Positive Partnerships

A Toolkit for the Greater Involvement of People Living with or Affected by HIV and AIDS in the Caribbean Education Sector

United Nations
Educational, Scientific and
Cultural Organization

Kingston
Office

Health and Human Development
A Division of Education Development Center, Inc.

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FOREWORD

It is with great pleasure that the UNESCO Kingston Cluster Office for the Caribbean, EDC's Health and Human Development Division, and the partners who contributed to its development and pilot testing offer this Toolkit for the Greater Involvement of People Living with HIV (GIPA) in the education sector throughout the Caribbean region and beyond.

Since the year 2000, interest in GIPA has been an issue of growing importance in the Caribbean. Accordingly, the UNESCO Kingston Cluster Office for the Caribbean declared its commitment to the GIPA principle in December, 2004, and worked throughout 2005 toward its application in the context of UNESCO-funded HIV and AIDS activities. A preliminary consultation by the UNESCO Kingston Cluster Office for the Caribbean in November 2005 emphasised the importance of the GIPA principle and the need for capacity building for people living with HIV.[1] At a meeting in 2006, the chair of the Caribbean Regional Network of People Living with HIV/AIDS (CRN+) and a representative from UNESCO Headquarters in Paris co-presented a paper, "GIPA and the education response to HIV and AIDS in the Caribbean," which pointed out continuing challenges to applying the GIPA principles and the need for more *meaningful* involvement of People Living with HIV.[2] In 2005, EDC applied the principles by involving People Living with HIV (PLHIV) in our joint Caribbean Leadership and Advocacy Campaign in three countries. This effort facilitated a greater awareness among these leaders of their own attitudes toward PLHIV and of the need for comprehensive education sector policies, which some countries later developed. These combined efforts pointed to the need for and benefits of educating and training both education sector staff and PLHIV about the many ways in which they can work together.

Undertaking the development of this Toolkit has itself been an application of the GIPA principle. People living with HIV shared the decision-making and implementation of activities, served as co-writers of this Toolkit, and participated fully with the Ministry of Education and Ministry of Health staff in two pilot countries: The Bahamas and Jamaica, serving as facilitators and providing feedback. These "positive partnerships" affirmed collaboration and mutual support among these stakeholders and sectors.

We hope this Toolkit will inspire all the stakeholders and PLHIV networks in the Caribbean and elsewhere to join together to make meaningful the empowerment and active involvement of people living with HIV in the education sector and, in the process, reduce HIV-related stigma and discrimination.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BNN+	The Bahamas National Network for Positive Living
CARICOM	The Caribbean Community
CBO	Community-based Organisation
CRN+	Caribbean Network of People Living with HIV/AIDS
GIPA	Greater Involvement of People Living with or Affected by HIV and AIDS
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
JN+	Jamaica Network of Seropositives
MOE	Ministry of Education
MOH	Ministry of Health
MOU	Memorandum of Understanding
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
PANCAP	Pan-Caribbean Partnership Against HIV/AIDS
PLHIV	People/persons Living with HIV
PPT	Microsoft PowerPoint (presentation software)
PTA	Parent-Teacher Association
UNAIDS	The United Nations Joint Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

The toolkit aims to assist education sector staff, networks of people living with HIV, and others to apply the principles for the greater involvement of people living with or affected by HIV and AIDS (GIPA) in a comprehensive approach for the education sector's response to HIV and AIDS.

The toolkit includes 10 activities, each requiring from 1 to 3 hours, which can be modified as needed. The activities introduce the basics of HIV and AIDS, the concept of GIPA, and ways its principles can be incorporated into a comprehensive approach for the education sector's HIV and AIDS initiatives. It includes capacity-building activities focused on advocacy skills. The issues surrounding stigma and discrimination, as well as confidentiality and disclosure, are addressed via case studies and role plays. These activities can help to create a supportive and enabling environment. Programme planning activities to operationalise the principles of GIPA include identifying partners, conducting a resource gap analysis, mobilising resources, and action planning.

This toolkit includes step-by-step lesson plans, handouts, and facilitator resources for each activity, with additional tips for individuals conducting the activities. Suggestions for monitoring and evaluation, with corresponding sample quizzes, are offered at the conclusion of each activity and at the end of the toolkit, to help users develop a more long-term approach to evaluation. The document closes with several appendices, including a glossary, guidelines for facilitators, and detailed descriptions of earlier models for a comprehensive approach in the education sector's response to HIV and AIDS.

INTRODUCTION

In the Caribbean, people living with HIV have participated in raising HIV awareness, in reducing stigma and discrimination, and in some workplace initiatives. However, statements by the Caribbean Community (CARICOM), such as the Port-of-Spain Declaration[3] and the Roseau Declaration[4], and networks of people living with HIV have called for greater involvement of people living with or affected by HIV and AIDS (GIPA), especially at the decision-making level. In order to achieve more meaningful involvement of people living with HIV, greater collaboration, and a reduction of stigma and discrimination, assistance is needed that maximises the skills of persons working with HIV initiatives. Opportunities need to be presented for improving skills and therefore becoming more comfortable with the implementation of the **GIPA principles**. This toolkit has been developed to address the needs of all persons interested in furthering GIPA at all levels of the education sector's response to HIV and AIDS.

People living with HIV want their voices to be heard. They need empowerment to play a significant role in HIV activities at all levels in the education sector. They need to collaborate with ministry staffs, policymakers, teachers, and parents in schools. By working together and adopting a comprehensive approach to HIV, the education sector can affect the behavioural and societal changes needed to reduce stigma and discrimination and to improve the quality of life for all staff and students. People living with HIV have actively contributed as co-writers of this toolkit and as co-facilitator of the orientation to the pilot test of this toolkit. Furthermore, people living with HIV have jointly planned activities from this toolkit together with staff from the Ministries of Education in The Bahamas and Jamaica, have facilitated several activities from this toolkit during the pilot test, and have provided subsequent feedback for final revision.

A comprehensive approach to HIV and AIDS requires the education sector to use all means at its disposal, including the adoption and operationalisation of the GIPA principles, to promote and protect the health and well-being of all staff and students. By addressing all facets in a comprehensive way, the education sector is fulfilling its mission of educating the citizens of tomorrow and supporting academic success. The components of a comprehensive approach include HIV and AIDS workplace policy; curriculum and instruction; access to services, care, and support; and the creation of a healthy physical and psychosocial learning environment.

BACKGROUND AND RATIONALE

There are many reasons for Ministries of Education (MOEs), networks of people living with HIV, and other groups to become involved in accelerating a **comprehensive approach to HIV and AIDS in the education sector** of the Caribbean.

The Caribbean has the second highest rate of HIV infection in the world. As an extremely influential and important part of society, the education sector has the potential to help safeguard the lives of hundreds of thousands of learners, educators, and their families. In addition, the number of children affected and orphaned by AIDS is rising rapidly. By adopting a comprehensive approach to HIV and AIDS, the education sector can help decrease the number of children infected and affected. Young people, who are one of the key populations vulnerable to HIV, should not be denied the essential knowledge and skills they need to protect themselves. The education sector can provide information about and **access to services** and help young people develop their skills in the context of a healthy, responsible lifestyle.

The education sector workplace employs thousands of staff who can benefit from HIV and AIDS-related workplace training programmes, **fair employment policies**, and benefits. To create a productive workforce and to sustain economic development, the education sector needs healthy students and teachers and working environments. If teachers or their families are not healthy, they cannot devote their energies to teaching; they may be frequently absent or even no longer able to work. If students or their families are not healthy, students cannot perform their best academically; they may miss classes or even withdraw from school entirely.

By virtue of their role in the community, schools, teachers, and other education leaders confer knowledge as well as values, beliefs, and **social norms**. Schools are the place to learn to confront **stigma** and **discrimination** and to practice tolerance and compassion. The education sector, in partnership with networks of people living with HIV, can assist in reversing the HIV and AIDS epidemic in the Caribbean, secure the rights of individuals most affected, and ensure the design and implementation of effective programmes.

Origins and history of GIPA

Strengthening the global response to the HIV and AIDS **epidemic** requires, at all levels, the active engagement of people living with HIV. Grounded in the **Denver Principles**[5] of 1983, the GIPA principles were formally outlined at the 1994 **Paris AIDS Summit**. There, 42 countries agreed to support an initiative to "strengthen the capacity and coordination of networks of people living with HIV and community-based organizations" to ensure "the creation of supportive political, legal and social environments."[6]

These principles were further elaborated in the 2001 United Nations (UN) **Declaration of Commitment on HIV/AIDS**,[7] which emphasised the importance of including people living with HIV in the design, planning, implementation, and evaluation of programmes and policies targeting the epidemic. This further stressed the need to actively engage those *affected* by HIV and AIDS, such as family members and caregivers.[2]

The Joint United Nations Programme on HIV/AIDS (UNAIDS) maintains its official position that "governments, international agencies and civil society must set, implement and monitor

minimum targets for the participation of people living with HIV, including women, young people and **marginalised populations**, in decision-making bodies." Moreover, these individuals must be involved "in developing funding priorities and in the choice, design, implementation, monitoring and evaluation of HIV programmes from their inception."[6] With this strong international foundation, GIPA is positioned to become an essential component of the HIV and AIDS response in the education sector.

Principles of GIPA

Participants at the 1994 Paris AIDS Summit declared several principles to promote GIPA, including the following:

- Support the greater involvement of people living with or affected by HIV and AIDS through initiatives to strengthen the capacity of and coordination of networks of people living with HIV and community-based organisations (CBOs) stimulating the creation of a supportive political, legal, and social environment.
- Involve people living with HIV and AIDS fully in decision-making, formulation, and implementation of public policies.
- Protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV and AIDS, through legal and social environments.
- Make available necessary resources to better combat the pandemic, including adequate support for people living with HIV and AIDS, non-governmental organisations (NGOs) and CBOs working with vulnerable and marginalised populations.
- Strengthen national and international mechanisms connected to human rights and ethics related to HIV and AIDS.[8]

The GIPA principles have been designed to promote conditions necessary for accelerating the international response to the epidemic. These principles may be organised into four functions: *improve access to services*, such as health care, counselling, or training; *support inclusion*, so that people living with HIV may provide informal peer support and **community outreach**; *facilitate broader participation* in more formal capacities where their expertise is recognised; and *ensure greater involvement in management*, policy-making, and **strategic planning**.[9]

GIPA in the Caribbean and the World

Significant progress has been made in the Caribbean over the past decade to involve people living with HIV in the response to the epidemic and related prevention activities. By 2001, all nations in the region had signed on to the UN Declaration of Commitment on HIV/AIDS. In 2006, a high-level meeting of MOEs and national AIDS authorities of CARICOM developed and endorsed the **Port-of-Spain Declaration**, which signified a renewed commitment to efforts aimed toward enhancing the education sector response to HIV and AIDS in the Caribbean.[10] In 2007, MOEs of the Organisation of Eastern Caribbean States (OECS) reaffirmed their commitment to the Port-of-Spain Declaration and issued a statement (**Roseau Declaration**) regarding the critical role of the education sector in response to HIV and AIDS.[4] Many countries have also provided ongoing progress reports regarding the implementation of these commitments, with five new countries in 2008 raising the total number submitting to 20.[11]

The Caribbean Regional Network of People Living with HIV and AIDS (CRN+) has been instrumental in enhancing the involvement of people living with HIV. Established in 1996, CRN+ leads the project *Institutional Strengthening of PLHIV Network in the Caribbean Region*, funded by the United States Centers for Disease Control and Prevention (CDC). Through this work, CRN+ is currently involved in a range of activities that include developing community-based care and treatment programmes, strategizing how best to provide support to regional advocates, and conducting in-country studies to assess knowledge and attitudes.[12] With funding from The Global Fund to Fight AIDS, Tuberculosis and Malaria, CRN+ has developed a community-based initiative designed to improve treatment preparedness and adherence, build **capacity** at local levels, provide **advocacy**, and establish systems for **monitoring and evaluation**.[13]

Most Caribbean countries have a local network of people living with HIV. For example, in Jamaica there is the Jamaica Network of Seropositives (JN+). The mission of JN+ is to advocate for the rights and concerns of people living with and affected by HIV through **empowerment, partnership** and **resource mobilisation**. In Guyana the Network of Guyanese Living with and Affected by HIV/AIDS (G+) is committed to the **sustainable** improvement of the quality of life for people living with HIV, through empowerment for positive living. Similar networks, such as the Trinidad & Tobago Network of People Living with HIV/AIDS (TTN+) and The Bahamas National Network for Positive Living (BNN+), exist throughout the Caribbean.

Some countries in other regions of the world have established **networks of HIV-positive teachers**. For instance, in 2003, after attending the International Conference on Sexually Transmitted Diseases and AIDS in Sub-Saharan Africa, two HIV-positive female teachers established the Kenya Network of HIV-Positive Teachers (KENEPOTE). The network acknowledges the crucial role of teachers since teachers are "also leaders in the church and the community, holding responsible positions, and are held in high esteem. Their countrywide distribution enables them to effectively advocate behaviour change."[14]

Barriers to GIPA: stigma and discrimination

Two of the greatest obstacles to **operationalising** the GIPA principles are stigma and discrimination, directed toward people living with HIV as well as their family members and friends.[15] The participation of HIV-positive individuals in HIV and AIDS activities, however, creates supportive and inclusive environments, which reduce stigma and discrimination and, in turn, lead to even greater levels of involvement. This cycle demands that the reduction of stigma and discrimination be among the first challenges tackled in advancing the GIPA principles.

Stigma is defined as "the process of devaluing people and viewing them negatively on the basis of a particular attribute, for example, their **HIV** status, **gender** or **sexuality**."[16] Stigmatisation is a dynamic process arising from the perception that there has been a violation of a set of shared attitudes, beliefs, and values.[17] In the Caribbean, HIV and AIDS may evoke deep-rooted prejudices and assumptions about **same-sex relationships**, **drug use**, and **sex work**.[18] The long-term effects of stigma and discrimination in the education sector are numerous. School enrolment and opportunities for learning are reduced among stigmatised students, who also experience higher rates of

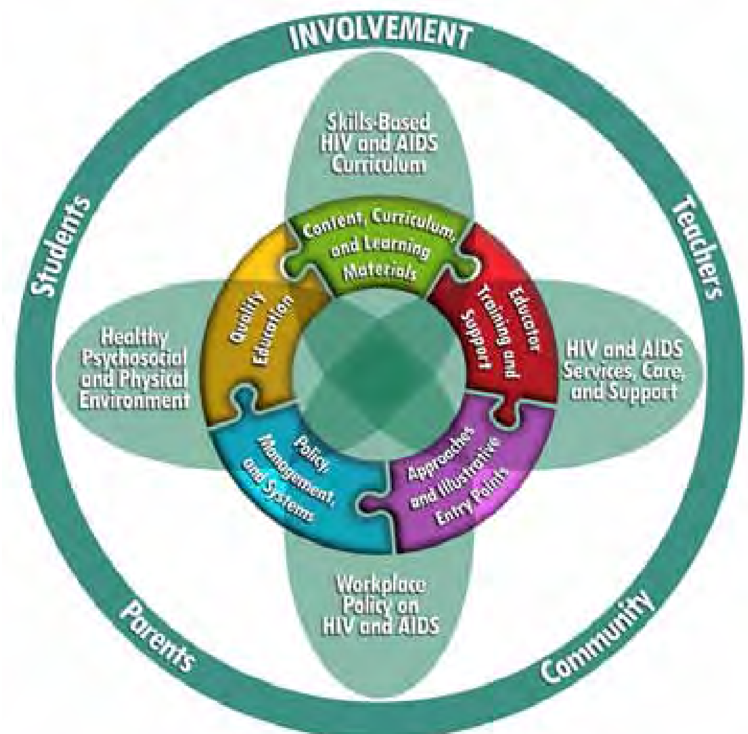
absenteeism and drop-out, as well as an increased vulnerability to child labour and exploitation in the developing world. Stigmatisation of education sector staff often results in lower productivity and increased absenteeism, as well as lower rates of testing, **disclosure** to partners, and care-seeking behaviour.[15]

There are four main approaches to reducing stigma and discrimination toward people affected by HIV and AIDS. Perhaps the most common, *information-based strategies*, attempt to directly address misconceptions and gaps in awareness, using a wide variety of formats, such as advertising, brochures and information packets, video and other media, and school presentations.[19] *Skill-building* aims to teach strategies for resolving negative attitudes or coping behaviours, skills for diffusing conflict situations, and knowledge of the roots of stigma. *Counselling*, conducted individually or in groups, provides information on HIV and AIDS, allows for more intimate discussion of concerns, and provides social support for behaviour change or maintenance of safe behaviours. *Contact* with people living with HIV may involve one-on-one conversations, testimonials by infected or affected individuals, and presentations and speeches.[17]

To support a healthy psychosocial and physical environment, people living with HIV can confront stigma and discrimination by disclosing to close friends and family, by speaking in classrooms, or by participating in debates and activities at national or regional levels. By choosing to directly address these issues within a framework that encourages the broad involvement in the education sector of individuals infected and affected by HIV, efforts to respond to the epidemic will be effective and unrelenting.

Comprehensive approach to HIV and AIDS in the education sector

A comprehensive approach to HIV and AIDS in the education sector goes beyond implementing a prevention **curriculum** in the classroom. To have a real impact, the education sector must address the many other challenges posed by the epidemic, including the need for workplace policies and training programmes for teachers and staff that address stigma and discrimination, a safe and secure learning environment for working and learning, and access to services for those living with HIV.[20] A comprehensive approach **involves** teachers, students, parents, and community members and employs all means at the education sector's disposal to promote and protect the health of students and staff and to mitigate the impact of HIV and AIDS on the system itself. The diagram on the next page (further explained in Section 2) illustrates how the most critical components of such a comprehensive approach interrelate and provide the foundation for successful partnerships and **interventions**.



Operationalising GIPA in the education sector

The GIPA principles are an integral component of a comprehensive approach to HIV and AIDS. Research and experience have revealed crucial linkages between GIPA and the development of a broad and effective HIV and AIDS response in the education sector. Programmes and curricula may be strengthened and better-targeted by involving people living with HIV in the design and implementation processes, given their first-hand knowledge about what is most relevant and needed. This involvement can be an empowering experience, improving the emotional and mental well-being of individuals most affected by the epidemic and providing a healthier psychosocial environment for working and teaching in the education sector.[16]

Stigma and discrimination can also be reduced as myths about the transmission and prevention of HIV are dispelled. Opportunities to meet people living with HIV and hear their stories offer individuals the benefit of first-hand knowledge, often revealing their assumptions and prejudices to be unfounded and false. Allowing for more open communication can contribute to a reduction in stigma and discrimination and help prevent the transmission of HIV, while creating a more **supportive environment** where individuals feel comfortable seeking treatment.[16] Moreover, some individuals may themselves choose to support others through counselling and homecare.[2]

Ensuring that people living with HIV are involved in *all stages* and *all aspects* of response and prevention activities requires participation in many different capacities. A pyramid illustrating these "**Levels of involvement of people living with HIV**" is introduced later in Activity 2.2 (Handout B) and can be directly adapted to comprehensive HIV and AIDS activities within the education sector. Within this framework, people living with HIV can be recognised as experts who can teach lessons, advocate for HIV and AIDS curricula in the school, design lessons, or co-facilitate trainings. In terms of workplace policies, individuals living with HIV can participate in decision-making or policy-making processes, as well as advocate for new or better policies that incorporate the GIPA principles. People living with HIV can become involved in the provision of services, care, and support through the development of requisite skill-sets and other experience.

ABOUT THIS TOOLKIT

Who should use this toolkit

This toolkit is for education sector staff, networks of people living with HIV, and others who want to gain knowledge, attitudes, and skills to apply the principles of GIPA by working together effectively to design and implement a comprehensive approach to HIV and AIDS in formal and non-formal education settings. The activities in this toolkit are NOT written for students, though principals and school administrators are part of the target audience.

Goal and objectives of the toolkit

The goal of this toolkit is to build the capacity of MOEs and networks of people living with HIV to adopt and operationalise the principles of GIPA to strengthen the education sector response to HIV and AIDS.

Implementing this tookit will	Related Activities in this toolkit
1. Deepen appreciation and awareness of HIV and AIDS and the GIPA principles	Activity 1.1: Sensitisation session: What are HIV and AIDS? Activity 1.2: Sensitisation session: What is GIPA?
2. Increase awareness of incorporating GIPA principles in a comprehensive education sector response	Activity 2.1: Sensitisation session: What is a comprehensive approach to HIV and AIDS in the education sector? Activity 2.2: Ways to incorporate GIPA in a comprehensive response to HIV and AIDS in the education sector
3. Build capacity of the education sector, people living with HIV and other partners to apply the GIPA principles in a comprehensive approach to HIV and AIDS in the education sector	Activity 3.1: Training workshop: advocacy for GIPA
4. Reduce HIV and AIDS-related stigma and discrimination	Activity 4.1: Sensitisation session: stigma and discrimination Activity 4.2: Workshop: voluntary disclosure versus exposure
5. Create supportive and enabling environments that facilitate the collaboration of people living with HIV at all levels of the education sector	Activity 5.1: Sensitisation workshop addressing confidentiality and a supportive and enabling environment

6. Identify and strengthen structures that help operationalise the GIPA principles in a comprehensive response	Activity 6.1: Building partnerships: identifying partners and conducting a resource gap analysis Activity 6.2: Resource mobilisation: organising an action plan and composing an MOU to operationalise the GIPA principles in the education sector

Anticipated outcomes

The activities in this toolkit will enable national education sector HIV and AIDS coordinators and/or other MOE staff to:

- » Plan, coordinate, and implement the MOE's HIV programme activities closely with people living with or affected by HIV (within and outside the ministry)
- » Understand and appreciate the unique environments, skills, and contributions of each sector and network of people living with HIV
- » Facilitate workshops (for participants from different levels) on GIPA principles, a comprehensive education sector approach, advocacy, and action planning
- » Plan, coordinate, and evaluate the meaningful involvement of people living with HIV in the MOE's HIV response (which may include MOE staff)

The activities in the toolkit will enable people living with HIV to:

- » Participate on a technical/management/planning committee to contribute meaningfully to HIV policy development and programme implementation
- » Facilitate workshops for the MOE (for participants from all levels) on stigma and discrimination
- » Conduct, jointly with people from the education sector, workshops for PTA, principals, secondary school students, and others to reduce stigma and discrimination

Structure of the toolkit

This toolkit includes six sections. Each contains interactive activities designed to stimulate discussion and encourage participants to think critically about developing and applying the skills needed to help ensure a greater involvement of people living with or affected by HIV and AIDS in the education sector.

Section 1:	Provides an introduction to the basics and complexities of HIV and AIDS, as well as an overview of the GIPA principles, with information and activities to help understand its benefits and barriers
Section 2:	Examines a comprehensive approach to HIV and AIDS in the education sector, with activities and practical examples for incorporating the GIPA principles
Section 3:	Explores how we can increase the capacity of individuals and organisations to operationalise the GIPA principles through advocacy efforts
Section 4:	Considers the causes and challenges of stigma as well as the effects of discrimination on the individual and workplace, using case studies that highlight issues of disclosure and **exposure**
Section 5:	Suggests a framework for the creation of supportive and enabling environments, with a particular focus on ensuring **confidentiality**
Section 6:	Examines steps for operationalising the principles of GIPA by establishing strong partnerships, conducting a **resource gap analysis**, and establishing an **action plan** that reflects a comprehensive approach

Each section is structured as follows:

1. Background
   a. Overview of the topic for the section ("What you need to know")
   b. Colour-coded facilitation/involvement tips for education personnel, health personnel, or network facilitators
2. Activity/ies
   a. Goal
   b. Target audience
   c. Time
   d. Objectives (cognitive/affective/behavioural)
   e. Preparation
   f. Methods
   g. Introduction of the exercise
   h. Steps of the exercise (including explanations on how to carry out the activity and information for the trainer/facilitator to ask and answer questions and lead discussions)
   i. Closure
   j. Monitoring and evaluation
3. Resources (needed for the activity), such as:
   a. Pre- and post-quiz
   b. Handouts
   c. Facilitator's resources
   d. PPT presentation (on CD-ROM)

How to use this toolkit

A single session is not enough to shift from an irregular application of GIPA to a more systematic and effective approach. Thus, this toolkit is most effectively used within an overall comprehensive approach to HIV and AIDS. For selecting and implementing activities from this toolkit, it is important to:

1. Build a foundation about HIV and AIDS and a logical sequence.

We recommend using the activities in a sequence—similar to that presented in this toolkit—that begins with basic information on HIV and AIDS, introduces GIPA, a comprehensive approach, and issues related to stigma and discrimination.

