to be undertaken to get to the next step?

<b>Stages of behaviour change</b>	<b>Peer education/BCC activities</b>
1. Unaware	
2. Informed on risks and protective response	
3. Aware of personal risk	
4. Intention to change	
5. Beliefs in advantages and disadvantages	
6. Belief that can personally change	
7. Trial assessment of new behaviour	
8. Sustained behaviour change	

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Handout 1.3.2 - Factors that determine Behaviour change



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### Session 1.4 – Wildfire simulation

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#### Aim

In order to be able to work effectively within the epidemic, it is important for participants to experience what it feels like to be exposed to HIV infection personally.

#### Learning objectives

The simulation enables the understanding of:

- The speed of transmission of HIV, the notion of a sexual network and ways to stop HIV sexual transmission
- What it may imply to be exposed to or infected with HIV: stigma and discrimination, emotional turmoil, need for support
- Various social factors that influence help seeking behaviour for men and for women
- The need to counsel those seeking to go for an HIV/AIDS test, as well as the necessity to create a supportive environment
- Why the epidemic affects all of us, not just others

#### Key points

1. Very difficult decisions have to be made once a person knows that he or she has been exposed to HIV infection
2. A supportive environment is needed to enable people to make these decisions

#### Materials and handouts

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