Reviewing the basics of HIV and AIDS may take some time if myths are to be dispelled, especially if participants do not have the appropriate knowledge. Building a sound foundation of HIV and AIDS basic knowledge is crucial before participants are ready to move to the next step.

Depending on the cultural context, especially prevailing gender norms, and participants' preferences, trainings may or may not be held separately for women and men.

2. Incorporate the activities into existing plans, if possible.

The activities in this toolkit have been designed to enrich already-existing efforts.

Activities can be integrated into existing plans and mandates that require GIPA, such as:

» Special trainings/**sensitisation** sessions on GIPA

- Ongoing activities, trainings, meetings, or workshops on HIV and AIDS
- Work sessions of small and large groups

3. Prepare to facilitate each activity.

For each activity:

- Review facilitator resources, copy handouts, and prepare any needed materials (such as flipcharts and markers) ahead of time.
- Determine if any modifications of the materials might be necessary to make the materials more relevant to the country and culture (e.g., local language) of your target audience.
- Ideally, make sure that a person living with HIV will participate in facilitating each activity and may share his or her story.
- If time does not allow for all the steps of an activity to be implemented, select those steps and resources that are most relevant to your target audience.
- At the beginning of the activity, introduce yourself (name, organisation, involvement in HIV work), and ask participants to briefly introduce themselves.
- Explain the aim of the training/sensitisation session.
- Facilitate the activities, as described, encourage participation in group work and plenary discussions, and answer any questions participants may have.
- Collect monitoring and evaluation information (as indicated at the end of each activity).

More tips for facilitation can be found in Appendix 1 ("Tips for facilitators"), and each section of this toolkit includes specific facilitation tips.

4. Conduct monitoring and evaluation components.

The end of each activity includes process and outcome evaluation measures. These are intended to evaluate short-term outcomes. The pre- and post-quizzes will help you monitor who is benefiting from the toolkit's activities and if there are any gaps in understanding that need review. (Sample questions and answers are provided at the end of each activity before other handouts.)

Long-term outcome evaluation methods and questions are provided in the "Monitoring and evaluation" section at the end of this toolkit (p. 187). The measures offered in that section would be part of a broader evaluation of the implementation of a comprehensive approach to HIV and AIDS in the education sector that purposely involves people living with HIV.

ORIENTATION TO THE TOOLKIT

We recommend an orientation meeting to prepare key staff, such as people from the MOE and MOH, local networks of people living with HIV, the National AIDS Programme, and other relevant agencies to take the lead using this toolkit to implement activities that operationalise GIPA in the education sector. The orientation meeting may be facilitated by the HIV focal point of the MOE and/or his/her designees.

The orientation meeting should extend over 1.5 days and address the following topics:

- » (½ day) Concepts of GIPA and comprehensive education sector response
- » (1 day) Overview of the GIPA Toolkit and how to use it, including action planning

Orientation meetings with participants who are familiar with GIPA and a comprehensive education sector response may be shortened to one day only. Below is a sample agenda for an orientation meeting, which can be adapted to fit local needs and schedules.

Sample agenda

Objective

The MOE focal point and people living with HIV will facilitate a one-and-a-half day orientation that involves the participation of the following groups and will equip them to implement the GIPA toolkit:

- » MOE staff
- » MOH and NAP
- » Persons from the local network of people living with HIV and networks of positive teachers
- » Staff from various agencies who will assist with the implementation of activities from the toolkit (optional)

Anticipated outcomes

After Day 1, participants will be able to:

- » Explain the concept of GIPA
- » Describe a comprehensive approach to HIV and AIDS in the education sector and the role that they can play in ensuring this

After Day 2, participants will be able to:

- » Explain and practice how to make use of the toolkit
- » Develop an action plan for selected GIPA activities
- » Describe how to monitor and evaluate the use of the toolkit and integrate monitoring and evaluation (M&E) into the action plan

Following the sample agenda are handouts for an action plan template and sample. The accompanying CD-ROM includes a PPT presentation that can be used where indicated in the agenda. The presentation is divided into activities as indicated.

DAY 1			
TIME	**ACTIVITY**	**EXPECTED OUTCOMES**	**RESOURCES**
9:00– 9:30 am	**Welcome and introductions** **Objectives of the workshop** Welcome participants to the workshop. Appreciate their dedication to this important issue, and thank them for their participation. Emphasise the importance of active participation at this orientation session since participants will take a leading role in implementing the GIPA toolkit. Using a PPT presentation, explain the workshop objectives, anticipated outcomes, and workshop agenda.	Participants will know each other and will have a clear understanding of the expectations and structure of the workshop.	[*name of presenter*] "Orientation" PPT
9:30– 9:50 am	**Overview of GIPA and the need to advocate for GIPA** Using a PPT presentation, give a short overview of GIPA globally and in the Caribbean and of how participants can contribute to making GIPA reality. (Discuss history, GIPA principles, and examples of GIPA in practice, including networks of positive teachers.) Allow time for questions.	Participants will be able to: » Explain the concept of GIPA and how to operationalise it	[*name of presenter*] "Orientation" PPT For background info, see Activity 1.2 of this toolkit
9:50– 10:30 am	**Small group work** Divide participants into small groups of 3–4, and ask them to discuss in their own words what GIPA means. Ask them to write down examples of how they can operationalise GIPA in their work. Ask groups to report back and discuss.	Participants will be able to: » Explain the concept of GIPA	[*name of presenter*] "Orientation" PPT

10:30–10:45 am	**BREAK**		
10:45–11:10 am	**Overview of a comprehensive approach to HIV and AIDS in the education sector** Using a PPT presentation, give an overview of a comprehensive approach to HIV and AIDS in the education sector; emphasise the importance of including GIPA in a comprehensive approach. Allow time for questions.	Participants will be able to: » Describe a comprehensive approach to HIV and AIDS in the education sector in their country and the role that they can play in ensuring this	[*name of presenter*] "Orientation" PPT
11:10 am–12:00 pm	**Small group work** Divide participants into small groups of 3–4 and ask them to discuss in their own words what a comprehensive approach to HIV and AIDS in the education sector means. Ask them to discuss their experience contributing to the education sector response to HIV and AIDS: » What elements have they seen getting the most focus? » What areas seem to be weak/ lacking in programming? » What could they do to support more comprehensive responses? » How would these responses be enriched by the involvement of PLHIV? *Ask groups to report back and discuss.*	Participants will be able to: » Describe a comprehensive approach to HIV and AIDS in the education sector	[*name of presenter*] "Orientation" PPT For background info, see Section 2 of this toolkit

12:00–12:15 pm	**Wrap-up for Day 1** Thank participants for their involvement. Ask participants to summarise main concepts (GIPA and comprehensive approach). Distribute a GIPA Toolkit to all participants, and instruct them to look it over before the next day of the meeting (Day 2), paying particular attention to the activities they want to implement. Remind participants to bring their copy of the Toolkit with them on Day 2.		GIPA Toolkit (*for all participants*)

DAY 2			
TIME	**ACTIVITY**	**EXPECTED OUTCOMES**	**RESOURCES**
9:00–9:15 am	**Welcome and Recap of Day 1** Welcome participants to Day 2 of the workshop. Review briefly the two concepts introduced on Day 1 (GIPA and a comprehensive approach to HIV and AIDS), and clarify any questions. Introduce the anticipated outcomes and agenda for Day 2.		[*name of presenter*] "Orientation" PPT
9:15–10:00 am	**Overview of the toolkit** Using a PPT presentation and copies of the GIPA Toolkit, give an overview of what is included, going step by step through each section. Give participants an opportunity to explore the toolkit on their own. For instance, ask them where they find the section with activities on stigma and discrimination and what is included in that section. Group work can actually make use of sections of the toolkit, discussing possible modifications based on local situations. Answer any questions.	Participants will be able to: » Explain and practice how to make use of the toolkit	[*name of presenter*] GIPA Toolkit "Orientation" PPT
10:00-10:15 am	**BREAK**		

10:15 am–12:00 pm	**Participants developing an action plan for implementing GIPA activities** Using a PPT presentation from GIPA tool-kit, explain action planning. Split participants into groups in which they will naturally work together to imple-ment activities. Ask participants to start developing a 1-year action plan (using the provided template and example) that fits into their existing goals and utilises activities from this toolkit to operationalise GIPA. Explain that activities can be modified to accom-modate time constraints.	Participants will be able to: » Develop an action plan for selected GIPA activities for one year	[*name of presenter*] [may need separate facilita-tors for each of the participant groups] Action Plan and Sample “Orientation” PPT
12:00–12:30 pm	**Reporting** Ask groups to report on their action plans and identify next steps. Allow time for discussion. Facilitator may conclude each of the reporting sessions, (e.g., common areas of work, how this links [or doesn’t] to a comprehensive educations sector response).		Flipcharts and markers
12:30–1:30 pm	**LUNCH BREAK**		
1:30–3:00 pm	**Modelling one complete activity.** Demonstrate one activity from the GIPA toolkit, using the activity sheets, hand-outs, and facilitator resources provided, (e.g., activity on stigma and discrimina-tion, which is central to GIPA). Debrief the activity	Participants will be able to: » Explain and practice how to make use of the toolkit	[*name of presenter*] “Orientation” PPT

3:00–3:15 pm	**BREAK**		
3:15–4:30 pm	**Monitoring and evaluation** Describe how to monitor and evaluate activities from the GIPA Toolkit, and achievement of objectives. Introduce existing M&E systems. Allow time for questions and answers. Have participants go into the groups in which they developed their action plans; ask them to strengthen the "Evaluation" section in their action plans (e.g., add concrete examples of how M&E can be achieved, what will be measured, when and by whom, and how reported). Ask for some volunteers to report.	Participants will be able to: » Describe how to monitor and evaluate the use of the toolkit	[*name of presenter*] "Orientation" PPT
4:30–5:00 pm	**Wrap-up** Review whether participants have achieved anticipated outcomes. Give workshop evaluation sheet. Make sure expectations are clear for next steps and participants feel prepared. Answer any questions that arise.		[*name of presenter*] "Orientation" PPT

Handout: Action Plan Template

Instructions: On this form, record one of your goals for operationalising GIPA and one objective to meet this goal. Identify the steps needed to achieve the objective in a year's time. Who will take responsibility for the completion of the step? When will the step be completed? What resources will be required? How will it be evaluated? Make additional copies of this page to create an action plan for additional goals, objectives, and years.

GOAL:

YEAR:

OBJECTIVE:

Activity	Timeframe	Person(s) responsible	Resources required	Evaluation

- Adapted from: WHO/UNESCO/EDC. (2000). *Local Action: Creating Health Promoting Schools.* Geneva: World Health Organization. Available from: http://www.who.int/school_youth_health/media/en/88.pdf

Handout: Action Plan Sample

Instructions: On this form, record one of your goals for operationalising GIPA and one objective to meet this goal. Identify the steps needed to achieve the objective in a year's time. Who will take responsibility for the completion of the step? When will the step be completed? What resources will be required? How will it be evaluated? Make additional copies of this page to create an action plan for additional goals, objectives, and years.

GOAL: Introduce the GIPA principles to the education sector

YEAR: 1
OBJECTIVE: Sensitise various personnel in the education sector to the principles of GIPA by March 31, 20xx

Activity	Timeframe	Person(s) responsible	Resources required	Evaluation
1) Conduct sensitisation workshop for the multi-sectoral HIV and AIDS committee.	*October 20xx*	*A. B.* *(e.g., MOE HIV focal point)*	*GIPA Toolkit, Activity 1.1* *Supplemental material*	*Workshop feedback form*
2) Conduct sensitisation workshop for principals.	*November 20xx*	*C. D.* *(e.g., MOE staff member)*	*GIPA Toolkit, Activity 1.1* *Supplemental material*	*Workshop feedback form*
3) Conduct sensitisation workshop for primary and secondary teachers.	*January 20xx*	*E. F.* *(e.g., person living with HIV)*	*GIPA Toolkit, Activity 1.1* *Supplemental material*	*Workshop feedback form*
4) Conduct sensitisation workshop for parents.	*February 20xx*	*G. H. and E. F.* *(e.g., teacher and person living with HIV)*	*GIPA Toolkit, Activity 1.1* *Supplemental material*	*Workshop feedback form*

SECTION 1

Orientation to HIV and AIDS and GIPA

This section is intended to introduce participants to basic information about HIV and AIDS and the benefits of the GIPA principles. It illustrates the complexities of behaviours and circumstances that contribute to the epidemic in the Caribbean; it will enable participants to gain a better understanding of why GIPA is important for a comprehensive approach to HIV and AIDS in the education sector. It will also improve participants' understanding of the barriers to operationalising the principles of GIPA.

What you need to know

What are HIV and AIDS?

HIV stands for Human Immunodeficiency Virus. It is a virus that infects cells of the **immune system** and impairs and destroys them. This process weakens the immune system and reduces the body's resistance to illnesses. **AIDS** stands for Acquired Immune Deficiency Syndrome. It is the condition that occurs when the immune system of a person with HIV is weakened to the point that he or she has difficulty resisting the effects of infections such as sexually transmitted infections (STIs), tuberculosis (TB), flu, pneumonia, and certain cancers.

HIV infection can be managed so that it progresses more slowly, but it cannot be cured. The main treatment is **antiretroviral** medications (ARV). Taking good care of one's health, including eating well and getting enough exercise and rest, can also help. AIDS cannot be cured.

Anyone can contract HIV. However, some behaviours, such as **unprotected sex** and injecting drugs use put people at higher risk. People who are infected with HIV can look and feel healthy and may not know for years that they are infected. However, they can infect other people no matter how healthy they seem. The only way to tell if someone is infected with HIV is with a blood test. When people with HIV do have symptoms, they are similar to those of many other common illnesses, such as fever, swollen glands, tiring easily, headaches, joint pain, diarrhoea, losing weight, and skin rashes.

What is GIPA?

GIPA stands for:

Greater

Involvement of

People living with or affected by

HIV and **A**IDS.

Where did GIPA originate?

In Denver, USA, 1983, a small group of people living with HIV put forth a set of principles on their human rights as citizens and their right to involvement in the HIV and AIDS response.

The Denver Principles—Recommendations for All People included:

We recommend that people with AIDS:

1. Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda, and to plan their own strategies

2. Be involved at every level of decision-making and specifically serve on the boards of directors of provider organisations
3. Be involved in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge[5]

Why is GIPA important?

- Programmes and curricula for HIV and AIDS are more effective when people living with HIV are involved in the planning, executing, and evaluating of such programmes.
- People living with HIV who are also employed by the education sector will benefit from an improved psychosocial environment, which will, in turn, assist their mental and emotional well-being.
- As stories are shared from persons infected or affected by HIV, stigma and discrimination will be reduced. Persons will challenge their myths of transmission and prevention.
- The reduction of stigma and discrimination will lead to greater support and action

Activity 1.1 focuses on HIV and AIDS and some of the most important terms and concepts that must be understood in order to establish a common foundation and language on which to explore the complexities and challenges of responding to the epidemic in the education sector. Activity 1.2 can be used to sensitise people to the principles of GIPA and promote critical thinking about benefits and barriers to operationalising the GIPA principles.

Facilitation tips

To make the topic come alive and "appeal to the heart" you may begin with a short film or testimony from someone who shares feelings about the stigma and discrimination experienced by teachers or students living with or affected by HIV and AIDS.

Facilitation tip for MOE personnel

Give examples of how MOE **collaborates** (or could collaborate) with MOH and people living with HIV on operationalising the principles of GIPA. Consider inviting a colleague from a health centre to facilitate the activity on basics about HIV and AIDS.

Tips for people living with HIV

Ensure that you know enough about the MOE involvement, and highlight how the programme will benefit people living with and affected by HIV.

Ask participants that are presently members of a support group or network of people living with HIV to give examples of how the support group/network has collaborated with MOH or MOE on operationalising the principles of GIPA.

Give practical examples of where people living with HIV have encountered some resistance toward their meaningful involvement, of how they have addressed it, and where they have made a difference.

Facilitation tip for MOH personnel

Give examples of how the MOH collaborates with the MOE and people living with HIV on operationalising the principles of GIPA and addressing these barriers and on which specific roles MOH staff may play.

ACTIVITY 1.1

Sensitisation session: What are HIV and AIDS?

Goal: To create a foundation of understanding regarding HIV and AIDS and an appreciation of the complexities surrounding transmission, prevention, treatment, and other elements.

Target audience: Education sector, line ministries involved with HIV work, network of people living with HIV

Time: 1 hour 50 minutes

Objectives: *At the end of the session, participants will be able to:*

- Discuss HIV and AIDS knowledgably and respectfully using appropriate language *(cognitive)*
- Identify individual behaviours by the level of risk for HIV infection, leading to more informed decision-making *(behavioural)*
- Begin thinking about gender-based issues, voluntary counselling and testing, and stigma and discrimination *(affective)*

Preparation: *Prepare in advance:*

- On a flipchart, create two columns. Write at the top of the first column "True" and at the top of the second column "False." Along the left side of the chart, in sequential order going down the page, write the numbers 1 through 7.
- On separate pieces of paper write, in large letters, "HIGH RISK," "LOW RISK," and "NO RISK." Place each of the three signs in three different locations of the room or meeting area.

Prepare the following materials to be used during this activity:

- Activity 1.1—PPT Presentation (included on CD-ROM)
- Handout A: HIV and AIDS: key terms
- Handout B: VCT, living with HIV, and treatment
- Handout C: High, low, and no-risk behaviour chart
- Flipchart, flipchart paper, and markers

Familiarise yourself with the contents of:

- Facilitator Resource A: True and False statements about HIV and AIDS
- Facilitator Resource B: Understanding the complexities of HIV: a story

Methods: Individual and group work

Introduction — 5 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. "Tips for facilitators").

Introduce the session, explain that coordinating an education sector-wide approach to reducing the impact of HIV and AIDS in the Caribbean requires a solid foundation of knowledge and sensitivity among all who are involved in the response. Indicate that this session involves activities that will help to more clearly understand HIV and AIDS, dispel common myths, and appreciate the complexity of high-risk behaviours, transmission routes, and options for prevention and treatment.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 10 min

Begin by asking the following question: "What are STIs, HIV, and AIDS? How are they related and how are they different?"

After a brief group discussion, distribute Handout A (HIV and AIDS: key terms"), and read the introductory section entitled "What are HIV and AIDS?" at the top of the page. Ask participants to review these terms at their convenience. The definitions and distinctions are critical for understanding some of the key issues around HIV and AIDS.

Step 3 — 20 min

Introduce the next activity: explain that you will read a series of statements about the transmission, prevention, treatment, and impact of HIV and AIDS. For each statement, you will ask for a show of hands if the statement is true or false. You will record each "vote" as a tally in each column, corresponding to the statement number. Following each statement and the tally of responses, you will provide the correct answer and a brief explanation.

Use Facilitator Resource A ("True and false statements about HIV and AIDS"), record all responses on the flipchart (prepared earlier), and then read the correct answer and explanation from the Facilitator Resource. After all statements and their correct answers have been read, discuss the questions and answers.

Distribute Handout B ("VCT, living with HIV, and treatment"). Explain that participants can use this reference themselves or to encourage and guide friends, family, or others to get tested and where to find treatment and support options.

Step 4 — 20 min

Label three areas in the meeting room: HIGH risk, LOW risk, and NO risk.

Ask participants to stand up and gather together away from the centre of the room. Explain that you will describe a series of behaviours, and for each behaviour participants will decide whether it represents high risk, low risk, or no risk of HIV transmission, and move to the sign that indicates their decision.

Refer to Handout C ("High, low, and no-risk behaviour chart"). Read aloud the behaviours in the ten highlighted rows, following the order indicated in the first column. Start at behaviour #1 "Vaginal sex without a condom," and instruct participants to move to any one of the locations marked with a paper sign. Read the correct answer (provided in the third column); complete this activity for all 10 behaviours. Clarify any questions that may arise.

Step 5 — 10 min

Distribute Handout C ("High, low, and no-risk behaviour chart"). Explain that this chart organises the behaviours described in this activity as well as many others by high, low, and no risk of HIV transmission.

Ask participants to talk about some of the misconceptions and surprises that may have emerged during the activity and to reflect on how they came to their decisions. For those behaviours that they were unsure of, were they influenced by the decisions of the other participants? Explain that this is similar to the way in which myths and misinformation may spread. When large numbers of individuals share a false belief, it is often very difficult to challenge them. Stigma and discrimination are often the result of fear.

Step 6 — 25 min

Read the story in the first section of Facilitator Resource B ("Understanding the complexities of HIV: a story"). Ask participants to consider aspects of the story they may have found particularly noteworthy.

Using a flipchart, record some of the ideas that participants share. Use the bullet-point list at the end of the Facilitator Resource and the final debrief section to cover topics or issues that were not raised in discussion.

Closure — 15 min

Use the PPT presentation (Activity 1.1—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity.

Ask participants to reflect on their experience in this activity and to write down on a piece of paper one thing they learned. Collect responses from participants.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

» Record how many people participated, and their affiliations.

Outcome:

» Compare responses from the pre- and post-quizzes.
» Record responses of participants to "Closure" question ("What is one thing that you learned through participating in this activity?").

Quiz answers

1. b

2. d

3. a. True
   b. False
   c. True
   d. False

4. a. iv
   b. iii
   c. v
   d. ii
   e. vi
   f. i

ACTIVITY 1.1

Quiz questions

1. AIDS stands for:

    a. Acquired Immune Degradation Syndrome
    b. Acquired Immune Deficiency Syndrome
    c. Acute Invasive Disease Sickness
    d. Acute Inflammatory Disorder Syndrome

2. You can become infected with HIV by which of the following? (Check all that apply.)

    a. Sharing eating utensils or cookware with someone who is HIV-positive
    b. Mosquito bites
    c. Hugging or touching someone who is HIV-positive
    d. Sex without a condom
    e. None of the above

3. True or False:

a. A person with AIDS always has HIV.	True	False
b. A person with HIV always has AIDS.	True	False
c. There is no cure for HIV or AIDS.	True	False
d. You can always tell if someone has HIV.	True	False

4. Match the following terms with their correct definition (write the appropriate number on the lines below):

a. Universal precautions ______________________ b. Epidemic ______________________ c. Immune system ______________________ d. Confidentiality ______________________ e. Stigma ______________________ f. ARV ______________________	i. Treatment for HIV-positive individuals, interfering with the ability of the HIV virus to replicate itself ii. Non-disclosure of any information (often medical) related to a particular individual by a third party that has been permitted to know this information through writing or oral communication iii. An infection or disease that has spread rapidly through a segment of the human population in a given geographic area iv. Safety measures to prevent blood-borne HIV transmission v. The parts of the body that fight germs in order to maintain health vi. The process of devaluing people and viewing them negatively on the basis of a particular attribute, for example, their HIV status, gender or sexuality

ACTIVITY 1.1
HANDOUT A: HIV and AIDS: key terms

What are HIV and AIDS?

HIV stands for Human Immunodeficiency Virus. It is a virus that infects cells of the immune system and impairs and destroys them. This process weakens the immune system and reduces the body's resistance to many different illnesses. AIDS stands for Acquired Immune Deficiency Syndrome. It is the condition that occurs when the immune system of a person with HIV is weakened to the point that he or she has difficulty resisting the effects of infections such as sexually transmitted infections (STIs), tuberculosis (TB), flu, pneumonia, and certain cancers.

HIV can be managed so that it progresses more slowly, but it cannot be cured. The main treatment is antiretroviral medications. Taking good care of one's health, including eating well and getting enough exercise and rest, can also help. AIDS cannot be cured.

Anyone can get HIV by having sex without a condom, sharing needles, or handling a bleeding injury of somebody who is HIV-infected (if you also have a cut). HIV can also be transmitted during breastfeeding if the mother is HIV-positive. People who are infected with HIV can look and feel healthy and may not know for years that they are infected. However, they can infect other people no matter how healthy they seem. The only way to tell if someone is infected with HIV is with a blood test. When people with HIV do have symptoms, they are similar to those of many other common illnesses, such as fever, swollen glands, tiring easily, headache, joint pain, diarrhoea, losing weight, and skin rash.

Key Terms

AIDS: (Acquired Immune Deficiency Syndrome) A disease of the body's immune system caused by the human immunodeficiency virus (HIV). AIDS is characterised by the death of CD4 cells (an important part of the body's immune system), which leaves the body vulnerable to life-threatening conditions, such as infections and cancers.

ADHERENCE: Strict compliance with a prescribed medication therapy in order to avoid resistance. This can be difficult due to the number of tablets that need to be taken, dose frequency, and side effects.

ANTIRETROVIRAL (ARV): A medication that interferes with the ability of a retrovirus, such as HIV, to make more copies of itself.

CD4 CELL: Also known as helper T cell or CD4 lymphocyte, a type of infection-fighting white blood cell. CD4 cells coordinate the immune response, which signals other cells in the immune system to perform their special functions.

COMBINATION THERAPY: Two or more medications used together to achieve optimal results in controlling HIV infection. Combination therapy has proven more effective than monotherapy (single-medication therapy), which is no longer recommended for the treatment of HIV.

CONFIDENTIALITY: The non-disclosure of any information (often medical) related to a particular individual by a third party that been permitted to know this information through writing or oral communication.

DISCLOSURE: Sharing information related to one's HIV status with one or various people.

DISCRIMINATION: Any form of arbitrary distinction, exclusion, or restriction based on a stigmatised attribute. Discrimination violates individuals' rights.

DRUG RESISTANCE: When an HIV drug, or treatment medication, becomes increasingly ineffective due to the virus going through genetic changes as it replicates in order to resist the drug.

EPIDEMIC: An infection or disease that has spread rapidly through a segment of the human population in a given geographic area.

HAART: (Highly Active Antiretroviral Therapy) A name given to treatment regimens that aggressively suppress HIV replication and its progression by using three or more anti-HIV medications.

HIV: (Human Immunodeficiency Virus) The virus that causes AIDS. Two types have been identified: HIV-1 and HIV-2. HIV-1 is responsible for most HIV infections throughout the world, whereas HIV-2 is found primarily in West Africa.

IMMUNE SYSTEM: The parts of the body that fight germs in order to maintain health.

MARGINALISED GROUPS: Those groups of individuals or communities whose social standing, power, or rights have been reduced to extremely low levels, often resulting in exclusion from beneficial services, programmes, policies. Marginalisation unfairly limits access to food, shelter, and other human necessities.

OPPORTUNISTIC INFECTION: An infection which rarely causes illness in people with intact immune systems, but which can become life-threatening for someone with HIV whose immune system is compromised.

PANDEMIC: An outbreak of an infection or disease, such as HIV and AIDS, that affects people or animals over an extensive geographic area (also known as a global epidemic).

PROPHYLAXIS: Treatment to prevent the onset of a particular disease or to prevent recurrence of symptoms of an existing infection that has been brought under control.

STI: (Sexually Transmitted Infection): Any infection spread by the transmission of organisms from person to person during sexual contact.

STIGMA: The process of devaluing people and viewing them negatively on the basis of a particular attribute, for example, their HIV status, gender, or sexuality.

UNIVERSAL PRECAUTIONS: Safety measures to prevent transmission of HIV and other blood-borne germs when providing first aid or health care. This involves wearing protective barriers such as gloves.

VACCINE: An injection of dead or weakened germs intended to cause the immune system to make antibodies to a particular germ.

- UNAIDS. (2007). Fast facts about AIDS. Geneva: UNAIDS. Available from: http://www.unaids.org/en/MediaCentre/References/default.asp
- AVERT. (2007, October). What is AIDS? Available from: http://www.avert.org/aids.htm
- http://aidsinfo.nih.gov/ContentFiles/GlossaryHIVrelatedTerms.pdf
- FRESH Tools for Effective School Health (http://www.unesco.org/education/fresh)
- CDC. (1996). Universal Precautions for Prevention of Transmission of HIV and Other Bloodborne Infections. http://www.cdc.gov/ncidod/dhqp/bp_universal_precautions.html

ACTIVITY 1.1
HANDOUT B: VCT, living with HIV, and treatment

Voluntary counselling and testing

VCT, or voluntary counselling and testing, is an important component of the global response to HIV and AIDS. An HIV test reveals whether the virus is present in the body. It is easier to detect antibodies produced by the immune system than the virus itself. These antibodies suggest the presence of HIV. For most people, it takes about three months for these antibodies to develop. During this "window period," that is from the time someone contracts the virus and before it is detectable, a person can infect others with HIV. It is therefore important to get tested.

Knowing your HIV status has two vital benefits. First, if you are an HIV-positive person, you can take necessary steps before symptoms appear to access treatment, care, and support services, thereby potentially prolonging your life for many years. Second, if you know you are infected, you can take all the necessary precautions to prevent the transmission of HIV to others.

There are many places where you can be tested for HIV: local health departments, hospitals, family planning clinics, and other locations. Always try to find testing at a place where counselling is provided regardless of the result of the HIV test. In all cases, the results of the HIV test must be kept absolutely confidential, and you must give your consent before being tested (often privately).

A negative test result means that no HIV antibodies were found in your blood at the time of testing. If you are HIV-negative, make sure you stay that way: learn the facts about HIV transmission and prevention and avoid engaging in unsafe behaviour. However, if you are in the "window period," there is still a possibility that you might be infected. Nevertheless, it is very important to be tested. What to do if you find out that you do have HIV is explored in the next part of this handout.

Living positively with HIV

If you find out that you have contracted the virus, a change of lifestyle may be necessary. Eating nutritiously, practicing good hygiene, and exercising regularly become increasingly important for people living with HIV, as these contribute to the building and repair of the body, and stress reduction. Issues related to sex and sexuality are also very important and as a result thought must be given to correct and consistent usage of condoms, or abstinence. People living with HIV should strongly commit to HIV and STI prevention. Social and spiritual supports are also very important; you should look for them with a social worker or a counsellor (for referral) or clergy if available in your area. Some groups—such as self-support groups run by people living with HIV, by churches, or by non-governmental or community-based organisations—may offer these services.

There are other important issues that individuals living with HIV should consider; they can make the difference between a successful and an unsuccessful attempt to live positively with HIV. These issues include the right to privacy, confidentiality, informed consent, and how you manage the

stressors of relationships, money, and time. Finally, since there is no known cure for HIV infection, HIV-positive persons need to seek out the latest information on agencies, policies, or programmes relating to prevention, care, support, treatment, and gender-related concerns.

In short, you can do the following to stay healthy:

» To the best of your ability, follow your doctor's instructions, keep your appointments, and take medicine exactly as prescribed.
» Get immunisations to prevent infections such as pneumonia and flu.
» Eat healthy foods and use safe drinking water.
» Exercise regularly to stay strong and fit.
» Get enough sleep and rest.
» Access individual counselling that can give you information about available prevention, care, and treatment options.
» Seek support for disclosure to your partner and couples counselling (if available).
» Follow-up with HIV testing and counselling for your partners and children.
» If you are pregnant, get information from your doctor on the prevention of mother-to-child transmission and advice on infant feeding.
» Get screening and treatment for other infections including TB, malaria, and other STIs.

Current status of HIV treatment

Presently, standard medical treatment consists of at least three antiretroviral (ARV) medications to suppress HIV and slow its progression. Use of ARVs has dramatically reduced AIDS-related disease and deaths since 1996 in countries where they are widely accessible. In recent years, access has significantly increased in low- and middle-income countries. While not a cure for AIDS, combination ARV therapy has enabled HIV-positive people to live longer, healthier, more productive lives by reducing the amount of HIV in the blood and increasing the number of CD4 cells (white blood cells that are central to the effective functioning of the immune system).

According to the World Health Organization, ARVs are not needed until a person with HIV has a CD4 blood cell count of 200 or less. When ARV treatment is needed, the treatment plan must be followed closely. Failure to take the medications as prescribed may result in treatment failure and the emergence of medication-resistant HIV.

Since new treatments and combinations of treatments are being developed all the time and a large variety of treatments are becoming more widely accessible, it is important to always get the most up-to-date information. In most countries, there is an office of the WHO that works with the country's Education For All and HIV/AIDS prevention (EFAIDS) coordinator to stay current with the latest treatments available in the country. Individuals also need to consult with their own doctors to determine which combination of medications is best for them, given their health and specific situation.

• UNAIDS. (2007). Fast facts about AIDS. Available from: http://www.unaids.org/en/MediaCentre/References/default.asap
• WHO. (2007). Antiretroviral therapy. Available from: http://www.who.int/hiv/treatment/en/index.html
• UNAIDS. (2008). Fast Facts About HIV Testing and Counselling. Available from: http://data.unaids.org/pub/FactSheet/2008/20080527_fastfacts_testing_en.pdf

ACTIVITY 1.1

HANDOUT C: High, low, and no-risk behaviour chart

Order Level	Behaviour	Risk
	Having multiple sexual partners	High
1	Vaginal sex without a condom	High
8	Anal sex without a condom	High
4	Sharing needles	High
5	Reusing a needle cleaned with water	High
	Breastfeeding if mother is HIV-positive	High
	Treating a bleeding injury while having an open wound or cut	High
	Oral sex without a condom	Low
9	Anal sex with a condom*	Low
2	Vaginal sex with a condom	Low
	Oral sex with a condom	Low
	Mutual masturbation	Low
	Treating a wound or bleeding injury, using universal precautions	No
	Self-masturbation	No
6	Kissing**	No
	Hugging	No
	Flirting	No
	Sharing a cup with someone who is HIV-positive	No
10	Sharing eating utensils or cookware with an HIV-positive person	No

	Touching someone who is HIV-positive	No
	Working with someone who is HIV-positive	No
	Breathing air	No
7	Sharing a toilet/latrine seat with someone who is HIV-positive	No
3	Handling or playing with animals	No
	Being near a person coughing or sneezing	No

*Risk is slightly higher than for vaginal sex with a condom because of the increased potential for condom breakage.

**Kissing is not considered a risk behaviour unless both partners have open cuts or sores in their mouths.

• Adapted from: EDC, EI, & WHO. (2005). *Teachers' Exercise Book for HIV Prevention (WHO Information Series on School Health 6.1).* Geneva: WHO. Available from: http://www.who.int/school_youth_health/resources/sch_document61_HIV_prevention_env2.pdf

ACTIVITY 1.1
FACILITATOR RESOURCE A: True and false statements about HIV and AIDS

1. There is no cure for HIV or AIDS.

True. There is NO cure for HIV or AIDS. Currently, there are medications that are able to lessen its effects and transmission, but they are not a cure for HIV or AIDS. There are currently no therapeutic or preventive vaccines for HIV.

2. HIV can be transmitted through mosquito bites.

False. The United States Centers for Disease Control and Prevention (CDC) has conducted studies indicating that HIV cannot be transmitted through the bites of mosquitoes or other insects. This has been shown to be true even in areas where there are many cases of AIDS and large mosquito populations.

3. You do not need to get tested for HIV if you have not had multiple sexual partners.

False. Though individuals who have sex with multiple partners are at higher risk of contracting HIV, you can get infected from a single HIV-positive partner, or even a spouse. Getting tested is the way to knowing your HIV status.

4. Condoms are an effective means of lowering the risk of HIV transmission.

True. When used correctly and consistently, condoms are a very effective means to prevent the transmission of HIV and other sexually transmitted infections (STIs). Studies have shown that condoms used in the correct manner are effective 98 to 100 percent of the time at preventing transmission.

5. Both heterosexual and same-sex couples are at risk for becoming infected with HIV.

True. Anyone who has unprotected sex or participates in other high-risk activities can contract HIV. According to a 2008 UNAIDS Global Report, heterosexual intercourse is the main mode of HIV transfer in the Caribbean.

6. You can always tell if someone is infected with HIV.

False. People who are infected with HIV can appear to be perfectly healthy. Many HIV-positive people are unaware that they are infected. These individuals can transmit HIV to others even if they are not presenting any symptoms. This is a major reason why testing for HIV is important.

7. Helping someone in an emergency situation who is bleeding puts you at an increased risk for becoming infected with HIV.

False. Unless you have an open wound that comes in contact with the blood of another individual who has HIV you are not at risk. The risk of transmission for a healthy and uninjured person who is assisting during an emergency situation is very low. It is recommended to use universal precautions.

• Adapted from: EDC, EI, & WHO. (2005). *Teachers' Exercise Book for HIV Prevention (WHO Information Series on School Health 6.1).* Geneva: WHO. Available from: http://www.who.int/school_youth_health/resources/sch_document61_HIV_prevention_env2.pdf

ACTIVITY 1.1

FACILITATOR RESOURCE B: Understanding the complexities of HIV: a story

Story: Isabel and Marcus

Marcus married Isabel shortly after discovering she was pregnant. By her third trimester, Isabel found it harder and harder to keep her morning routine. She got up before dawn every day to prepare breakfast. She used pots and pans that had been passed down to her from her mother, worn and slightly rusted, but strong. She was young and had not planned to be pregnant yet, but Marcus' repeated refusal to wear a condom meant that she would be a mother within weeks.

Her husband left each day for work, constructing homes in town out of rebar and concrete. Isabel would stay and work in the garden and around the house, often with little or no interaction with any of her neighbours. She tended their garden and fed their pigs. Mosquitoes took advantage of the summer humidity, which forced her to wear only thin wraps and light, sleeveless dresses. Though he only worked in daylight hours, Marcus often returned home long after dinner, after Isabel had gone to bed.

The morning Isabel went into labour, she was at the market. Luckily, one of the other women gathering water immediately found a driver to take her to the local clinic. For nearly 10 miles, Isabel rode inside the cab of the truck, overwhelmed by the smell of diesel, the man's hacking cough, and her contractions, which were becoming more frequent and more painful. Shortly after arriving at the clinic, she gave birth to baby girl and, shortly after that, fell asleep. When she awoke, a nurse told Isabel that her blood test was HIV-positive.

Questions for discussion

1. What factors/circumstances put Isabel at risk for HIV infection? What are some possible ways she might have become infected?
2. What could be done, at the individual, family, community, and national levels, to lower the risk for HIV infection?
3. How do gender roles and inequalities impact the transmission of HIV?
4. What are some of the circumstances that might prevent Isabel from receiving HIV treatment?
5. What could be done, at the individual, family, community, and national levels, to support Isabel?

Facilitator notes to guide discussion

Isabel may not be aware of her own risk for HIV infection

- Assumes husband is faithful
- May not have information or knowledge about the transmission of HIV or how to prevent infection
- May not have access to condoms
- Husband refuses to wear condoms
- She may be afraid to ask husband to wear condoms or get tested; may be taken as perceived infidelity on her part
- Social norms may dictate husband should not wear condom
- Social norms may prevent her from getting tested for HIV

Treatment challenges

- Many HIV-positive people may appear and feel healthy and be unaware that they have contracted HIV and will not receive treatment early on
- Medicine may not be available
- Medicine may not be affordable
- May be difficult adhering to the treatment schedule: steps or direction may be complicated; may require regular treatment intervals; individuals may not have a clock or refrigerator; or work and busy schedule may prevent regular treatment opportunities

Transmitting HIV to her child

- Can transmit HIV to child while in the womb
- Can transmit HIV to child during birth through blood
- Can transmit HIV to child through breast milk
- Transmission risk can be lowered through ARV treatment during pregnancy
- Transmission risk can be lowered through the use of Nevirapine during the first few days of life

Ways Isabel could NOT have contracted HIV in the story

- Using cookware
- Handling animals
- Through mosquito bites
- Being near someone who is coughing

ACTIVITY 1.2

Sensitisation session: What is GIPA?

Goal: To explore the meaning and benefits of GIPA and sensitise a variety of audiences to the importance of operationalising the principles of GIPA principles.

Target audience: Education sector, other line ministries involved with HIV work, network of people living with HIV

Time: 1 hour 40 min

Objectives: *At the end of the session, participants will be able to:*

» Identify benefits and barriers of GIPA *(cognitive)*
» Express the need to sensitise people about GIPA *(affective)*
» Present GIPA principles, their importance, and what participants will do differently to operationalise them *(behavioural)*

Preparation: *Prepare the following materials to be used during this activity:*

» Activity 1.2—PPT Presentation (included on CD-ROM)
» Handout A: GIPA fact sheet
» Flipchart, flipchart paper, and markers

Familiarise yourself with the contents of:

» Facilitator Resource A: What are the barriers to GIPA?

Methods: Brainstorm, presentation, group work and group presentations, individual writing

Introduction — 10 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. “Tips for facilitators”).

Introduce the session by telling participants that they will spend some time brainstorming on what is GIPA. Later in the session they will be asked to present the benefits of GIPA. The lesson will start with a short quiz to stimulate thinking.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 10 min

Brainstorm with participants the following question: "What is GIPA?" Record all responses on flip-chart paper.

Then ask participants to reflect and write a sentence on:

- How they are helping to ensure the greater involvement of people living with or affected by HIV and AIDS at work and in their community
- What roles people living with HIV could potentially assume in the education sector response to HIV and AIDS

Step 3 — 10 min

Use the PPT presentation (Activity 1.2—PPT Presentation, included on CD-ROM) to highlight some of the history of GIPA, and discuss why it is important to incorporate GIPA principles in all activities of the education sector. Respond to any questions that may arise for clarification.

Step 4 — 10 min

Divide participants into small groups. Ask them to discuss the benefits and challenges to operationalising the GIPA principles in the education sector. (Ask each group to identify a reporter who will be responsible for writing the group's two lists: Benefits and Challenges.)

Step 5 — 10 min

Ask each group to report. Record responses on a flipchart and review them when all groups have reported.

Step 6 — 30 min

Ask each group to develop a short skit that addresses the concept of operationalising GIPA.

For instance, the skit could depict an interaction between a principal and a parent who does not want an HIV-positive teacher to teach his children or does not want to have an HIV-positive child be the classmate of his child. The principal explains the concept and benefits of greater involvement of people living with HIV.

For 15–20 minutes, ask groups to think about the main players and main arguments of the skit.

For 10–15 minutes, ask some groups to play out their skits.

Closure — 15 min

Challenge participants to select one suggestion on the flipchart paper to implement or to strengthen an action that they are already doing. Ask them to write it under the sentence that they wrote earlier in the session.

Distribute Handout A ("GIPA fact sheet"), and ask participants to post in a prominent place in their office.

Ask participants again what GIPA is, how their understanding has grown because of this workshop, and what they will do differently as a consequence of what they have learned. Encourage them to revise their earlier sentence as they now see fit.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

» Record how many people participated, and their affiliations.

Outcome:

» Compare responses from the pre- and post-quizzes.
» Record responses of participants to "Closure" questions (What is GIPA? How has your understanding changed because of this workshop? What will you do differently as a consequence?)

You may choose to hand out these questions in written form and collect the responses.

Quiz answers

1. b
2. c
3. a. True
   b. True
   c. False
   d. True
4. d

ACTIVITY 1.2 Quiz questions

1. What does GIPA stand for?
   a. Greater Illness Prevention Activities
   b. Greater Involvement of People Living With or Affected by HIV and AIDS
   c. Granting Infected People Access to Treatment and Services
   d. Guaranteed Investigation and the Promotion of Advanced Research

2. Which of the following is NOT a principle of GIPA?
   a. To involve people living with HIV and AIDS fully in decision-making, formulation, and implementation of public policies
   b. To protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV, through legal and social environments
   c. To encourage national leaders to investigate the origins of HIV and determine those responsible for the epidemic

3. True or False: Operationalising the GIPA principles can help to . . .

a.	. . . reduce stigma and discrimination.	True	False
b.	. . . create a more supportive workplace environment.	True	False
c.	. . . spread myths around HIV transmission.	True	False
d.	. . . engage people living with HIV in the creation of HIV and AIDS curricula	True	False

4. Which of the following is a potential step that can be taken to address the many barriers to implementing the GIPA principles?
   a. Secure a full commitment to GIPA principles by the education sector and other sectors.
   b. Create an action plan, outlining the next steps of the organisation.
   c. Avoid the distraction caused by obstacles and remedies, by disregarding them.
   d. Both A and B
   e. Both B and C
   f. All of the above
   g. None of the above

ACTIVITY 1.2

HANDOUT A: GIPA fact sheet

What is GIPA? GIPA stands for:

GREATER **I**NVOLVEMENT OF **P**EOPLE LIVING WITH OR AFFECTED BY HIV AND **A**IDS

What are the principles of GIPA?

» To involve people living with HIV and AIDS fully in decision-making, formulation, and implementation of public policies
» To protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV and AIDS, through legal and social environments
» To strengthen national and international mechanisms connected to human rights and ethics related to HIV and AIDS
» To strengthen the capacity and coordination of networks of people living with HIV and community-based organisations, stimulating the creation of a supportive political, legal, and social environment
» To make available necessary resources to better combat the pandemic, including adequate support for people living with HIV and AIDS and for non-governmental organisations (NGOs) and CBOs working with vulnerable and marginalised populations

What are the benefits of GIPA?

The involvement of people living with HIV would encourage:

» Protection and exercise of the civil right to participate
» A reduction in stigma and discrimination
» Greater support for people living with HIV
» More effective programmes and curricula for HIV and AIDS, as people living with HIV are involved in planning, implementing, and evaluating such programmes
» Improved psychosocial environment for persons with HIV who are employed by the education sector and thus improved mental and emotional well-being
» Removed myths about transmission and prevention of HIV

What are challenges to GIPA?

» Personal fears related to stigma and discrimination
» Lack of strong role models
» Poor health
» Lack of education or relevant technical skills
» Lack of confidence
» Poverty

- » Gender differences
- » Lack of information about opportunities
- » Policies that discriminate against the involvement of people living with HIV, such as mandatory testing and travel restrictions
- » Lack of policies to encourage the involvement of people living with HIV
- » Lack of funds to support volunteer involvement of people living with HIV
- » Negative attitudes of staff and directors who look down on people living with HIV

Addressing stigma and discrimination may be challenging because of the myths associated with HIV and AIDS. In addition, providing opportunities that are meaningful to people living with HIV may also be challenging.

What can you do?

- » Advocate for the greater involvement of people living with or affected by HIV and AIDS.
- » Set a good example yourself and involve people living with HIV.
- » Support those who support GIPA.
- » Learn more about the GIPA principles and what you can do to operationalise them.

- Adapted from: Chong, S., & Gray, G. (2005). *"Valued voices" GIPA toolkit: A manual for the Greater Involvement of People Living With HIV/AIDS.* Bangkok: Asia Pacific Network of People Living With HIV/AIDS (APN+) & Asia Pacific Council of AIDS Service Organisations (APCASO).
- For the original Declaration of the 1994 Paris AIDS Summit please visit: http://data.unaids.org/pub/ExternalDocument/2007/theparisdeclaration_en.pdf

ACTIVITY 1.2

FACILITATOR RESOURCE A: What are the barriers to GIPA?

Putting GIPA principles into practice has met with many challenges. Many barriers prevent and deter the meaningful involvement of people living with HIV. These barriers include:

Social factors—characteristics of societies in which people living with HIV reside

- Stigmatisation and discrimination, which can prevent people living with HIV from the opportunities to participate meaningfully in the comprehensive approach
- Poverty and underdevelopment
- Gender differences
- Discrimination against marginalised groups that are most affected in some parts of the region
- Lack of solidarity among people living with HIV themselves, reflecting the prejudices of the wider society

Institutional factors—characteristics of organisations with which people living with HIV may become involved

- Lack of information about opportunities.
- Policies that discriminate against people living with HIV, (e.g., mandatory testing of HIV during recruitment, travel restrictions on people living with HIV).
- Lack of policies that encourage the involvement of people living with HIV: affirmative employment policy; confidentiality and disclosure policy; sick leave and health insurance policies.
- Lack of funds that support involvement of HIV-positive volunteers, (e.g., to reimburse travel expenses, pay for childcare, or cover loss of earnings while contributing).
- Negative attitudes of staff, boards of directors, or donors; looking down on people living with HIV and seeing them only as patients or victims.
- Lack of strong role models to influence and inspire more people living with HIV to get involved.
- Lack of information or training by the education sector surrounding the issues of confidentiality and disclosure. This in turn, may prevent persons from being willing to disclose their status.

Personal factors—characteristics of people living with HIV who are or could become involved

- Fear of stigma, discrimination, or violence
- Negative attitudes and preconceived notions that may prevent positive behaviours and attitudes toward HIV and exclude people from equal opportunities
- Lack of support system
- Poor health, causing inability to meet commitments to be involved consistently
- Concern about the risk of exposure to opportunistic infections, such as TB, or the risk of psychological impacts
- Language barriers, including knowledge of only a minority language
- Lack of education or relevant technical skills, including not being able to read
- Poverty and the need to earn a living, difficulty in affording transport or childcare or other practical measures underlying the ability to contribute
- Lack of confidence in the ability to contribute, or lack of motivation to do so

To successfully operationalise the principles of GIPA, many of these barriers must be identified and the necessary steps should be taken to investigate the real practical and psychological obstacles to the greater involvement of people living with or affected by HIV and AIDS. Such steps could include but are not limited to:

1. Securing a full commitment to GIPA principles by the education sector and other sectors
2. Critically assessing the GIPA status of the education sector
3. Identifying obstacles and remedies, including existing policies that help as well as hinder
4. Creating an action plan, outlining the next steps of the organisation

- Cornu, C., & Dua, R. (2003). *The involvement of people living with HIV/AIDS in the delivery of community-based prevention, care and support services in Maharashtra, India.* A diagnostic study. Washington, DC: Population Council, Horizons. Available from http://www.aidsalliance.org/graphics/secretariat/publications/ipl0602_India_PLHA_study_report.pdf

SECTION 2

A comprehensive approach to HIV and AIDS

This section begins to incorporate GIPA principles into the education sector's delivery of HIV and AIDS programmes. It gives the opportunity to practice programme planning by applying the principles of GIPA to a comprehensive approach.

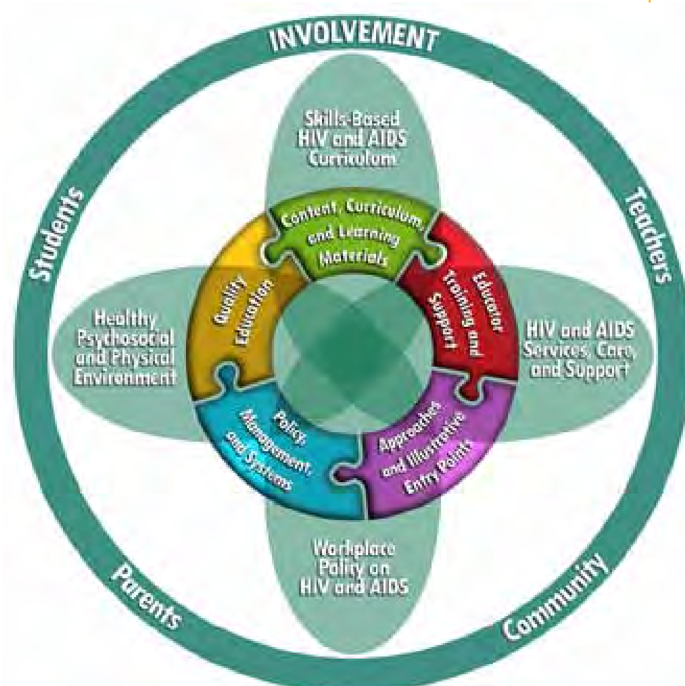
Over the years, agencies in the Caribbean have worked with people living with HIV. However, one of the challenges has been how to collaborate with people living with HIV in the education sector in a more meaningful and productive way. Having explored the benefits of GIPA in Section 1, we now turn our attention to how those involved can work together in presenting a united, strong, and sustainable effort to make the principles of GIPA a reality.

What you need to know

Implementing a comprehensive approach means using all means at the education sector's disposal to promote and protect the health of students and staff, and to mitigate the impact of HIV and AIDS on the system itself.[21]

Different models have been used to illustrate a comprehensive approach. The one used in this toolkit is derived from earlier models,[22,23] which are described in greater detail in Appendix 3. These earlier models emphasised similar components, but are strongest when viewed together, as in the new figure below.

The model for developing a comprehensive approach to HIV and AIDS in the education sector requires a balance of programmes and policies that are **complementary** and **participatory**: *complementary*, so that resources committed to one area may also be used in another area, and *participatory*, meaning that students, teachers, parents, and community are actively engaged.



This new model involves three layers:

1. Four overlapping components that balance curriculum, school environment, services, and policy to address HIV and AIDS in the education sector
2. Five key interlocking strategies to bridge the four components above and offer mechanisms for implementation
3. The active involvement of school community members at all levels

Why adopting a comprehensive approach to HIV and AIDS is important

There are many reasons why the education sector must do more to strengthen its response to HIV and AIDS:

» *The Caribbean has the second highest rate of HIV infection in the world.* As an extremely influential and important part of society, the education sector has the potential to help safeguard the lives of hundreds of thousands of learners, educators, and their families.
» *The number of children affected and orphaned by AIDS is rising rapidly.* By adopting a comprehensive approach to HIV and AIDS, the education sector can help decrease the number of children infected and affected.
» *The education sector is a workplace employing thousands of staff* who can benefit from HIV and AIDS-related workplace training programmes, fair employment policies, and benefits.
» *Young people, who are one of the key populations vulnerable to HIV, are being denied the essential knowledge and skills they need to protect themselves.* The education sector can help them develop these skills in the context of a healthy, responsible lifestyle and provide information about and access to services.
» *To create a productive workforce and to sustain economic development, the education sector needs healthy students and teachers.* If teachers or their families are not healthy, they cannot devote their energies to teaching; they may be frequently absent or even no longer work. If students or their families are not healthy, students cannot perform their best academically, they may miss classes or even withdraw from school.[22]

Activity 2.1 allows participants to reflect, respond, and think critically of ways to strengthen the education sector's response to HIV and AIDS by adopting and implementing components of a comprehensive approach.

Activity 2.2 encourages participants to work together and map out how they will apply GIPA principles in a comprehensive approach to HIV and AIDS in the education sector.

Facilitation tips

Activities 2.1 and 2.2 should be offered together or in close sequence.

If there seems to be a need to review basic information about HIV and AIDS (including how HIV is spread, common behaviours that lead to HIV infection, and HIV treatment) please refer to the handouts and facilitator resources provided for Activity 1.1.

For the original UNESCO/EDC and EDUCAIDS models of a comprehensive education sector response to HIV and AIDS, refer to Appendix 4. ("Additional models for a comprehensive approach to HIV and AIDS")

Facilitation tip for MOE personnel

The facilitator should note the general areas where people living with HIV are working in any way with the education sector before the PPT presentation. These should be displayed for all participating to see.

Tips for people living with HIV

The facilitator may list the participants' present activities in any area of the education sector and examine these against the comprehensive approach for GIPA. Write down and display findings for later discussion.

Facilitation tip for MOH personnel

The facilitator should note the general areas where people living with HIV are working in any way with the health sector (e.g., as treatment adherence counsellors/peer counsellors) before the PPT presentation. These should be displayed for all participating to see.

Explain the added value of having the education and health sectors collaborating in the overall response, how involving people living with HIV contributes to the health sector response (e.g., treatment education, care, and peer-support) and can similarly benefit the education sector.

ACTIVITY 2.1

Sensitisation session: What is a comprehensive approach to HIV and AIDS in the education sector?

Goal: To deepen understanding of a comprehensive approach to HIV and AIDS in the education sector.

Target audience: MOE staff; administrators in education, HIV core group for education; HFLE coordinators and teachers; people living with HIV group representatives; parent-teacher representatives

Time: 1hour 10 min

Objectives: *At the end of the session, participants will be able to:*

» Describe what a comprehensive approach to HIV and AIDS means for the education sector *(cognitive)*
» Appreciate the value of adopting a comprehensive approach in the education sector *(affective)*
» Commit to apply various components of a comprehensive approach to their HIV programming *(behavioural)*

Preparation: *Prepare the following materials to be used during this activity:*

» Activity 2.1—PPT Presentation (included on CD-ROM)
» Handout A: A comprehensive approach to HIV and AIDS in the education sector
» Flipchart paper or overhead projector with erasable markers and transparencies, index cards

Methods: Presentation, group sharing, discussion

Introduction — 5 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. “Tips for facilitators”).

Introduce the session by telling participants that they will spend some time brainstorming on how to operationalise the principles of GIPA in the education sector. Later in the session they will be asked to present.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 10 min

Ask participants to reflect on what they do to assist with the HIV and AIDS work in the education sector and to write their reflections.

After 3 minutes, have participants share with a nearby partner what they have written.

Step 3 — 15 min

Use the PPT presentation (Activity 2.1—PPT Presentation, included on CD-ROM) to illustrate the comprehensive approach to address HIV and AIDS in the education sector. Answer any questions participants may have.

Step 4 — 10 min

In plenary, ask the group to state the main tenets of a comprehensive approach. Have a volunteer record the answers.

The tenets should include:

- Workplace policy on HIV and AIDS
- Healthy psychosocial and physical educational environment
- Skills-based HIV and AIDS curriculum
- Access to HIV and AIDS services, care and support

The answers may also include the following strategies:

- Policy, management, and systems development
- Quality education
- Content, curriculum, and learning materials development
- Educator training and support
- Approaches and illustrative entry points
- Involvement at all levels

Step 5 — 20 min

Divide into small groups and ask each group to think about what HIV and AIDS policies, activities or programmes are already in place in their ministry and to identify the gaps. Have someone in each group record. Stimulate their thoughts by asking questions such as:

- Do you have an HIV and AIDS workplace policy?
- Is there a healthy psychosocial and physical educational environment, free from stigma and discrimination?
- Is there a skills-based HIV and AIDS curriculum? Are teachers prepared and supported to deal with sensitive HIV-related issues with young people, such as sexual orientation?
- Do you have access to HIV and AIDS services, care and support?

Reconvene for the groups to share what is in place and the gaps they have identified. Then discuss the value or benefits of adopting a comprehensive approach to their HIV and AIDS programmes.

Closure — 10 min

On small index cards, ask participants to make a written commitment identifying one or two concrete next steps toward implementing a comprehensive approach in their own HIV and AIDS programming. On the other side of the index card, ask participants to write their name and contact information. Ask participants to share their commitments.

Collect the cards for use in next activity and for later follow-up on the commitments made. Be sure to return the commitment cards to participants after you have made copies.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

- Record how many people participated, and their affiliations.

Outcome:

- Compare responses from the pre- and post-quizzes.
- Record the answers to the question about the main tenets of a comprehensive approach.
- Record the elements already in place and which can be strengthened.
- Write down the commitment that persons made at the end or give them a pledge card to fill out.

Quiz answers

1. a. True
   b. False
   c. False
   d. True
   e. True

2. a, d, e, g

3. a. iv
   b. v
   c. iii
   d. i
   e. ii

ACTIVITY 2.1

Quiz questions

1. True or False

a. The Caribbean has the second highest rate of HIV infection in the world.	True	False
b. The number of children affected and orphaned by AIDS is decreasing.	True	False
c. Young people usually have the knowledge and skills they need to protect themselves.	True	False
d. The education sector is a workplace employing thousands of staff.	True	False
e. To create a productive workforce and to sustain economic development, the education sector needs healthy students and teachers.	True	False

2. Which of the following are the major components of a comprehensive approach to HIV and AIDS in the education sector? (Circle your selections.)

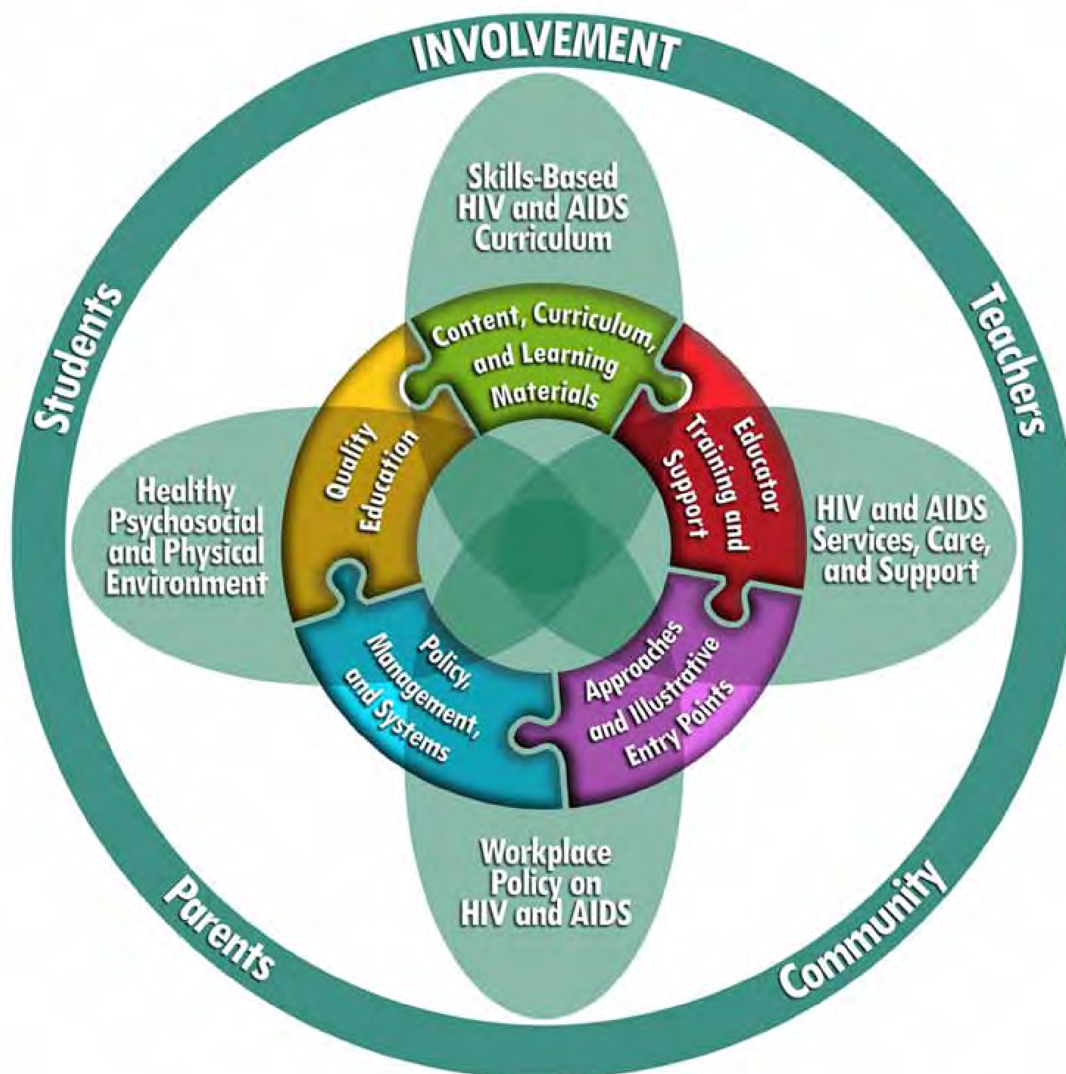
a. Workplace policy on HIV and AIDS
b. Clean bathrooms and kitchens
c. Oral rehydration therapy
d. Skills-based HIV and AIDS curriculum
e. HIV and AIDS services, care, and support
f. Giving young people the chance to learn from their mistakes
g. Healthy psychosocial and physical environment
h. Prevention of community involvement

3. Match the following terms with their correct definition (write the appropriate number on the lines below):

a. Complementary ____________	i. Students, teachers, parents, and community members are actively engaged
b. Comprehensive Approach ____________	ii. A setting, such as a school or other workplace, that offers protection from harmful issues (including stigma and discrimination, and gender inequity)
c. Holistic Strategy ____________	iii. Maximizing the use of opportunities and entry points in different contexts, in a balanced way
d. Participatory ____________	iv. Resources committed to one area may be called to bear on another area
e. Supportive Environment ____________	v. Using all available means to promote and protect the health of students and staff and to mitigate the impact of HIV and AIDS on the system itself

ACTIVITY 2.1

HANDOUT A: A comprehensive approach to HIV and AIDS in the education sector



This new model involves three layers:

1. Four overlapping components that balance curriculum, school environment, services, and policy to address HIV and AIDS in the education sector
2. Five key interlocking strategies that bridge the four components and describe implementation
3. The active involvement of school community members at all levels

Those involved in the response to HIV and AIDS in the education sector must concentrate not only on each of these layers individually, but also on where and why they intersect. Some of the important features of these intersections include the following:

» **A skills-based HIV and AIDS curriculum** is part of *quality education* which uses *content, curriculum and learning materials* that are rights-based, gender-responsive, and culturally sensitive. *Teachers are trained in* pre- and in-service training to implement the skills-based curriculum.

» **HIV and AIDS Services and Care** are offered as part of *teacher support,* which may include voluntary counselling and testing and access to mental health and nutrition services. HIV and AIDS services and support must extend to students as well. School health and feeding programmes and peer education might be current or possible *entry points* to link to.

» **A Workplace Policy on HIV and AIDS** may require a holistic *approach* and set out to establish the *policy, management, and systems* to support such an approach. Policies may include a workplace policy free from stigma and discrimination, gender inequity, and other harmful issues.

» **A Healthy Psychosocial and Physical Environment,** including supportive and safe environments for all educators and learners, is required by the established *policy, management, and systems*. Such a healthy school environment is a prerequisite for *quality education* that promotes the involvement of people living with HIV and AIDS.

» **Involvement** of teachers, students, parents, and community in planning and implementing a learner-centred, inclusive, and culturally sensitive comprehensive approach.

Based on two earlier models:

- UNESCO & EDC. (2005). Leading the way in the education sector: *Advocating for a comprehensive approach to HIV and AIDS in the Caribbean*. Newton, MA: EDC. Available from: http://www.caribbeanleaders.org/advocacy/PDFs/Advocacy%20and%20Leadership%20Workbook.pdf
- UNESCO & UNAIDS. (2008). *EDUCAIDS: Framework for Action. 2nd* Ed. Geneva: UNESCO. Available from: http://unesdoc.unesco.org/images/0014/001473/147360E.pdf

For more detail, see Appendix 4. “Additional models for a comprehensive approach to HIV and AIDS”

ACTIVITY 2.2

Ways to incorporate GIPA in a comprehensive response to HIV and AIDS in the education sector

Goal: To integrate GIPA at all levels of the education sector

Target audience: MOE staff; administrators in education, HIV core group for education; HFLE coordinators and teachers; people living with HIV group representatives; parent-teacher representatives

Time: 1 hour 45 minutes

Objectives: *At the end of the session, participants will be able to:*

» Give examples of how GIPA can be incorporated into a comprehensive approach to HIV and AIDS in the education sector *(cognitive)*
» Recognise the worth of a collaborative effort in the comprehensive response *(affective)*
» Commit to incorporating the principles of GIPA in all HIV and AIDS activities in the education sector *(behavioural)*

Preparation: *Prepare the following materials to be used during this activity:*

» Activity 2.2—PPT Presentation (included on CD-ROM)
» Handout A: Practical examples of incorporating GIPA in a comprehensive approach
» Handout B: Levels of involvement of people living with HIV
» Handout C: Roles of people living with HIV in HIV/AIDS-related activities
» Handout D: Action plan for incorporating GIPA in a comprehensive approach
» Flipchart paper and markers

Methods: Discussion, group work, and group presentations

Introduction — 5 min

(If this session does not follow on the same day after Activity 2.1, introduce yourself and the participants and give a brief recap of Activity 2.1)

Introduce the topic, and state the goal and objectives. Tell the group that this activity involves application of the commitment they made in the previous session. They will identify ways to implement a comprehensive approach to HIV and AIDS in their HIV-related work.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 10 min

Refer participants to Handout A ("Practical examples of incorporating GIPA in a comprehensive approach"), and review the practical examples listed of incorporating GIPA principles in a comprehensive approach to HIV and AIDS in the education sector. Ask participants for other examples.

Step 3 — 15 min

Explain that people living with HIV can be involved in programme planning and implementation at different levels in a comprehensive approach to HIV and AIDS. Review the levels of involvement (Handout B) for people living with HIV and specific roles of people living with HIV (Handout C). Ask participants to give examples.

Step 4 — 40 min

Divide participants into groups of no more than four; it is preferable to group people who work together. Ensure, if possible, that there is a person living with or affected by HIV in each group. Ask groups to select a recorder and a presenter.

Give participants Handout D ("Action plan for incorporating GIPA in a comprehensive approach") and explain the task. Ask participants to think about the components of a comprehensive approach to HIV and AIDS in the education sector, and start to develop an action plan incorporating one or two activities per component for the involvement of people living with HIV that could be implemented within the next year (or half year). If time is limited, groups may just focus on one component of a comprehensive approach, with each group addressing a different component.

Step 5 — 20 min

Have the groups post their action plans around the room. Have each group present its plan.

Closure — 15 min

Use the PPT presentation (Activity 2.2—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity.

In whole group discussion, guide participants to at least three benefits of including GIPA in a comprehensive approach (e.g., see introduction to this section) and lead a group discussion of concrete steps from the action plans for a few selected benefits.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

- Record how many people participated, and their affiliations.

Outcome:

- Compare responses from the pre- and post-quizzes.
- Record the benefits of incorporating GIPA, as stated by participants.
- Collect data on action plans written by groups.

Quiz answers

1. a. 5
   b. 3
   c. 1
   d. 6
   e. 2
   f. 4

2. f

3. a. True
   b. False
   c. False
   d. True
   e. True
   f. True

ACTIVITY 2.2

Quiz questions

1. Rank the following roles for people living with HIV in terms of their level of involvement in HIV and AIDS activities (1=Highest Level; 6=Lowest Level)

    a. ______**Contributors:** people living with HIV who are only marginally involved in activities

    b. ______**Implementers:** people living with HIV who carry out real but instrumental roles in interventions (e.g., peer educators or outreach workers)

    c. ______**Decision-Makers:** people living with HIV who participate in decision-making or policy-making bodies, and their inputs are valued equally with all the other members.

    d. ______**Target audiences:** people living with HIV who find that activities are aimed at or conducted for them en masse rather than as individuals.

    e. ______**Experts:** people living with HIV who are seen as important sources of information, skills, and knowledge, and participate in the design and evaluation of interventions.

    f. ______**Speakers:** people living with HIV who primarily act as spokespersons in campaigns, or are asked to "share their views" at meetings, but otherwise do not participate.

2. Which of the following is an appropriate area in which people living with HIV should participate?

    a. Policy making process
    b. Programme development and implementation
    c. Leadership and support, group networking, and sharing
    d. Advocacy
    e. Campaigns and public speaking
    f. All of the above

3. True or False:

a. Workplace policy directed toward involving people living with HIV can help to avoid relocation complications.	True	False
b. Public disclosure of HIV status should be required for participation in the comprehensive approach.	True	False
c. People living with HIV should be recognised specifically as patients or people who receive services.	True	False

d. National newspapers, radio, and networks of people living with HIV are all effective ways to disseminate information about an HIV and AIDS-related policy or programme. True False

e. People living with HIV should take an active role in decisions about planning and implementing a comprehensive HIV and AIDS approach in education. True False

f. An action plan outlines the "who, what, and when" for addressing objectives. True False

ACTIVITY 2.2

HANDOUT A: Practical examples of incorporating GIPA in a comprehensive approach

South Africa

South Africa developed the GIPA Workplace Model. This model created a policy that aimed at engaging people living with HIV from the local community, a practice that helped to avoid relocation complications, increased the sustainability of the programme, and harnessed valuable knowledge of local conditions.

In this model most people living with HIV are involved as experts who help design interventions, as implementers and public speakers. This work has shown that the GIPA Workplace Model can add considerable value to workplace response to the epidemic. The involvement of people living with HIV can complement and build upon a comprehensive approach to HIV and AIDS in the education sector, which includes a workplace policy; a healthy psychosocial and physical education environment, skills-based HIV and AIDS curriculum; HIV and AIDS services, care, support; and involvement of students, teachers, parents, and community.

People living with HIV (PLHIV) learned about the opportunity through information disseminated in national newspapers, on the radio and directly to networks of people living with HIV. In addition to selecting GIPA fieldworkers from applications received in response to the advertisement, programme workers also recruited additional fieldworkers who possessed particular skills that the programme desired.

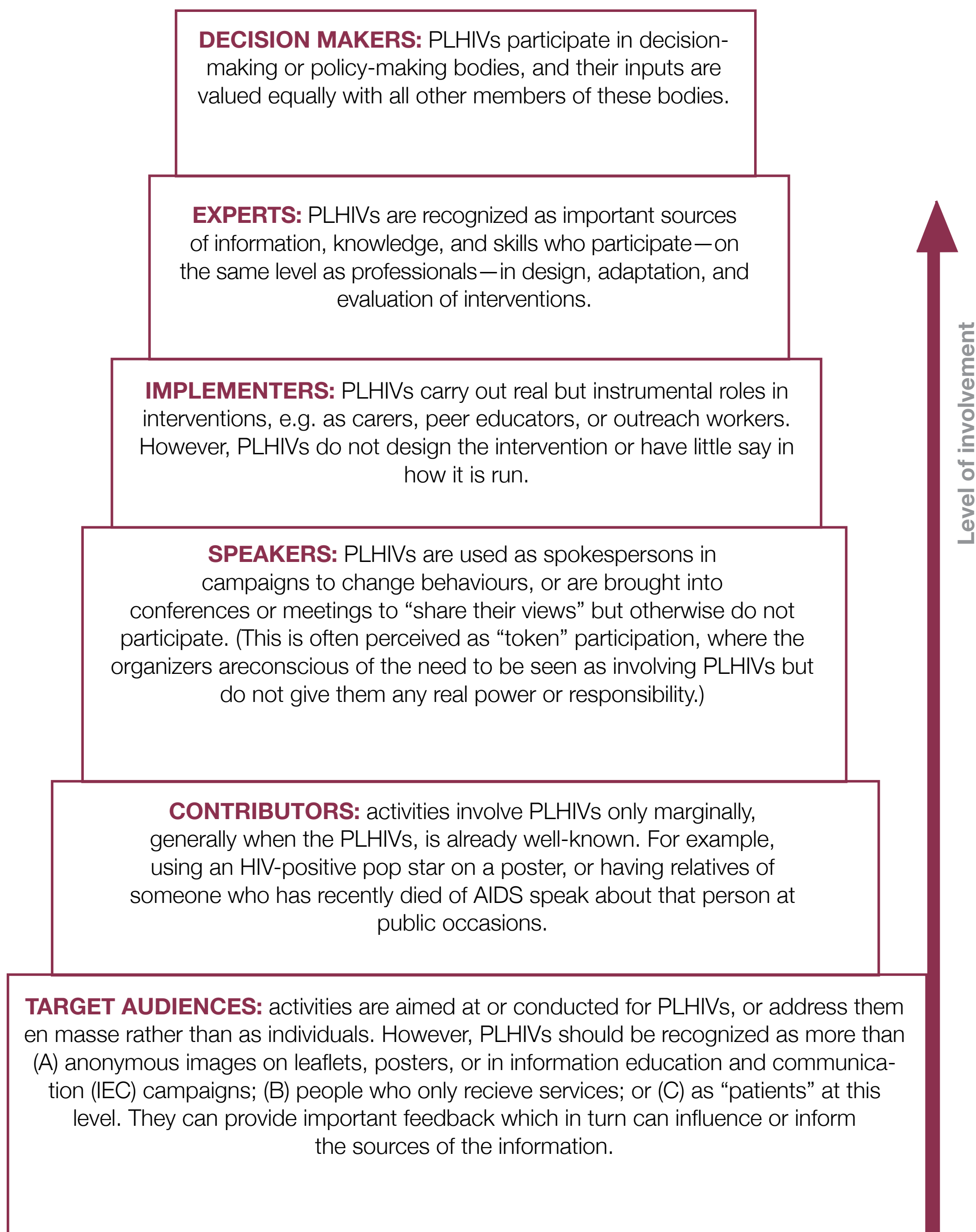
Caribbean

In the Caribbean, several countries, including The Bahamas, St. Lucia, St. Kitts, Trinidad & Tobago are incorporating GIPA principles as part of a comprehensive approach to help shape the response of the education sector to HIV and AIDS. Ministries of Education have collaborated with PLHIV in developing the education sector HIV and AIDS policy and strategic plan for students and staff working for the Ministry. People living with and affected by HIV understand their situation better than anyone and are often best placed to represent the needs of PLHIV in decision- and policy-making forums. The involvement of PLHIV at the level of policy-making gives PLHIV a voice, and strengthens the education sector HIV and AIDS policy and strategic plan.

• Simon-Meyer, J., & Odallo, D. (2002). The faces, voices and skills behind the GIPA Workplace Model in South Africa. In *UNAIDS Best Practice Collection*. Geneva: UNAIDS. http://data.unaids.org/Publications/IRC-pub02/JC770-GIPA-SA_en.pdf

ACTIVITY 2.2

HANDOUT B: Levels of involvement of people living with HIV



• Source: Van Roey, J. (1999). *From principle to practice: Greater Involvement of People Living with or Affected by HIV/AIDS* (GIPA). Geneva: UNAIDS. Available from http://data.unaids.org/Publications/IRC-pub01/JC252-GIPA-i_en.pdf

ACTIVITY 2.2

HANDOUT C: Roles of people living with HIV in HIV/AIDS-related activities

The examples below, from a UNAIDS policy brief on *The Greater Involvement of People Living with HIV,* describe ways in which people living with HIV might be involved in specific activities.

Policy-making process: People living with HIV participate in the development and monitoring of HIV-related policies at all levels.

Programme development and implementation: People living with HIV provide knowledge and skills toward universal access through participation in the governance of global organisations, such as UNAIDS and the Global Fund, and in the choice, design, implementation, monitoring, and evaluation of prevention, treatment, care and support programmes, and research.

Leadership and support, group networking and sharing: People living with HIV take leadership of HIV support groups or networks, seek external resources, encourage participation of new members, or simply participate by sharing their experiences with others.

Advocacy: People living with HIV advocate for law reform, inclusion in the research agenda, and access to services, including treatment, care, and support; as well as for resource mobilisation for networks of people living with HIV, and for the broader response.

Campaigns and public speaking: People living with HIV are spokespersons in campaigns or speakers at public events and in all other arenas.

Personal: People living with HIV are actively involved in their own health and welfare. They take an active role in decisions about treatment and self-education about therapies, opportunistic infections, adherence to treatment, and prevention.

Treatment roll-out and preparedness: People living with HIV support treatment roll-out through educating others on treatment options, side effects and adherence; and they are involved as home-based and community health care workers.

• Joint United Nations Programme on HIV/AIDS [UNAIDS]. (2007). *The Greater Involvement of People Living with HIV* (GIPA), Policy Brief. Geneva: UNAIDS. Available from http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf

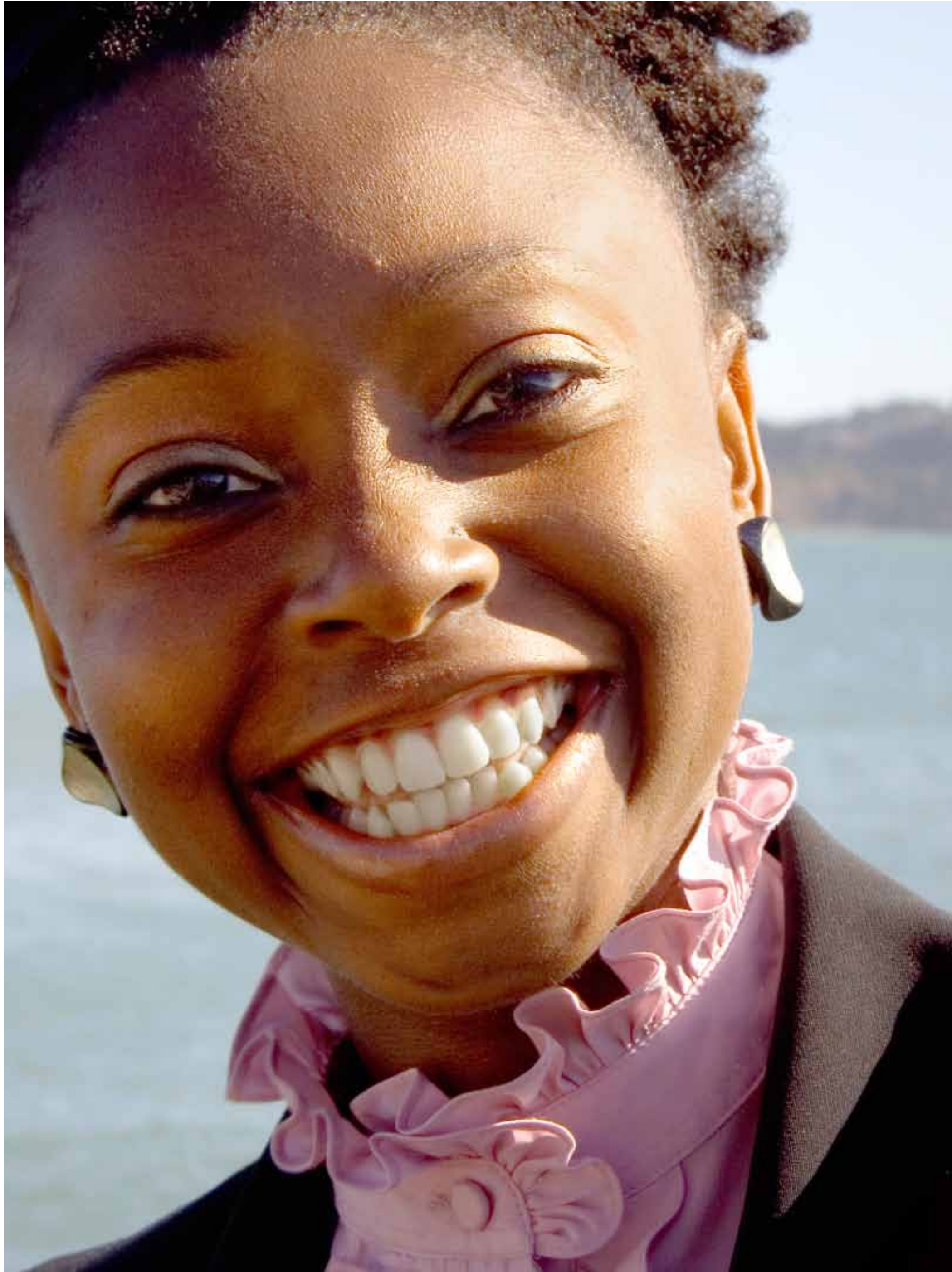
ACTIVITY 2.2

HANDOUT D: Action plan for incorporating GIPA in a comprehensive approach

For each component of a comprehensive approach to HIV and AIDS in the education sector, think of a few activities that you could do to incorporate people living with HIV in a meaningful way.

Component of a comprehensive approach: (Example: *Healthy psychosocial school environment***)**

Description of Activity & Target Audience	Timeframe	Person(s) Responsible	Resources Required	Evaluation
Example: Co-facilitate a workshop on stigma and discrimination for principals of high schools	June 20xx	MOE focal point, PLHIV network member	GIPA Toolkit, Activity 4.1 Supplemental materials	Individual feedback forms



SECTION 3

Capacity building for the application of GIPA principles

This section is intended to build the capacity of the MOEs and national networks of people living with HIV to advocate for operationalising the principles of GIPA in all levels of the education sector.

What you need to know

What is advocacy?

Advocacy is "a skill used to influence public policy, laws, regulations, resource allocation (especially that of funds) and access to services through various forms of persuasive communication."[24]

Advocacy is about the empowerment of persons to have a voice in the decision-making process on issues that affect their lives. Often targeted to reach the heart and mind of decision-makers in political, social, and economic institutions, advocacy can result in changes that directly affect people's lives. Common methods of reaching decision-makers include meetings, letters, phone calls, mass media, and demonstrations.[22]

Why do you need to advocate for GIPA in the education sector?

- To achieve formal responses from governments and NGOs to operationalise the GIPA principles
- To allow people living with HIV to participate at the decision-making level

Over the years, it has become increasingly evident that advocating for GIPA is necessary to implement a coordinated response to the HIV epidemic. Since the introduction of GIPA principles, this effort has been advocated for and by people living with HIV, with little formal response from governments and NGOs alike. On the other hand, GIPA has become the backbone of many interventions worldwide.*

UNAIDS research has shown that people living with HIV can participate at a variety of levels, ranging from relatively marginal activities, such as appearing on posters or handing out pins at carnival, to participating in decision-making or policy-making bodies. Advocacy is needed to achieve involvement of people living with HIV at the decision-making level.

What are the steps of an advocacy strategy?

Steps of any well-planned advocacy strategy include:

1. Analyze your cause.
2. Identify your audience and influencers.
3. Create a clear message.
4. Take persuasive action.
5. Evaluate your impact.

* The AIDS Support Organisation (TASO) in Uganda, formed in 1988 under the leadership of a woman whose husband had died of AIDS; the Asia Pacific Network of People Living with HIV/AIDS (APN+), formed in 1994 to lobby against stigma and discrimination in the region; and Philly Lutaaya, who died in 1988 and is considered a 'father of GIPA' for his belief in confronting discrimination and living positively. The Gauteng Province Intersectoral AIDS Programme recruits people with HIV/AIDS from local support groups as speakers in provincial government workplace programmes.

Activity 3.1 is meant to be used with individuals who will be advocating for the involvement of people living with HIV at all levels of the MOE. This activity will equip participants with skills and strategies needed to make a strong case for including people living with HIV in all education sector activities.

ACTIVITY 3.1

Training workshop: advocacy for GIPA

Goal: To equip people to advocate for the GIPA principles in the education sector.

Target audience: Influential persons from all sectors to whom key staff in the MOE will listen.

Time: 2 hours

Objectives: *At the end of the session, participants will be able to:*

» Describe the steps of an effective approach to advocacy *(cognitive)*
» Express a personal commitment to advocate for operationalising the principles of GIPA in the education sector *(affective)*
» Develop an advocacy strategy for operationalising the principles of GIPA *(behavioural)*

Preparation: *Prepare the following materials to be used during this activity:*

» Activity 3.1—PPT Presentation (included on CD-ROM)
» Handout A: The advocacy wheel
» Handout B: Rapid appraisal
» Handout C: Audience assessment tool
» Handout D: Creating a clear message
» Handout E: The message triangle
» Handout F: Your message triangle—worksheet
» Handout G: Principles of persuasion
» Handout H: Action plan outline
» Handout I: Evaluation chart and self-evaluation
» Flipchart with flipchart paper and markers

Methods: Presentation, group work, and group presentations

Introduction — 5 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. “Tips for facilitators”).

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 5 min

Ask participants to think of a time when they tried to influence the decision of some person or organisation. Have them briefly jot down a few words to describe what skills they used. Write the list of words they offer on a flipchart.

Refer to their words as you introduce the term advocacy.

> Advocacy is "a skill used to influence public policy, laws, regulations, resource allocation (especially that of funds) and access to services through various forms of persuasive communication."[24]
>
> Advocacy is about the empowerment of persons to have a voice in the decision making process on issues that affect their lives. Often targeted to reach the heart and mind of decision-makers in political, social and economic institutions, advocacy can result in changes that directly affect people's lives. Common methods of reaching decision-makers include meetings, letters, phone calls, mass media and demonstrations.[22]

Step 3 — 5 min

Point out that effective advocacy is extremely important for the advancement of GIPA in the education sector. During the session they will be asked to develop an advocacy strategy for GIPA.

Brainstorm with participants the following question: "Why is it important to advocate for applying the principles of GIPA in the education sector?" Record all responses on flipchart paper.

Step 4 — 5 min

Introduce "The advocacy wheel" (Handout A), which shows the five steps of the advocacy process. Tell participants that they will go through the steps of the advocacy wheel today and will practice each step in groups. Divide into groups of 3–4 participants. Mention that the resources used in today's workshop are available in print and to download from the Internet.[‡]

Step 5 — 20 min

Divide participants in groups of up to 4 people for the duration of this activity. Explain the "Rapid appraisal" (Handout B), and ask participants to complete this appraisal form to the best of their knowledge, to get a quick and valuable guide to what the education sector is doing to involve people living with HIV in a comprehensive approach to the epidemic. Provide 10 minutes for participants to respond to the handout; then ask a few individuals to report out. Ask each team to select an issue that they want to advocate for, based on the rapid appraisal.

[‡] For more information, see: UNESCO & EDC. (2005). *Leading the way in the education sector: Advocating for a comprehensive approach to HIV and AIDS in the Caribbean.* Newton, MA: EDC. Available from: http://www.caribbeanleaders.org/advocacy/PDFs/Advocacy%20and%20Leadership%20Workbook.pdf

Step 6 — 20 min

Distribute the "Audience assessment tool" (Handout C), and explain that participants will identify the audience to whom they want to advocate for a particular issue that they identified in the previous step. Ask them to fill out the handout. After the activity, ask a few individuals to report back on process and share what they have developed.

Step 7 — 25 min

Use Handout D ("Creating a clear message") to look at how to create a good advocacy message and to give tips for making a message accessible and meaningful. Then explain "The message triangle" (Handout E).

Have participants use Handout F ("Your message triangle—worksheet") to create their own message triangle pertaining to the issue they have worked on in Step 4.

After the activity, ask a few teams to role-play delivering their message if they were to see the person they want to advocate to in an elevator ("elevator speech").

Step 8 — 20 min

Advise participants that once they have analysed their issue, chosen their audience, and developed their message, the time has come to take action. They must communicate their message in a persuasive manner to their target audience. Brainstorm a number of ways to present their message (for example, making a phone call, writing a letter, setting up a face-to-face meeting, organising a workshop). Point out that they will often need to employ more than one method and that repeating the message using complementary methods can reinforce the influence on the audience.

Review the "Principles of persuasion" (Handout G). Then introduce the "Action plan outline" (Handout H), and ask participants to decide which advocacy strategy they will use with their selected target audience and fill out the handout.

After the activity, ask a few individuals to share what they have developed and take a few minutes to clear up any questions.

Step 9 — 5 min

Explain that after implementing the advocacy strategy, you must measure what you have accomplished and what remains to be done. Evaluating efforts frequently can ensure that data and lines of reasoning remain in tune with a changing situation. Distribute Handout I ("Evaluation chart and self-evaluation").

Closure — 10 min

Use the PPT presentation (Activity 3.1—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity.

Ask participants to recap the important aspects they learned today about advocating for GIPA and what their next steps will be.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

» Record how many people participated, and their affiliations.

Outcome:

» Compare responses from the pre- and post-quizzes.
» Record responses of participants to the question in the closure.
» Collect and make copies of the completed handouts.

Quiz answers

1. c

2. f

3. a. 1
   b. 3
   c. 4
   d. 2
   e. 5

4. a. True
   b. True
   c. False
   d. True
   e. False

ACTIVITY 3.1
Quiz questions

1. What is the most appropriate definition of advocacy?
    a. A strategy to prevent the transmission of HIV by reducing human interaction and contact in different settings, such as schools or other workplaces
    b. The power of a high-level decision-maker to enact laws, policy, and other regulations without challenge or contribution from others
    c. A skill used to influence public policy, laws, regulations, resource allocation (especially that of funds), and access to services through various forms of persuasive communication
    d. The requirement for people living with HIV to provide donations in support of the implementation of HIV and AIDS-related policy and programmes

2. Which of the following are the primary goals of GIPA advocacy in the education sector?
    a. Ensure that individuals living in areas of high HIV prevalence are kept to minimal social and physical interaction.
    b. Collect enough financial support from, specifically, people living with HIV to sustain intervention efforts directed toward improving their health and minimizing the impact of the virus.
    c. Achieve formal responses from governments and NGOs to operationalise the GIPA principles.
    d. Allow people living with HIV to participate at the decision-making level.
    e. Both A and B
    f. Both C and D
    g. All of the above
    h. None of the above

3. Order the following steps of an advocacy strategy (1=First; 5=Last):
    a. ______ Analyze your cause.
    b. ______ Create a clear message.
    c. ______ Take persuasive action.
    d. ______ Identify your audience and influencers.
    e. ______ Evaluate your impact.

4. True or False. Creating a clear message means using . . .

a.	. . . specific examples taken from your own or your audience's experience.	True	False
b.	. . . simple but colourful words and one-liners.	True	False
c.	. . . statistics, percentages, graphs, and charts	True	False
d.	. . . what your audience knows and believes as a basis for discussion	True	False
e.	. . . terminology from social science, psychology, and education	True	False

ACTIVITY 3.1

HANDOUT A: The advocacy wheel

Below are more detailed explanations of each of these steps, along with corresponding parts of an advocacy success story in italics.

1. Analyze your cause.

Effective advocacy begins with accurate information and in-depth understanding of the issue you want to address. You must assess the current situation so that you can determine exactly what needs to be done and formulate action steps. You may use a rapid appraisal framework to analyze various aspects of your cause.

For instance, you may conduct a rapid assessment to see which components of a comprehensive approach to addressing HIV and AIDS in the education sector are currently in place in your school and to what extent.

2. Identify your audience and influencers.

Review the results from the previous step one at a time; identify your audience for each and those who would best be able to influence that audience. If you understand who your specific audience is and what motivates and concerns them, you will be better able to shape a message that achieves your intended purpose.

For instance, you may identify whom to talk to about improving skills-based HIV and AIDS curricula in your school, whom to influence about making changes in your school's workplace policy, and with whom to talk to improve HIV and AIDS services, care, and support.

3. Create a clear message.

Create a powerful message that will speak to your audience's motivations, beliefs, and attitudes. You must focus on why your audience will care. Use a message triangle to define a series of action statements, action strategies, and a call to action.

For instance, you may create a message that expresses that "We need to create a healthy psychosocial educational environment (*what?*) so that learners and educators know that they will be safe from harm, cared for, and treated with respect (*why?*), and we will do so by establishing and enforcing clear regulations about stigma and discrimination, confidentiality, gender equity, and sexual harassment (*how?*)."

4. Take persuasive action.

Once you have analyzed your cause, chosen your audience and influencers, and developed your message, the time has come to take action. You must now deliver your message persuasively to your target audience. Use an action plan framework to help organise these activities.

For instance, you may create an action plan that includes steps for making initial contact, such as sending a letter, making the case during a meeting and/or with a package of materials, and following up with a phone call.

5. Evaluate your impact.

While implementing your action plan and afterward, you need to measure what you have accomplished and what remains to be done. Evaluating your efforts frequently can ensure that data and lines of reasoning remain in tune with a changing situation. It also allows you to revisit and refocus your strategy if needed.

For instance, you may record what type of communication you used, what kind of materials you distributed, how many people you reached, and what their initial feedback was. Using this information, you may modify your strategy for going forward or continue as planned.

- UNESCO & EDC. (2005). *Leading the way in the education sector: Advocating for a comprehensive approach to HIV and AIDS in the Caribbean.* Newton, MA: EDC. Available from: http://www.caribbeanleaders.org/advocacy/PDFs/Advocacy%20and%20Leadership%20Workbook.pdf

ACTIVITY 3.1
HANDOUT B: Rapid appraisal

Complete this appraisal form to the best of your knowledge to get a quick and valuable guide to what the education sector is doing to involve people living with HIV in a comprehensive approach. (After the workshop you may gather additional information to fill in any pieces that you did not know.)

Component of a comprehensive approach	Assesment			Action	
	What is currently in place?	*Are PLHIV involved?*		*What action could be taken within the next 6–12 months?*	Do Not Know
		Yes (how?)	No		
Workplace policy on HIV and AIDS					
Develop policy.					
Implement policy.					
Healthy psychosocial and physical environment					
Develop guidelines for a healthy learning environment.					
Implement guidelines for a healthy learning environment.					

Component of a comprehensive approach	Assesment			Action	
	What is currently in place?	*Are PLHIV involved?*		*What action could be taken within the next 6–12 months?*	Do Not Know
		Yes (how?)	No		
Skills-based HIV and AIDS curriculum					
Develop HIV and AIDS curriculum or lessons.					
Implement HIV and AIDS curriculum or lessons.					
HIV and AIDS services, care, and support					
Ensure access to HIV and AIDS services, care, and support.					
Implement HIV and AIDS services, care and support.					

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ACTIVITY 3.1
HANDOUT C: Audience assessment tool

Identify your audience for the particular issue you identified in the previous step. If you understand who your specific audience are and what motivates or concerns them, you will be better able to shape a message that achieves your intended purpose.

1. Who make up your audience for a particular issue that you would like to influence? (Record the agency/agencies and name/s of people.)
2. What do you know about your audience that may influence how they process information (gender, age range, occupation, where they live and work, socioeconomic status, educational background, political background)?
3. What drives your audience's motivation, attitudes, and behaviour (e.g., interests, incentives, pressures, and personal experiences)? What are their roles and responsibilities and how can they advance your cause?
4. What attitudes, beliefs, and knowledge do your audience have about the issues you want to address? Include their prior knowledge and attitudes about the education sector's response to HIV and AIDS.

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ACTIVITY 3.1

HANDOUT D: Creating a clear message

Your message will be effective if you can answer two key questions:

1. So what? What difference does your issue make to the people you are addressing?
2. Who cares? Why should they care?

Tips for making your message accessible to and meaningful for your audience:

» Your message should be immediate (that is, have a level of urgency that the audience can identify with) and relevant to your audience.

» Use specific examples taken from your own or your audience's experience to paint a picture that reinforces your key points.

» Use colourful words, one-liners to capture your audience's attention and engage them in your talk. If your message is too complex, your audience will tune it out, and you will have lost an opportunity to reach them. An example of a powerful one-liner is "education is the only vaccine for AIDS."

» Instead of relying on statistics, percentages, graphs, and charts to get your message across, describe the data in terms that are easier for your audience to grasp. You might consider using "social math" to illustrate your points and to make abstract data more concrete. Social math blends stories and numbers by providing comparisons with familiar things. It usually works by analogy, linking numbers to meanings to help individuals relate to and understand statistics better. For example: "One out of two HIV-positive people in the Caribbean are in their prime productivity years" instead of "Fifty percent of those diagnosed with HIV in the Caribbean are between 25 and 35 years old."

» Your message should reinforce positive impressions of the audience about what you would like them to do. For example, focus on a specific interest they might have in a comprehensive approach.

» You need to understand negative images so you can prepare to address such issues. Do not ignore the audience's scepticisms or concerns, because your audience will not ignore them. For example, if previous efforts to implement a policy have failed, you need to discuss exactly how you are doing things differently and more effectively this time.

» Include at least two or three clear statements that begin with "I need you to. . . . " They will give the audience clear direction on how they can act on behalf of your cause.

» Begin with what your audience knows and believes. Then build on these points and show how a shift or a change in behaviour can create a win-win situation for everyone.

» Avoid the jargon of social science, psychology and education; such language can cause you to lose your audience's attention.

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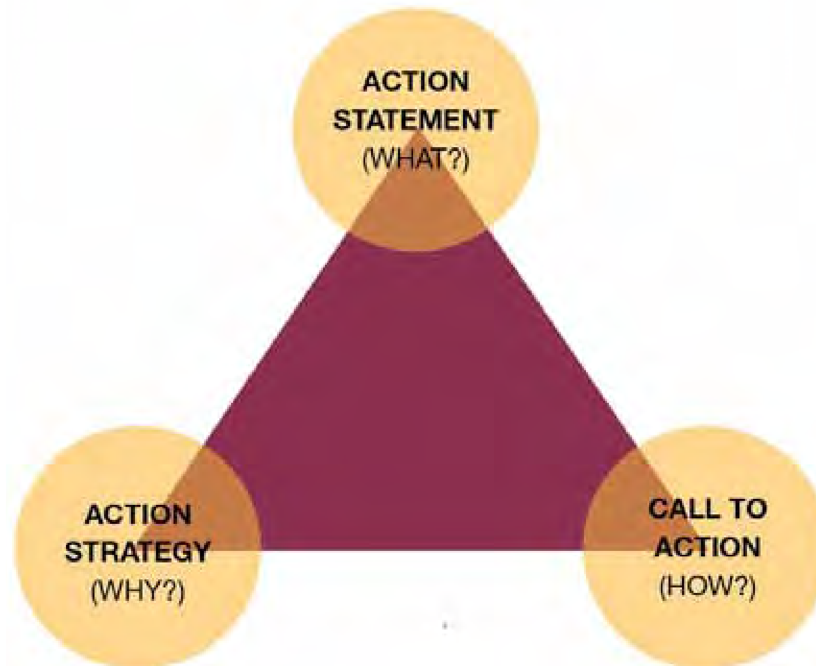
ACTIVITY 3.1

HANDOUT E: The message triangle



Sample Key Messages:

What? We need a policy that ensures that HIV-positive teachers can continue to work in our school.
Why? Teachers may feel uncomfortable disclosing and fear they might lose their job if they do so.
How? We need to establish a small committee immediately to draft a workplace policy that guarantees that teachers living with HIV are assured of their continued employment in our school.

What? We need PLHIV as co-developers and facilitators of our HIV and AIDS curriculum.
Why? PLHIV, drawing on experience, can develop and deliver more powerful messages.
How? Connect within the next month with the local PLHIV network and engage PLHIV to co-develop or modify activities of the existing HIV and AIDS curriculum and to deliver them in the classroom.

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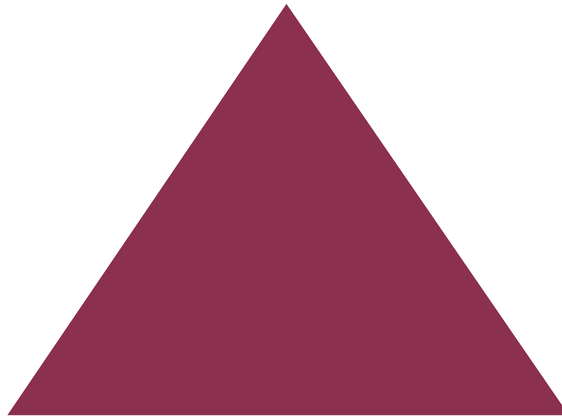
ACTIVITY 3.1

HANDOUT F: Your message triangle – worksheet

1) What?

....



2) Why?

....

3) How?

....

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ACTIVITY 3.1

HANDOUT G: Principles of persuasion

Dr. Robert Cialdini, professor of psychology at Arizona State University and author of the book, *Influence: The Psychology of Persuasion*, is an expert on what it takes to get people to say yes. To enhance the persuasiveness of your message, you might consider using the following principles developed by Dr. Cialdini:

1. **Commitment and consistency.** It is important to gain commitment for acts, even if they are just small acts, because when people commit they tend to behave in ways that are consistent with that commitment. Having individuals sign a statement is a good way of reinforcing their commitment.
2. **Social proof.** When deciding how to act, people often use information about how others behave to influence their own decision. Use examples that others can relate to.
3. **Scarcity.** People are more likely to act if the opportunity to do so is available only once and there is a loss associated with not acting. Present your cause so that it conveys urgency.
4. **Reciprocation.** People usually try to repay in kind what another has given them. Try to relate how the actions you are suggesting are similar to or will reinforce other constructive efforts that your audience can relate to.
5. **Authority.** People with titles (important positions) and those that are known to be experts can exert a lot of influence. Recruit them to assist in your cause.
6. **Liking.** People prefer to say yes to requests from those they know or like. Look for persons (for example, a well-liked teacher) who can speak to the audience you are targeting, and ask them if they will support your cause.

As shown above, an effective presenter needs to be trustworthy, confident, clear, and attentive to the audience's knowledge and capacity for action.

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ACTIVITY 3.1
HANDOUT H: Action plan outline

Task	Activity	Target audience	Timeline for action	Person(s) responsible	Resources needed	Indicator(s) for Monitoring & Evaluation
Making initial contact						
Examples: *Write letters, enclosing descriptive materials, flyers, and/or brochures.* *Make phone calls.* *Hold breakfast or lunch meeting.*						
Making the case						
Examples: *Meet with officials and other decision-makers.* *Make a presentation to and hold a discussion with a select group.* *Provide packets of materials.* *Attend legislative or other public meetings.* *Attend conferences of health or education associations.*						

Task	Activity	Target audience	Timeline for action	Person(s) responsible	Resources needed	Indicator(s) for Monitoring & Evaluation
Following Up						
Examples: *Make follow-up calls.* *Develop relationships with media editors and/or reporters.* *Hold press conferences.* *Write editorials and/or news articles.* *Arrange audience's contacts with model programmes.* *Appear on radio and/or television talk shows.* *Organise broad support through petitions and/or educational forums.*						

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ACTIVITY 3.1
HANDOUT I: Evaluation chart and self-evaluation

Start Date:

End Date:

Target number of meetings:

Target number of people to meet with:

Date and Place	Type or channel of communication	Participants	Materials Distributed	Initial feedback received
Total in 6 months:	*No. of meetings:*	*No. of Participants:*		

Self-Evaluation

You have many competing demands on your time and advocating for a specific cause requires your constant attention and effort. Self-evaluation during the advocacy process can help you determine ways to improve your strategy and make sure your efforts are well placed. At regular intervals during the process, ask yourself the following questions:

- What is working?
- What is not working?
- What needs to be changed?

After six months, revisit the “Rapid appraisal” form in Step 1 (Handout B), and fill out relevant sections again with updated information. Review, in particular, changes that your advocacy effort has influenced. The changes that have occurred since your initial rapid appraisal are a good indicator of your progress. Remember that even a small change is an important milestone!

If change did not occur, you might want to revisit Steps 1 through 5 to determine how you might improve your strategy. Perhaps you want to present your message in a new way. Perhaps it would help to identify other influencers or define your target audience differently.

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SECTION 4

Stigma and discrimination

Section 4 helps participants to explore how perceptions about people living with HIV impact their lives. False perceptions drive fear, myths, and false information that can lead to inappropriate action and ill treatment. Participants will examine the concept of stigma and its causes. They will consider the effects of discrimination on the individual and the workplace, using case studies; they will look at strategies for dealing with stigma, discrimination, and disclosure.

What you need to know

What is stigma?

Stigma is defined as "the process of devaluing people and viewing them negatively on the basis of a particular attribute, for example, their HIV status, gender, or sexuality."[16]

Example in a workplace: A person harassing or refusing to work with a co-worker because of his or her real or perceived HIV-positive status.

What is discrimination?

Discrimination refers to "any form of arbitrary distinction, exclusion, or restriction based on a stigmatised attribute. Discrimination violates individuals' rights."[16]

Example in a workplace: Firing or relocating an employee because of (real or perceived) HIV-positive status or denying the employee a promotion, raise, reasonable accommodation, health insurance, professional development, or other benefits.[16]

What is disclosure?

Disclosure in a workplace setting is defined as "sharing information related to one's HIV status with one or various colleagues."[15] Disclosure may be made with the express or tacit condition of confidentiality or be very public in nature.

Activity 4.1 can be used to help participants understand how they feel about stigma and how it can lead to discrimination against people living with HIV or AIDS. The activity begins with a short pre-test.

- » Step 2 of Activity 4.1 (*Where do you stand?*) is a values clarification exercise that allows the group time to think through the statement, assume a position based on their personal values and beliefs, and speak openly and honestly about it.
- » Step 3 is a role play and discussion, which requires some time. Ideally, the room can be set up with sofa or soft chairs for the five participants who perform the play, and with a radio.
- » Step 4 is a labelling simulation, for which the group requires enough space and time to move around the room, examine the labels, and give a response. It may require rearrangement of the room or moving to another area for ease of conducting the exercise. Inform participants that they will be asked to explain how they feel about the responses they experienced from others in the exercise.

Activity 4.2 can be used to address issues around disclosure. It consists of three different role plays that address various considerations of when and why to disclose, when to seek counselling, voluntary versus non-voluntary

disclosure, and acceptance of one's status. The room for this activity should be conducive to group work.

Facilitation tips

For participants to participate freely, they need to feel assured that the facilitator will provide a non-judgemental atmosphere and mutual respect. Because HIV and AIDS are sensitive topics, expressing one's position can provoke problematic views. Each facilitator should be adequately sensitised about HIV and AIDS, ready to clarify any misconceptions or misinformation. Similarly, someone (e.g., local co-facilitator) should be prepared to address any cultural and ethical concerns that may arise, concerns that might otherwise undermine the transfer of knowledge or the participants' ability to share their position and interact freely.

If not enough time is available for 2+-hour activities, you can select one or two components of each activity only (e.g., values clarification, script, simulation, one or two role plays with discussion).

For facilitating the processing of role plays, please see Appendix 1.

Facilitators are encouraged to adapt the scripts used in this section to local dialect. For the script used in Activity 4.1 (Handout A), an example is provided in Facilitator Resource A.

If participants appear to need a review of basic information about HIV and AIDS (including how HIV is spread, common behaviours that lead to HIV infection, and HIV treatment), please refer to the handouts and facilitator resources provided for Activity 1.1. Advise participants that if, at any time, they feel 'overwhelmed' by any portion of the content of the sessions they should (discreetly) alert a resource person (facilitator or presenter).

Facilitation tip for MOE personnel

Give practical examples of where and how HIV and AIDS-related stigma and discrimination have affected teachers, learners, schools, and broader communities—based, if possible, on the use of personal testimonies—and outline lessons learned so far from an MOE perspective, including in terms of GIPA.

Ensure the group is heterogeneous, (e.g., male and females, teachers, administrators, parents, students, and people living with HIV, if possible).

Tips for people living with HIV

As far as possible, provide concrete examples of how HIV and AIDS-related stigma and discrimination have affected your life or the lives of persons you know, and what has worked in terms of addressing them, as well as difficulties encountered in terms of disclosure of HIV status. If you wish and feel comfortable doing so, consider disclosing your HIV status, only at some point during the session or at the end (not at the beginning). Your sharing can help participants to engage further in meaningful discussions on the topic, based on their eventual reactions.

Share any additional resource material on living with HIV or AIDS with the workshop organisers for distribution.

Facilitation tip for MOH personnel

Give examples of the implications of HIV and AIDS-related stigma and discrimination for the effective use of and benefit from VCT or of treatment and care services, and highlight the role of the education sector in this regard, from an MOH perspective.

Discuss the importance of dealing with stigma within the framework of the National Strategic Plan and/or National AIDS Programme.

ACTIVITY 4.1

Sensitisation session: stigma and discrimination

Goal: To understand how much participants know about stigma and discrimination, how they reflect and establish the link between their perception and expectations of various behaviours, and how these perceptions generate stigma. To discuss issues of stigma and discrimination as they relate to the people *affected* by HIV.

Target audience: Education sector, other line ministries involved with HIV work

Time: 2 hours 40 minutes

Objectives: *At the end of the session, participants will be able to:*

- » Identify aspects of stigma and discrimination, their root causes, and ways to counteract them *(cognitive)*
- » Empathise with stigmatised persons *(affective)*
- » Identify how their own actions can contribute to the stigmatisation or de-stigmatisation of people living with HIV *(behavioural)*

Preparation: *Prepare in advance:*

- » Set up the room for the values clarification exercise: Mount Agree and Disagree posters (Facilitator Resource B) in opposite areas of the room.
- » Prepare Character labels (Facilitator Resource C).

Prepare the following materials to be used during this activity:

- » Activity 4.1—PPT Presentation (included on CD-ROM)
- » Handout A: Script: Marva and her friends (or Facilitator Resource A, if using the local dialect)
- » Facilitator Resource B: Position statements
- » Facilitator Resource C: Character labels
- » Flipchart, flipchart paper and markers or blackboard and chalk, masking tape

Methods: Values clarification, discussion, role playing, simulation, individual writing

Introduction — 10 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves by name and one word that will contribute to the rules for each participant's engagement. For the setting of these rules, write the word "ROPES" on the flipchart and ask participants whether they can agree to these and to add their own to the example below:[25]

Example:

R – Respect

O – Openness

P – Participation

E – Education

S – Sensitivity

Review the objectives of the session, and explain ground rules (see Appendix 1. "Tips for facilitators"). Explain that the session includes values clarification, role play, and labelling exercise. It will begin with a short quiz. Advise them, if necessary, that the exercise requires rearrangement of the room or moving to another area from their seats.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 35 min

Ask all participants to stand in the centre of the room away from the two position statements. Using Facilitator Resource B ("Position statements"), read the first statement and ask participants to move to the Strongly Agree or Strongly Disagree position poster, according to their beliefs.

Give the group a minute to settle down and ensure that no one is left on the borderline. Then ask participants to clarify their agreement or disagreement with the statement. Explain that some statements are value-loaded to encourage discussion.

Encouraging participants to speak openly helps them add value to their experience and respond to clarifications relating to myths, false information, or prejudiced expressions. Show support and care to people who become emotional when they identify with some of the issues raised.

Repeat this process for the remaining statements.

DISCUSSION POINTS:

» For which statements was it difficult to choose a side? Why?
» How many participants selected a side by trusting widely accepted views instead of facts?
» How may a person's view on these statements contribute to self-stigma?

Explain that stigma and discrimination are often related to groups and behaviours that are not accepted by the "mainstream" society, such as men having sex with men, sex workers, and drug users that drive the HIV epidemics in many places. It may be helpful for learners to become aware of their values.

Step 3 — 50 min

Divide participants into two or more groups. Distribute Handout A ("Script: Marva and her friends"). Give participants a few minutes to read and assign roles, and ask them to perform the script.

After the performances, have the groups discuss the experience.

DISCUSSION POINTS:

» What do you think about the attitude and behaviour of Able, Charlene, Doris, and Blind Man? Regarding Doris and Blind Man, do you think there is any justification for their words?
» Which person's (or persons') behaviour do you most identify with? Which do you least identify with? State reasons.
» What ideas from your earlier group discussions might help you or others to recognise the folly and pointlessness of stigma and discrimination as they relate to HIV and AIDS?

Step 4 — 30 min

Distribute the Character labels (Facilitator Resource C) to all participants; instruct them not to look at the character labels until told to do so.

Pin one label on each volunteering participant where he or she cannot read it.

Ask participants to move around the room/workshop area, look at each label, and give their own natural responses to the person wearing the label.

After 10 to 15 minutes reconvene the group to discuss their experiences.

DISCUSSION POINTS:

» How did you feel as you talked to someone based on his or her label? Why?
» How did you feel being on the receiving end of reactions from others? Why?

Closure — 25 min

Use the PPT presentation (Activity 4.1—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity. Respond to questions and engage participants in a discussion on:

- Why is it important to reduce or challenge stigma and discrimination?
- What is the role of the education sector in reducing stigma and discrimination?

Then ask participants to write a brief paragraph reflecting on how they think this experience will affect their own actions in their relations with people living with HIV.

Distribute the Activity Quiz, once again, to participants, and ask them to fill it out individually. Collect responses.

Monitoring and evaluation

Process:

- Record how many people participated, and their affiliations.

Outcome:

- Record responses from participants during discussion sections.
- At the end of the session collect the write-ups about how this experience will affect their relations with people living with HIV.
- Compare responses from pre- and post-quiz.

Quiz answers

1. d

2. a. Discrimination
   b. Discrimination
   c. Stigma
   d. Discrimination
   e. Stigma

3. e

4. a. True
   b. True
   c. False
   d. False

ACTIVITY 4.1

Quiz questions

1. Which of the following define(s) stigma and discrimination?

   a. The process of devaluing people and viewing them negatively on the basis of a particular attribute, for example, their HIV status, gender, or sexuality
   b. Any form of arbitrary distinction, exclusion, or restriction based on some attribute, such as gender, ethnicity, religion, sexual orientation, or HIV status
   c. Neither A nor B
   d. Both A and B

2. Identify whether each of the following is an example of stigma or an example of discrimination:

a. Firing or relocating an employee because of his or her (real or perceived) HIV-positive status	Stigma	Discrimination
b. Assigning patients who are living with HIV a lower priority than others, by treating them last or refusing to provide needed care because of their status	Stigma	Discrimination
c. Harassing or refusing to work with a co-worker who is known, or believed to be, living with HIV	Stigma	Discrimination
Denying an employee known, or believed to be, living with HIV a promotion, raise, health insurance, or other benefits because of his or her status	Stigma	Discrimination
Taunting or accusing another student of promiscuous behaviour who is known, or believed to be, living with HIV	Stigma	Discrimination

3. Which of the following are factors that contribute to HIV and AIDS-related stigma and discrimination?

   a. HIV and AIDS are life-threatening
   b. People are scared of contracting HIV
   c. Fear of same-sex relationships
   d. Lack of HIV-related knowledge
   e. All of the above

4. True or False:

a. In many countries young people living with HIV are denied their right to go to school. True False
b. People living with HIV are often thought of as being "responsible" for becoming infected. True False
c. Stigma and discrimination affect only those living with HIV. True False
d. Nothing is being done to stop worldwide HIV-related stigma and discrimination. True False

ACTIVITY 4.1

HANDOUT A: Script: Marva and her friends

This script involves five friends engaged in a conversation about a radio broadcast highlighting the experiences of a woman ("Mrs. M") who is living with HIV. To them she is a respected public figure and as a result her story creates much discussion about HIV and people living with HIV. Marva, who lives with HIV and is a tenant of Mrs. M, works as a teacher; she contributes to the conversations carefully, without disclosing her status.

Marva: [Sigh] Mrs. M sounds so alive and healthy, I am happy for her.

Able: She is very brave to be telling the world that she is living with HIV. I wonder if she is not afraid of what others may think about her and her family.

Charlene: I often think about that and what I would do. I would be so afraid.

Able: If anything like that should happen to me, I would not tell anyone. I would die from stress, especially knowing how people treat with people living with HIV. She has children going to school?

Marva: She has children going to the very prestigious schools in the city, but they are coping well with this situation. She has been living a long time with their support.

Charlene: I heard that her husband infected her and died from AIDS some time ago. I will never understand her courage to care for him when he got ill. If I were in her situation, I would have killed him before.

Marva: You are only saying that now. Her situation is not unique; there are thousands of women who are HIV-positive like her.

Able: Honestly, if I find out, I will curl up and just die, and for that reason, I am not going to do the test!

Marva: Better than that, if Mrs. M did that she would have possibly died and left both her children fatherless and motherless. And she would not have been able to start the treatment to live longer. [Pointing at Doris] Why are you so quiet?

Doris: I wonder if the school authorities know that the children of HIV-positive parents are attending our schools. Marva, I can't believe that you know that she has HIV and never tell anyone.

I have visited her house on many occasions, even ate and drank there. I also know now that her kids go the school like our children.

Marva: I am so very shocked by all of you. What's the difference now that you all know? Surely that does not mean that you and your children are at risk of contracting HIV only because you now know she has it.

Doris: I still can't believe that something as risky as this happened and you never told us before so we can take the necessary precaution. I think that this raises some serious questions.

Marva: Please remember that you cannot contract HIV from casual contact and that people who are living with the virus are not a threat to their communities and should be treated with respect and dignity like all of us.

Doris: I know that you are always a nice and friendly person, but this time you seem to be putting a great deal of effort in backing the people infected with HIV!

Blind Man: I have been listening to you all talking and believe that Doris is right. Marva seems to be putting much effort in defence of infected people.

Marva: Yes! I do it because it could be anyone of us and we would need support.

Blind Man: I have known you a very long time, but can I ask you a few questions?

Marva: Feel free.

Blind Man: You live in the same house with her?

Marva: Right now I am her tenant.

Blind Man: You use the same facilities such as bathroom and kitchen?

Marva: Yes! We even used the same common living area. I am not concerned about my contracting HIV from her since I know that HIV can't be transmitted by casual contact. I also use the same dishes and utensils as her. She even cooks and bakes very well.

Blind Man: Then you eat after she cooked and baked? Are you sure that she has HIV?

Marva: She is not sick in bed, but everybody living in the house and guests eat when she cooks and bakes.

Blind Man: I have greater respect for you. I am not sure if I would have been able to do what you are doing.

DISCUSSION POINTS:

- Identify the person whose attitude you liked most/least and why.
- What did you observe? Were there any surprises? Who else had the same or different experience?
- What struck you most about the conversation? How might it have been different?
- What does that suggest to you about yourself and your group?
- What does that suggest to you about life in general?
- Does that remind you of anything? What does that help to explain?
- How does this relate to other experiences? What do you associate with that?
- How could you apply this experience? What aspect would you find useful?
- How was this for you?
- How might it have been more meaningful?

ACTIVITY 4.1

FACILITATOR RESOURCE A: Script in local dialect: Marva and her friends

Below is an example of adapting the script in Handout A to a Jamaican setting. Feel free to adapt any of the scripts to your local environment.

Marva: Buoy Mrs. M sounds so good, mi happy for her.

Able: What a way she brave, she nu fraid.

Marva: Fraid fi what?

Able: Me would just fraid, if anything like that ever happen to me, me naw tell nobody. Me tink me would dead before de virus kill me.

Marva: But look how long it happen to her and she still living.

Charlene: But de husband dead doh. Mi can't understand how she look after him. Me personally, would kill him before him dead.

Marva: Yu just sey that now but when real situation face yu nobody know what them would do.

Able: Dat no true, mi know from now that mi will curl up and just dead.

Marva: Yu don't have to do that, if Mrs. M did do dat she would dead lef her children both fatherless and motherless. [Turns to Doris] Why yu so quiet?

Doris: Me so shocked me can't talk. Marva mi cant believe yu never tell mi, an Me all go to the house an mi never nuh.

Marva: What's the difference? Now that yu know, what, what?

Doris: Mi naw talk, cause yu a go vex wid mi. A just can't believe dat something as big as this an yu never tell mi. Mi fraid a yu, mi tink mi could trust yu. It seem like yu would see mi in danger an nu sey noting to mi. Aye sa. Aye sa mi tink mi shuld stop talk.

Marva: It's not my business to talk. Is my bosses business, and I can't tek her business on de road. Yu wound't want me to tell your business to anybody.

Doris: I finish talk.

Blind Man: Yu really work for that lady?

Marva: Yes, for over ten years now.

Blind Man: I have not known you a very long time, but can I ask you a few questions?

Marva: Feel free.

Blind Man: You live in the same house with her?

Marva: No, not right now but I was a live-in helper in that house for many years.

Blind Man: You use the same dishes that she use?

Marva: Yes. She is the only one in the house that is HIV-positive and all the other six people that live there use the same dishes.

Blind Man: You drink out the same glass that she use?

Marva: Yes, everyone in the house use the same dishes.

Blind Man: Are you sure that she is really really sick with HIV?

Marva: She is not sick in bed, she loves to cook and she can bake very well.

Blind Man: Then you eat after she cook?

Marva: Yes, me and everybody that comes to the house.

Blind Man: I see you in a different light, you are definitely a better person than I am.

DISCUSSION POINTS:

» What do you think about the attitude and behaviour of Able, Charlene, Doris and Blind Man? Regarding Doris and Blind Man, do you think there is any justification for their words?
» Which person's (or persons') behaviour do you most identify with? State reasons.
» From our group discussions, are there any ideas that have arisen that would help you personally or assist others in recognising the folly and pointlessness of stigma and discrimination as it relates to HIV and AIDS?

ACTIVITY 4.1

FACILITATOR RESOURCE B: Position statements

Position Posters: Write each of these positions on a flipchart; post them on opposite sides of the room before the activity starts.

STRONGLY DISAGREE

STRONGLY AGREE

Position Statements: Statements to be read to participants according to the instructions in Step 4.

Position Statements	Agree	Disagree
1. People living with HIV are themselves to blame for contracting the virus as a result of their immoral behaviour and risky practices, (e.g., they are sex workers, men who have sex with men, users or injectors of drugs).		
2. Teachers who look sick should be tested for HIV and fired if they are found to be HIV-positive.		
3. People with HIV should only be allowed to work if they are in perfect health.		
4. Once you are aware of your HIV-positive status, you should abstain from sex for the rest of your life.		
5. A child who is HIV-positive is a risk to the rest of the school population.		
6. Every school should have a care and support programme for both teachers and students, as well as for the community.		

Position Statements	Agree	Disagree
7. Teachers should be afraid to deal with children of HIV-positive parents since they can pass on the infection.		
8. It is acceptable for a male spouse to evict his HIV-positive female partner for fear of HIV transmission.		
9. People with HIV should be isolated from their communities.		
10. I feel comfortable inviting someone with HIV or AIDS into my house for a weekend.		
11. I would advocate for HIV-positive men, irrespective of their sexual orientation, to be cared for in the same way as other people who are HIV-positive.		
12. Women with HIV should not be allowed to have babies.		
13. My child should not be attending the same classroom as an HIV-positive child.		
14. HIV should be an issue for the education sector, to be treated like any other serious illness affecting members of the community.		
15. HIV screening is necessary for the protection of the school community.		

Position Statements: Suggestions for acceptable responses.

Note: Facilitators should bear in mind that responses to the statements should not be limited to the following but may include others as necessary.

1. Make reference to the importance of showing compassion and respect for people living with HIV, many of whom already blame themselves for contracting the virus and experience ill treatment by society. This compounds the situation by running the epidemic underground and putting more people at risk for HIV infection. Mentioning the statistical evidence that the primary mode of transmission in Caribbean countries is heterosexual sexual activity is another useful approach.
2. It would be not only discriminatory but also unethical to request the teacher's HIV test results; use of such information to fire him or her would further breach international standards protecting the human rights and fundamental freedoms of people living with HIV.
3. The *ILO Code of Practice on HIV/AIDS and the World of Work* states in its principle on *continuation of employment relationship* that "HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions."[26]
4. Emphasise that people living with HIV can enjoy sexual activity if they do it safely, that is, using a condom consistently and correctly at every act of sex with water-based lubricant, if necessary. However, abstaining, postponing, and delaying sex are also very useful options for people to include in their decisions about sex with their partner(s).
5. Emphasise that HIV cannot be transmitted by casual contact. Therefore, a child or parent who is HIV-positive is NOT a risk to the rest of the school population. Refer to HIV and AIDS basic facts (Activity 1.1 Handouts) for more information.
6. Raise issues relating to new developments within the education sector in terms of care and support services for teachers and students. It is debatable whether the school should extend services and support to the surrounding community.
7. HIV cannot be transmitted by casual contact, so a child whose parents are HIV-positive cannot pass on HIV infection to anyone. Refer to HIV and AIDS basic facts (Activity 1.1 Handouts) for more information.

8. Raise issues relating to new development within the health sector—access to treatment and treatment adherence with consistent and correct condom usage.
9. Separating people living with HIV from their communities will not reduce HIV transmission or make the community safer; it would further breach international standards protecting the human rights and fundamental freedoms of people living with HIV.
10. Challenge the participants to share how they feel about doing this, since there is no correct response. It is debatable. Ensure that participants know that HIV cannot be transmitted by casual contact such as sharing dishes or bathrooms or hugging an HIV-positive person.
11. Treatment and health care should be made available to everyone, irrespective of gender or sexual orientation. Different groups of people may require different kinds of support and attention from the health sector, but care should be universal and equitable.
12. Through the Prevention of Mother to Child Transmission (PMTCT) programme, many women living with HIV are deciding to have children, especially knowing their human rights and fundamental freedoms. A mother who takes antiretroviral treatment during her pregnancy may protect her children from being HIV-positive.
13. HIV cannot be transmitted by casual contact, so an HIV-positive child does not put children attending the same class at risk for HIV infection. Refer to HIV and AIDS basic facts (Activity 1.1 Handouts).
14. The *ILO Code of Practice on HIV/AIDS and the World of Work* states that "HIV/AIDS is a workplace issue and should be treated like any other serious illness/conditions in the workplace" and "workers with HIV/AIDS should be treated no less favourably than workers with other serious illnesses in terms of benefits, workers' compensation and reasonable accommodations." "This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic."[27]
15. Screening persons for HIV infection will not reduce HIV transmission, or make the school community safer, but it would further breach international standards protecting the human rights and fundamental freedoms of people living with HIV.

- International Labour Organization [ILO]. (2001). An *ILO code of practice on HIV/AIDS and the world of work.* Geneva: ILO. Available from http://www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf
- UNAIDS. (2002). *An overview of HIV/AIDS related stigma and discrimination, Fact sheets.* Geneva: UNAIDS.

ACTIVITY 4.1

FACILITATOR RESOURCE C: Character labels

Prepare character labels (on 11 x 4 ½ printing paper) for each participant.

- gay man
- lesbian
- sex worker
- thief
- male prisoner
- female prisoner
- mad man
- mad woman
- coke-head
- homeless person
- blind man
- male teacher
- female teacher
- principal
- vice principal
- nurse
- HIV-positive principal
- street child
- pregnant 12-year-old
- clown
- movie star
- fashion model
- shy girl
- politician
- murderer
- drug dealer
- rich man
- bus driver
- nerd
- unemployed father
- unmarried woman
- notorious pastor
- banker
- religious leader
- popular singer
- outspoken journalist
- guidance counsellor
- street beggar

Note: For a larger group of participants the facilitator can suggest that participants develop additional labels of their own. They can also print several labels of the same characters then mix them up among themselves.

ACTIVITY 4.2

Workshop: voluntary disclosure versus exposure

Goal: To examine issues around voluntary disclosure and involuntary disclosure (exposure).

Target audience: Education sector, other line ministries involved with HIV work, members of networks of people living with HIV

Time: 2 hr 40 min

Objectives: *At the end of the session, participants will be able to:*

- » Define and distinguish between disclosure, non-disclosure, partial disclosure, and full disclosure ***(cognitive)***
- » Empathise with the decision to disclose or not disclose HIV status ***(affective)***
- » Counsel peers on issues involving disclosure of HIV status ***(behavioural)***

Preparation: *Prepare in advance:*

- » Write discussion questions on flipchart

Prepare the following materials to be used during this activity:

- » Activity 4.2—PPT Presentation (included on CD-ROM)
- » Handout A: Script: disclosure—Paula, Donnette, and Sandy
- » Handout B: Script: disclosure vs. exposure—school teacher Vivia
- » Handout C: Script: disclosure—Bryan, Vincent, and Claude
- » Handout D: Tools for disclosure
- » Facilitator Resource A: Levels of disclosure
- » Flipchart and markers, index cards

Methods: Role plays, group work, discussion, individual writing

Introduction — 5 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. "Tips for facilitators").

Review the objectives of the session, and explain ground rules (see Appendix 1. "Tips for facilitators"). Explain that the session will include three role plays and discussions. It will begin with clarifying some basic assumptions.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 15 min

Explain that HIV infection is still considered highly stigmatised; therefore many people living with HIV have specific challenges around who knows or has access to personal information relating to HIV infection.

It is up to each individual to choose to disclose or not disclose. Discuss the different "Levels of disclosure" (Facilitator Resource A).

Step 3 — 40 min

The following role plays will help us to reflect on this perspective on disclosure.

Ask for 4 volunteers. Ask them to look over and perform the script on Handout A ("Script: disclosure – Paula, Donnette, and Sandy"), which is about women stating their reasons for not disclosing their status.

Divide participants in groups of 3 or 4. Ask them to use the questions provided at the end of the script to guide their discussion. After 15–20 minutes, address these questions in the large-group discussion, and ask small groups to share what they discussed.

Step 4 — 40 min

Divide participants into groups of 4. Distribute Handout B ("Script: disclosure vs. exposure—school teacher Vivia"), and ask them to re-enact the script.

Then ask groups to respond to the discussion points provided at the end of the script. After 10–15 minutes of small-group discussions, ask members of each group to share and discuss with the whole group.

Step 5 — 35 min

Ask participants to return to their groups of 4. Distribute Handout C ("Script: disclosure—Bryan, Vincent, and Claude"). Ask each participant to take the role of one person in the script, and re-enact the script in groups.

Then ask them to use the questions provided at the end of the script to guide their discussion. In large-group discussion, ask participants "What do you think accounts for the differing levels of disclosure?" Record their responses on the flipchart.

Closure — 20 min

Use the PPT presentation (Activity 4.2—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity and strategies to deal with disclosure as an HIV-positive person or a recipient of the information.

Ask participants to jot down on index cards a few points they learned about disclosure, and how they would advise a friend who tested HIV-positive about his or her options to disclose. Ask a few participants to share.

Distribute the Activity Quiz, once again, to participants, and ask them to fill it out individually. Collect responses.

Distribute Handout D ("Tools for disclosure").

Monitoring and evaluation

Process:

» Record how many people participated and their affiliations.

Outcome:

» Compare results of pre- and post-quiz of participants.
» Collect the write-up at the end of the session about how this experience will affect their relations with people living with HIV.
» Record responses from participants during the discussions.

Quiz answers

1. g

2. a. Partial
   b. Full
   c. Full
   d. Non
   e. Partial

3. b

4. a. True
   b. True
   c. False
   d. True

ACTIVITY 4.2

Quiz questions

1. In which of the following jobs would public, non-voluntary disclosure of an employee's HIV status be acceptable?

   a. School teacher
   b. Nurse in a clinic or hospital
   c. Restaurant or food service worker
   d. Government employee
   e. Both A and C
   f. Both B and D
   g. None of the above
   h. All of the above

2. Identify whether each of the following is an example of full, partial, or non-disclosure of HIV status:

   a. Telling one's partner but absolutely no one else. Full Partial None
   b. Telling a colleague to whom you recently disclosed that you want everyone at work to know your status. Full Partial None
   c. A politician who chooses to reveal his/her status on television. Full Partial None
   d. Discussing treatment and medication options with one's own health care provider. Full Partial None
   e. Mentioning your HIV-positive status to friends one at a time to see how each responds. Full Partial None

3. If someone discloses their HIV status to you, which is <u>not</u> an appropriate response?

   a. Encourage the individual to seek counselling and get treatment
   b. Share the information with others so that they may be protected
   c. Ask what you can do to help
   d. All of the above

4. True or False:

a.	Disclosure of HIV status can help you access the medical services, care, and support you need.	True	False
b.	Disclosure of HIV status can help to protect yourself and others.	True	False
c.	Once you have disclosed your status, it is almost impossible to help others avoid infection.	True	False
d.	As more people disclose their HIV status, it will help to reduce HIV and AIDS-related stigma and discrimination.	True	False

ACTIVITY 4.2

HANDOUT A: Script: disclosure—Paula, Donnette, and Sandy

This script involves a focus group discussion with women to gather information from HIV-positive persons about disclosure. Participants are from various social groups, and they are at different stages of self-acceptance and disclosure.

Leader: We are here today to try to talk about disclosure. We are going to record this session as a teaching tool or a way to inform others of some of the challenges that we face as we try to find our way through the many ramifications of HIV. As women, we sometimes have the peculiar task of being the only parent that is present in our children's life. The first question I have for you is in two parts. First, how long have you been diagnosed? And second, what do your children know about your illness?

Paula: I was diagnosed four years ago. My 40-year-old husband and I were separated when he died five years ago of what I thought was an asthma attack. When I was hospitalised for pneumonia, I found out that he died from the complications of the virus.

My children ages 14, 12 and 10 keep asking me questions about my illness and especially about the medication.

I don't foresee a time when I will ever tell them. I feel a little ashamed. When I think of telling them I actually get what I call 'hot flashes'. I imagine that they are feeling very insecure and anxious. I hope that they do not hear it from someone else. I will deal with that reality when it faces me.

Leader: What about you, Donnette?

Donnette: I am 50 years old and have worked in the civil service all my life. I was diagnosed five years ago when my dermatologist sent me to do an HIV test after my skin rash would not respond to many months of treatment. I have had a hard time processing all the new information that is now a part of my life, especially because before diagnosis I was almost celibate for two years.

I never married and I will never tell my two grown sons in England and Canada about my HIV status. A woman my age must get some kind of old age sickness anyway. I have always felt that old age does not have a lot to recommend it, and this is worsened by the HIV.

Leader: How long have you known, Sandy?

Sandy: Four years now. I was 32 years old. A friend called me and informed me that an ex of mine had a baby that was born with the virus. When my test came back positive I was shocked because I used condoms 99 percent of the time. I was upset when I realised that the medication that HIV-positive people take was the same that he told me he was taking for his back pain.

I told my teenage son who lives with my mother that I am HIV-positive. I bought a lot of condoms for him to share with his friends because I was so afraid for him. At first he was reluctant to talk with me, but now says his friends come to him to talk about safe sex.

Leader: My second question concerns other family members other than your children: Have you told any member of your family? Anyone can answer.

Sandy: I told my mother, my brother, and my sister. My sister accompanied me to do the AIDS test and is very supportive of me. My mother is angry with me because she had warned me about sleeping with him. However she calls me every week to check up on me, and I am free to call her anytime.

Paula: I wish I had such a supportive mother. I asked my pastor to tell her, and when we spoke afterwards on the phone it was a disaster. We were shouting at one another. She told me that she was ashamed of me, and I told her that she should do an HIV test too. I have not disclosed to any of my three sisters. They are suspicious because they visited me in hospital.

Donnette: Thank God my mother is dead. I could not tell her. I have not told my two sisters or my many half-brothers. I will bear my pain alone. I do not want their pity and sympathy.

Leader: The final area that I want you to speak to is friends and your workplace. Did you share your HIV status with them?

Paula: My supervisor at work is also my friend, so it was easy to tell her. I trust her, and she is not judgemental. I have also shared my status with my pastor and some members of my church.

Donnette: I have whispered it to friends at my workplace, and at church. I trust them and I can call on any of them at any time. My church family is praying for me.

Sandy: I do not feel it is necessary to disclose to friends or workmates now. I am not sick. I am not taking medicine yet, and feel fine. I think in the future I will tell them, but not now.

Leader: Some people are saying that HIV-infected persons should have some counselling. Do you agree?

Sandy: No. I have never spoken to a counsellor, and I hope I never have to.

Donnette: That is not for me.

Paula: My pastor keeps suggesting it, but it is just one more person to tell.

DISCUSSION POINTS:

» Which of the women do you think needs counselling the most? Which do you think would voluntarily go into counselling first?
» Do you think it is necessary for Paula to disclose to her sisters? What about her children?
» As an older person, do you think it is necessary for Donnette to disclose to her sons and her sisters? If you do, how would you convince her to do so? What are some of the arguments you would use?
» Which of the three women do you think is in the best position emotionally? Give reasons for you answers.

ACTIVITY 4.2

HANDOUT B: Script: disclosure vs. exposure—school teacher

Vivia

Vivia is a school teacher. She tested positive for HIV while in a hospital with a bout of pneumonia. Luckily for her, she became aware of her illness during the summer holidays when she was in the country, far away from where she worked in Kingston. There are no outward signs of her infection, and she thinks that the other staff members do not know or suspect that she is ill. She is here to talk to a counsellor as she feels depressed because she believes the attitudes of her colleagues might have changed and also because her doctor has advised her to do so.

Rev. Jobs: I am glad to see you today. You were unable to make the first two appointments.

Vivia: I told my doctor to tell you that I am ill. I still can't believe that I am HIV-positive. It seems so foreign and strange to me. It is as if I am talking about someone else.

Rev. Jobs: Are you having difficulty accepting that you are ill or talking about it?

Vivia: On both accounts, Rev, I still cannot understand how my life has taken a turn for the worst. I thought that when my husband was killed that would have been the lowest time in my life.

Rev. Jobs: Do you miss your husband?

Vivia: I am not sure. I miss the financial part and I don't know if I can manage with the children and their needs. But my husband was a terribly abusive man, and I tell myself that I stayed because of the children. He told me that when he was finished with me, no man would want me. I did not know that HIV was included in his package. I thought he was only talking about killing my spirit and zest for life.

Rev. Jobs: Do you think that your husband has succeeded in what he set out to do to you?

Vivia: I don't know. I just don't know. What I do know is that physically I am now trying to survive because of my children. My doctor told me that my T-cell count and my viral load are all in good shape. I am teaching and handling my workload competently. But I am replaying my whole life over in my head and mind. I get the impression that other teachers are starting to suspect that something is not quite right with me.

Rev Jobs: Have you told any member of staff, any member of the administration?

Vivia: Yes, I told my vice principal over the phone. I felt compelled to do so because I was absent from school for nearly a week. She told me that I could count on her for confidentiality. I believed her but when I came back to school, she was absent for two weeks.

The head of my department came to me and asked me how I was, and I could not stop crying.

Rev. Jobs: I don't understand why you were so upset. You were not at work for some time, so it is understandable that the head of your department would inquire about you.

Vivia: I am so upset with myself, in the same way that I seem to be manufacturing tears now . . . that's exactly how the tears would not stop.

Rev. Jobs: Please explain your thought process to me.

Vivia: I felt the vice principal told her about my illness.

Rev. Jobs: You do realise that you are upsetting yourself before you have concrete proof?

Vivia: Yes, and I have further compounded the matter by being so emotional and have behaved in such a way that I have cast suspicion on myself.

Rev. Jobs: Let us examine that together. I think you are too hard on yourself. Let us talk about the best-case scenario. The vice principal did not disclose your HIV status. Think about what the head of your department knows about you that might explain your emotional response to her question.

Vivia: I might be having some issues with my son or my daughter or even my mother. She does not know details about any of these matters.

Rev. Jobs: Exactly.

Vivia: What about the worst-case scenario?

Rev. Jobs: And what is that?

Vivia: The vice principal broke her confidentiality agreement with me, and the whole staff and probably some students know about my status.

Rev Jobs: That would be a very serious matter, but it's nothing that we can't handle together. Right now I think that you made a judgement call and you told someone about your status. Trust your instincts until you have concrete proof that your confidentiality was broken. Can we talk again in two weeks?

DISCUSSION POINTS:

» Discuss the best-case and worst-case scenarios from the point of view of:
  - Vivia
  - Vice principal
  - Head of department
  - Rev. Jobs

ACTIVITY 4.2

HANDOUT C: Script: disclosure—Bryan, Vincent, and Claude

This script involves a focus group discussion with men to gather information from HIV-positive persons about disclosure. Participants are from various social groups, and they are at different stages of self-acceptance and disclosure.

Leader: We are here to talk about disclosure. We might be taping this session so that others can see the challenges we face. How long have you known, and have you disclosed to anyone?

Bryan: I am here only because I love my sister very much and she pressured me into talking to you. She told me that my identity will be protected. I have known for five years now. I don't have any children. The first person I told was my partner Broderick. We have since parted, and he is still HIV-negative.

It was distressing to disclose to my mother, brothers, and sister. My mother and sister are very supportive. However my brothers are angry with me and think that my lifestyle is to blame for my HIV status.

Claude: I am not gay like Bryan and probably would have stayed away if I knew that he was going to be here. Three years ago I had a stroke, and the doctor told me that I was HIV-positive while I was in hospital. I have one boy and two girls, all in their twenties. I did not have to tell my daughters or my girlfriend because my sister told them for me. My girlfriend does not have the disease and we are still together.

Leader: What about you, Vincent?

Vincent: I have known for the past four years. I have no idea how I became infected. My wife of over 30 years is also HIV-positive, and she has moved out of our bedroom. She told our children, and my son does not speak to me, and my daughter does so only when necessary. If it were up to me, I would not have told my children because I think it's none of their business. I think I have had it for a longer time, but the doctors had a hard time diagnosing me.

Leader: You haven't mentioned anything about friends or persons outside of your family circle.

Claude: Since I nearly died, I think the six people at my work place guessed, but only my boss knows for sure. She and my sister talk all the time. She has been helping with my health insurance. I think I am very lucky. My sister said it is a result of her prayers. My landlord, a little old lady, said that she sympathises with my situation and she helps

me out a lot. I am not sure how she knows. To date everyone seems nice to me and I am back at work after a very long sick leave.

Vincent: I have many friends, but I think it's none of their business. I will never disclose. My wife wants me to tell my brother in Canada and my sister in Atlanta, but my lips are sealed. My doctor thought that coming here would be a good idea.

Bryan: Unlike Claude, I am a graphic artist; I own my own business, so I don't think I have to disclose to anyone there. I do work for six high schools, so I do not want my HIV-positive status to get out in the public. I have friends whom I have told, and they are supportive of me. But I wish that my family, especially my brothers, would accept and speak to me. I feel the loss of my brothers' friendship deeply.

Leader: Gentlemen, what about going to see a counsellor or a psychologist for assistance with any problems you might have?

Vincent: Assist me? I am here to help, I don't need any help. I am fine with the way things are. It's unfortunate that I got infected but I can't control the actions and attitudes of my family and I am not about to explain myself or my actions to anyone. I am an adult after all.

Claude: I'm quite fine. I have my medication, I am all right. I encourage my sister not to worry and she tells me I am living in a dream world. But I am all right. I am quite fine and doing well.

Bryan: I don't see how talking to somebody would help my brothers to talk to me. Maybe they should see a counsellor.

Leader: Thank you, gentlemen.

DISCUSSION POINTS:

» On an acceptance scale of their HIV-positive status (where 1 = full acceptance and 5 = non-acceptance), circle where you would place Bryan, Vincent and Claude.

Bryan:	1	2	3	4	5
Vincent:	1	2	3	4	5
Claude:	1	2	3	4	5

Give reasons for your answers. What do you think accounts for the differing levels of disclosure?

ACTIVITY 4.2

HANDOUT D: Tools for disclosure

- Tool A: Disclosure considerations when interviewed by the media
- Tool B: Disclosure considerations when dealing with the community
- Tool C: Points to consider when disclosing to family members

Tool A: Disclosure considerations when interviewed by the media

- Have a good understanding before the interview begins what the reporter generally plans to cover. You should be able to get that information from the person arranging the interview
- If you are nervous or anxious, ask to do role-playing ahead of time. Ask the person arranging the interview to play the role of reporter. It is a good way to settle those nerves and consider how best to answer some questions you expect to be asked.
- Be clear in your mind what you are comfortable in disclosing about your personal life so that if a question is asked that you do not want to answer you will not go beyond your boundaries. Do not make these decisions during the course of the interview. Have your own internal ground rules set ahead of time.
- You have agreed to be interviewed and identified by the media. That does not mean anyone else in your life has agreed. Confidentiality of others must be respected.
- If there are people in your life who you believe would not object to being identified and discussed, clarify this with them up front and before the interview.
- A reporter may ask you the same question in several different ways in an effort to elicit more information than you are willing to provide. Do not let him or her badger you. If you do not want to answer the question—no matter how it is asked—do not give in.
- If you are confused about what the reporter is asking in a particular question, ask the reporter to re-phrase the question. Do not try to guess. This is your life and your story; you have every right to be certain what is being asked of you!
- You may well know more about HIV than the reporter you are talking to knows. If the reporter says something that is factually incorrect, do not let it stand. Correct the record. It will not be helpful to you, or the reporter, to be associated with a factually flawed story.
- At the end of the interview, if you feel the reporter has missed some key points, say so. A reporter usually will be grateful for that kind of help because the information will make for a stronger story.
- Do not be fooled. A reporter is not your friend. The ***story*** is a reporter's friend, so he or she will do what is best for the story. Do not get lulled into a comfort zone where you may say something you will later regret.
- Once you have told a reporter something, there is no taking it back. That is why this kind of preparation is necessary.

Tool B: Disclosure considerations when dealing with the community

Establish the five "W's" of disclosure—Who, What, When, Where, and Why.

- **Who:** Who invited you? Who will you be talking to?
- **What:** What is your message? What do you want to tell people about your HIV infection, and what are you expecting from the persons you are disclosing your HIV status to?
- **When:** When will you be presenting? For how long?
- **Where:** Where will this activity be taking place—venue?
- **Why:** Why did they select you?

Consider:

- Whether you are ready for this
- Equipping yourself to use different methods to communicate your message
- The amount of time you need to deliver and accomplish your task
- Enquiring about institutional confidentiality policy and how it applies to you, especially if you have not shared your HIV status with your family, friends, or other loved ones
- Who may be linked to the information you are about to disclose and whether you may be involuntarily disclosing them, (e.g., spouse, partner(s), children, parents, and significant others).

Remember:

- Always bear in mind that you need to protect your emotional well-being.
- You don't have to tell the circumstances surrounding your sexual history.
- Highlight care issues (diet, hygiene, treatment, and adherence) and how you addressed them.
- Highlight social support needs of people living with HIV.
- Highlight the risk of sharing and that it can affect your life in ways you haven't considered or prepared for.
- Be clear about the content of your presentation.
- If you have feelings of uncertainty about disclosing it is ok—since these are normal reactions in this situation.
- You have a virus; it does not mean that you have done something wrong. You do not have to apologise to anyone for being HIV-positive.
- Be selective! You don't have to tell everything. Keep it simple.
- Know your audience. Determine who comprises the audience.
- Summarise.
- Express your appreciation.
- Evaluate by soliciting feedback on your presentation.

Tool C: Points to consider when disclosing to family members

Establish the five "W's" of disclosure – Who, What, When, Where, and Why.

- **Who:** Who do you need to tell?
- **What:** What do you want to tell people about your HIV infection, and what are you expecting from the person(s) you are disclosing your HIV status to?
- **When:** When should you tell them?
- **Where:** Where is the best place to have this conversation?
- **Why:** Why are you telling them?

Remember:

- The choice is yours to tell or not to tell.
- You don't have to reveal every detail of your life story.
- Avoid being hard on yourself as a result of your HIV status and the challenges you experience when thinking about disclosure.
- Draw on the support and experience available through local organisations (e.g., websites, newsletters, and books about personal experiences).
- Seek support on the matter of disclosure from local resources (e.g., social workers, people living with HIV, competent counsellors).
- There is no perfect way to disclose.
- Remain optimistic! Fearing a bad reaction is not unusual. Be patient and remember that you will get through it, no matter how difficult it seems it will be.
- Be selective! You don't have to tell everyone. Telling people without fully considering it may affect your life in ways you have not considered or prepared for.
- If you aren't sure about disclosing, remember that this is a common feeling for many individuals in similar situations.
- You have a virus; it does not mean that you have done something wrong and should apologise to anyone for being HIV-positive.
- If you feel compelled to give details, do it incrementally. Keep it simple.

• "Getting prepared for a media interview: How to maximize the impact of your message," The Henry J. Kaiser Family Foundation and GMAI. Available from http://www.thegmai.org/Preparing%20for%20an%20Interview.pdf. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.

ACTIVITY 4.2

FACILITATOR RESOURCE A: Levels of disclosure

Non-disclosure	The person who is diagnosed with HIV does not see the necessity to share information relating to his/her HIV status with anyone (individual or institution) except the health care professional who provides treatment and care and who must guarantee confidentiality. *Few people living with HIV remain at this stage.*
Partial disclosure	The person who is diagnosed with HIV sees the necessity, finds courage and strength to share information relating to his/her HIV status in some kind of detail to family, friends, and significant others for social support purposes. *Most people living with HIV fall within this category as it covers a range from telling one person to many. Whoever is told is asked and expected to keep this confidential*.
Full disclosure	The person who is diagnosed with HIV sees the necessity, finds the courage and strength to share information relating to his/her HIV status with community institutions, family, and friends that are relevant to his/her well-being, such as places of work, worship, and education. This disclosure may be for advocacy purposes, to gain wider community acceptance, and/or to obtain access to social services. *Few people living with HIV attain this stage.*

SECTION 5 Creating a supportive and enabling environment

This section highlights the conditions that are extremely important if people living with HIV are to work freely and feel comfortable and productive in their environments.

What you need to know

What is confidentiality?

Confidentiality, as it pertains to HIV, means that any medical information gathered from an individual, whether oral or in written form, must not be disclosed. The education sector's employees, student population, or parents and guardians are not obligated to disclose their status to any of the education sector's authorities.

Why is confidentiality important?

Voluntary counselling and testing (VCT) is one area where confidentiality is extremely important. The education sector should establish policies that give guidance on this area. All employees should be educated about testing—where they can access the testing and be offered pre-testing counselling as well as post-testing counselling when the test is administered.

A work place policy should be in effect to address the concerns of any person who experiences breaches of confidentiality.

If the environment is to be caring, supportive, and enabling, members of the education sector (administrators, all employees, students, parents and guardians, including people living with HIV at every level) must receive information about and practice confidentiality at every level.

Activity 5.1 is intended to help make this concept meaningful. The workshop should be interactive and practical. It will give all participants practice in confidentiality, through role play, scenarios, and practical exercises to examine the reasons why confidentiality is important and should not be breached. It also deals with designing plans to begin the process of a supportive and enabling environment.

Facilitation tips

This exercise must be done after the activities on stigma and discrimination (Section 4, Activities 5 and 6). It is important to understand the relationship between stigma and discrimination, voluntary or involuntary disclosure, and their impact. It must not be a talk session but a demonstration session of best practices. This session should be co-facilitated by a trained counsellor, social worker, or a health worker who does VCT.

If there seems to be a need to review basic information about HIV and AIDS (including how HIV is spread, common behaviours that lead to HIV infection, and HIV treatment) please refer to the handouts and facilitator resources provided for Activity 1.1.

Facilitation tip for MOE personnel

As far as possible and when relevant, consider using the document *HIV and AIDS workplace policy for the education sector in the Caribbean* as a basis and resource material for some aspects of the discussions to be initiated in this session, if such a policy has been adopted in your country (available from http://unesdoc.unesco.org/images/0014/001472/147278e.pdf).[28]

Tips for people living with HIV

Make use of personal testimonies that are relevant to this topic, and highlight the perspective of people living with HIV. Every piece of information should be kept confidential—not only medical, but also social information.

Facilitation tip for MOH personnel

Highlight the system that may be used to maintain confidentiality. Explain the difference between privacy, confidentiality, and secrecy.

As far as possible and when relevant, consider using the document *HIV and AIDS workplace policy for the education sector in the Caribbean* as a basis and resource material for some aspects of the discussions to be initiated in this session, if such a policy has been adopted in your country (available from http://unesdoc.unesco.org/images/0014/001472/147278e.pdf).[28]

ACTIVITY 5.1

Sensitisation workshop addressing confidentiality and a supportive and enabling environment

Goal: To ensure that measures are in place to facilitate a supportive and enabling environment for people living with HIV in the education sector.

Target audience: MOE staff, including HIV Coordinator, HFLE Coordinator, other education sector administrators; principals and teachers; people living with HIV group networks; representatives of the National Student Council and the National Parent Teachers' Association.

Time: 3 hours (1/2 day)

Objectives: *At the end of the session, participants will be able to:*

- Define confidentiality *(cognitive)*
- Respect the issues of confidentiality as they relate to incorporating GIPA in the education sector *(affective)*
- Make a commitment to create an environment that is supportive and enabling for people living with and affected by HIV *(behavioural)*

Preparation: *Prepare prior to the session:*

- Meet with the co-facilitator to decide roles
- Determine how to sort participants by group
- Familiarise yourself with Facilitator Resource A: Considerations for maintaining confidentiality
- Write definition of confidentiality on flipchart

Prepare the following materials to be used during this activity:

- Activity 5.1—PPT Presentation (included on CD-ROM)
- Handout A: Case studies
- Handout B: Checklist
- Handout C: Factors that can ensure a supportive and enabling environment
- Handout D: Code of conduct
- Flipchart paper, markers, index cards

Methods: Oral presentation, demonstration exercises of confidentiality, role play, group exercise, individual writing

Introduction — 10 min

Introduce yourself and the co-facilitator and ask participants to briefly introduce themselves by stating (1) why they are present and (2) one thing that they would like to get out of the workshop. Review the objectives of the session, and state ground rules (see Appendix 1. "Tips for facilitators"). Distribute the Activity Quiz and collect once completed.

Tell participants that the workshop will give some information on how to create support in environments where people who are living with or affected by HIV may be placed. Note that there will be opportunities for hands-on training and use of their experiences to begin the process of creating a supportive environment.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 10 min

Give the definition of confidentiality (see introduction section to this activity) and write it on a flipchart.

Highlight that there must be a trusting relationship between the health care provider or counsellor and the client as it relates to HIV disclosure. The provider must not disclose the HIV status of his client, no matter who is requesting the information. It is unethical and could be unlawful to share this information with anyone even in the education sector.

Ask participants to write the definition of confidentiality down on their note pads and post it where it can be seen and shared with other colleagues in their workplace.

Step 3 — 20 min

Co-facilitators model the responses when someone shares something private and confidential, such as HIV status. Ask a volunteer to suggest a highly confidential statement. Co-facilitators demonstrate possible responses, such as ensuring confidentiality and non-disclosure of the statement to others. Point out that both the use of body language and the words said are important for this exercise.

Ask participants to partner with one person and practice the art of hearing and responding to something confidential.

After the activity, ask participants what their feelings were, and write them on the flipchart.

Step 4 — 1 hour

Divide the participants into groups, as determined prior to the exercise.

Co-facilitator distributes Handout A ("Case studies") with one scenario to each group and asks participants to read the scenario in the group. Give time for role playing of the scenarios and answering the questions that follow. Circle the room to make sure that the individuals in each group understand the scenario and are participating. Ask them to prepare a presentation of their case and main points of discussion for plenary.

After groups have worked through the case studies, convene groups to plenary to share their role play and answers. Ask participants to critique the group presentations constructively, first by offering encouraging comments and then by adding any points that may need further clarification.

Step 5 — 1 hour

Ask participants to work in groups and use the Checklist (Handout B), which will be distributed to measure how their present environment supports the ethics of confidentiality.

Then distribute Handout C ("Factors that can ensure a supportive and enabling environment") to help participants fill in the missing gaps if a supportive environment is to be achieved.

Ask participants to share in groups their particular situation and what needs to be done.

Group reconvenes and presents what they have shared. Discuss and give feedback in plenary.

Closure — 15 min

Distribute Handout D ("Code of conduct") as a resource.

Use the PPT presentation (Activity 5.1—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity.

Challenge participants to take action on at least one of the needs that they have identified. Ask participants to write down their commitment on an index card, and collect the cards for follow-up. Make sure participant has a copy to take home in order to remember the commitment.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

- » Record the number of persons who participated and note their represented groupings.

Outcomes:

- » Compare responses from the pre- and post-quizzes.
- » Record the answers to the case studies and role plays.
- » Record the responses to the checklist and the activities to be followed up and reported on.
- » Record the commitments.

Quiz answers

1. a. iv
   b. v
   c. ii
   d. iii
   e. i

2. e

3. a. True
   b. True
   c. True
   d. False

4. g

ACTIVITY 5.1

Quiz questions

1. Match the following terms with their correct definition (write the appropriate number on the lines):

a. Confidentiality ____________	i. A personal action or decision is made by an individual with his or her consent
b. Enabling ____________	ii. The ability of an individual to protect personal or sensitive information about themselves
c. Privacy ____________	iii. Personal or sensitive information is shared among a select group of people, but hidden from others
d. Secrecy ____________	iv. Ensuring that personal or sensitive information about another person is not revealed
e. Voluntary ____________	v. Interactions or relationships that allow individuals to develop and grow positively

2. Which of the following should be a part of a voluntary counselling and testing (VCT) programme to ensure its success?

   a. Education sector should establish policies that provide guidance.
   b. All employees should be educated about testing and where it can be accessed.
   c. Counselling should be offered both before and after testing.
   d. Members of the education sector should practice confidentiality.
   e. All of the above

3. True or False:

   a. Nurses and doctors must ensure the confidentiality of their patients. True False
   b. School teachers must ensure the confidentiality of their peers and students. True False
   c. Peer support programmes should help to provide an enabling environment in which to disclose safely. True False
   d. Peer support programmes should help to ensure that individuals admit their mistakes and bad behaviours. True False

4. The personal or sensitive information of which individuals should be kept confidential?

   a. Those who have, or may have, HIV
   b. Those who have chosen to have an HIV test or have been counselled about a test
   c. Those who are receiving treatment that suggests he or she may have HIV
   d. Those who may have had experiences that put him or her at risk for HIV infection
   e. Both A and C
   f. Both A and D
   g. All of the above

ACTIVITY 5.1

HANDOUT A: Case studies

CASE STUDY 1: Testimonial by Vivene Gooden

I am in my thirties. I am married but presently separated from my husband. We have three children together. I did a six-months course in Child Care. I did very well and gained a certificate. I got a job looking after two small children ages two years ten months and five months. I enjoyed looking after the children, and my boss was very nice and considerate toward me.

I listened to the radio programme where Mrs. M told the whole island that she was HIV-positive and some of the struggles she had to go through. Tears came to my eyes, especially because I remembered my own aunt and uncle in-law and how they suffered before they both died of AIDS. Some of my family deserted them and would not even go to visit them when they were ill.

The following day when I was talking to my boss, I asked her if she had listened to the radio programme. She said she had, and expressed sympathy toward Mrs. M. I felt comfortable to tell her about my aunt and how difficult it was for me because I could not get some of her own children, my cousins, to visit her. She listened attentively. I also told her that I knew Mrs. M and had been working some weekends with her for the past two years.

She immediately changed toward me. For the six months that I worked there she sometimes would use the same bathroom that I used. After our talk she stopped doing this and went upstairs every time to use a bathroom there. Next, she stopped using the utensils that I used. I continued looking after the children but there was so much tension in the house that I left the job soon after this.

DISCUSSION POINTS / GROUP WORK:

» Discuss the change of attitude of Vivene's employer toward her.
» Account for and try to explain the disparity between the employer's action in allowing Vivene to look after her children and scorning her at the same time.
» List the ways in which you think Vivene was stigmatised and/or discriminated against.
» Imagine you are Vivene's employer; state your fears.
» Imagine you are Vivene; explain your feelings of hurt and disappointment at your employer's behaviour.

CASE STUDY 2: The Dilemma

Anna is a teacher, the head of the mathematics department at a high school in the Caribbean. She is married to the bursar, who has been working at the school for over 20 years. Recently Anna has been depressed and has come to the principal who is her friend to confide in her. Her husband, the bursar, told her last year that he had tested positive for HIV. He asked her to accompany him to his doctor, who told her that she should do the test, too. The test came back negative, but the doctor informed her that she should test every six months for at least three years. She wants her husband to talk to her about how he got infected, but he has refused. He has also refused to go to any mediator/counsellor, and she is having difficulty with pretending that everything is fine in her marriage. He has asked her not to tell anyone, not their three adult children and certainly no member of their families on his side or hers. By telling her principal, she has breached their agreement of confidentiality, a promise implicit in his stance on disclosure of his HIV status.

DISCUSSION POINTS / GROUP WORK:

» What if anything should the principal do? She has a very good relationship with her bursar.
» What should Anna do next?

CASE STUDY 3: Sherlon

Sherlon is a 14-year-old high school student. Two years ago her father died from complications due to contracting HIV. It was not until after his death that her mother informed her of the real cause of her father's death and said that she, the mother, was also infected. It was very difficult for her to attend school because in her district it seemed like everyone knew. Two of her friends stopped talking to her because they were afraid of her. She passed her high school examination for school in a rural community, but her aunt decided she should come and live with her and attend a high school in the city. She is now in eighth grade. Recently her new English teacher, in introducing herself to the class, mentioned that she was from Sherlon's district and has family living there. She also recognised Sherlon's last name and asked her if she was from that district or had relatives living there. Sherlon is terrified that what happened to her in primary school where she was scorned by her peers will happen again. She believes that the teacher will tell other teachers and sooner or later the students in her class will know and the nightmare will begin again. She was distraught when she told her aunt about the situation.

DISCUSSION POINTS / GROUP WORK:

» What is her aunt to do?
» What is her teacher to do?
» What is Sherlon to do?

CASE STUDY 4: Kimberlyn

I am a school nurse at a prominent high school. Over the past nine months I have noticed one particular twelve year old, Kimberlyn, coming to the nurse's station quite a lot. Her main complaint usually has to do with sinusitis, but she has had the flu several times this year. She is a very bright and articulate young student and speaks a lot about her mother. She asked me if it was possible for sinusitis to be genetic because her mom was constantly sick with her sinuses too. But she noted that it couldn't be because both her mother and stepfather suffered from sinusitis and flu-like symptoms very often. On another occasion she remarked; "Nurse I am a little concerned and worried about my mother and Al, my stepfather, they seem to be ill all the time. In the beginning it was just my mother who visited the doctor every other week and the hospital twice, and now unbelievably he has joined her. What would happen to me if anything happened to them?" When I went home that night her words rested on my mind.

Two weeks after this incident her mother came to my station looking for Kimberlyn. She was in the bathroom, where I had a chance to sit and talk with her for a few minutes. I could not help noticing that her beautiful skin had now changed. She tried to conceal with makeup, a skin rash that was all over her face and extended to her arms. I believe that this family is in trouble. I believe Kimberlyn might have the virus. I believe the mother is HIV-positive.

DISCUSSION POINTS / GROUP WORK:

- What is the nurse to do?
- Does she have any authority, moral or otherwise, to do or say anything to anyone? She is overwhelmed by the dilemma in which she has found herself, especially because she has grown attached to Kimberlyn.

ACTIVITY 5.1

HANDOUT B: Checklist

The following items are to be considered before a draft of any change in the environment can be addressed.

1. In the table below, tick NO/YES if this exists in your institution or workplace.
2. Then, fill in the other two columns, as appropriate.
3. Then use Handout C ("Factors that can ensure a supportive and enabling environment"), and fill in the column that is labelled "What needs to be done" and add additional "Aspects of HIV work" that your institution needs to address.

Aspects of HIV work	YES	NO	How this work is presently done	What needs to be done
SERVICES: Do you have access to health services (e.g., school nurse, first aid kits)?				
SERVICES: Is there any information available on voluntary counselling and testing?				
POLICY: Do you have an HIV workplace policy?				
EDUCATION: Does health education on HIV and AIDS address confidentiality?				

Aspects of HIV work	YES	NO	How this work is presently done	What needs to be done
ENVIRONMENT: Are there any peer support programmes?				
ENVIRONMENT: Do you have a supportive environment?				
(ADD OTHER ASPECTS)				

ACTIVITY 5.1

HANDOUT C: Factors that can ensure a supportive and enabling environment

1. The education sector must have a policy that covers the following aspects related to HIV:
   - Information on services and referrals for voluntary counselling and testing
   - Availability of care and support to persons and families who are living with HIV
   - Ensuring an environment that meets the emotional, psychosocial, and physical needs of all persons in the education sector
   - Ensuring gender equality in the context of HIV and AIDS (facilitating deliberate steps to address the unique and cross-cutting issues that affect the creation of a supportive and enabling environment for women and men to act in preventing HIV infection and mitigating the impact of AIDS)
   - No tolerance of stigma and discrimination
   - Observing fair labour practices
   - Providing training and materials for First Aid
   - Developing a code of ethics
   - Creating partnerships
   - Setting guidelines for confidentiality
2. The entire education sector must be involved at all levels: from ministers of education, administrators, and all educational institutions' employees to the students and their parents or guardians.
3. Setting up peer support groups that will advocate for the causes of people living with HIV
4. Guidelines put in place for schools to adopt a health and wellness programme
5. Creation of HIV or Health clubs within educational institutions.

- Clarke, D., Constantine, C., Oommen, M., Ross, V., and Vince Whitman, C. (2008). *Step by step: a guide to HIV and AIDS policy development for the education sector, Caribbean Education Sector HIV and AIDS Capacity Building Programme*. Newton, MA: CARICOM, UNESCO, and EDC.

ACTIVITY 5.1

HANDOUT D: Code of conduct

What to consider when writing a code of conduct

» Review any existing codes that are available, and modify them if necessary.
» If there is no code, begin the drafting policies, utilising all the stakeholders through various methods such as focus groups, open discussion, and written comments.
» Distribute the code for input from all stakeholders.
» Organise awareness and educational campaigns.
» Monitor and evaluate the initiative.

Sample Code of Conduct:

PRINT NAME CLEARLY: ____

1. I agree to …………………*[Fill in]*……………………
2. I agree to …………………*[Fill in]*……………………
3. I agree to …………………*[Fill in]*……………………
4. I understand that the following behaviour(s) is (are) appropriate conduct. *[List appropriate behaviour(s).]*
5. I understand that the following behaviours are samples of inappropriate conduct (Please note that this list is not exhaustive). *[List inappropriate behaviour(s).]*

I understand the need to agree to the above items. I realise and agree that if I do not abide by these rules, I may lose the privilege of being involved in the work of…*[Fill in]*…as a result of my actions.

I, as a participant agree to abide by these guidelines.

_____________________________ Signature _______________ Date

I, as the administrator agree to these guidelines.

_____________________________ Signature _______________ Date

• Adapted from: http://www.globalcompliance.com

ACTIVITY 5.1

FACILITATOR RESOURCE A: Considerations for maintaining confidentiality

Confidentiality

One of the major barriers to voluntary counselling and testing (VCT) and disclosure is a lack of confidentiality protections of one's status. Policies and procedures should be established to address this concern. An HIV and AIDS workplace policy for Southern Africa, for example, stipulates that "all personal medical information, whether oral, written, or in electronic format, obtained from individual or third parties will be treated as confidential."

Information must be kept confidential in situations where the person has or may have HIV; has chosen to have an HIV test or has been counselled about having the test, is receiving or has received treatment or counselling that suggests he or she may have HIV, may have had experiences that put him or her at risk of contracting HIV, has a close association or relationship with someone with HIV.

Involuntary disclosure and breaches of confidentiality

The education sector should be prepared to deal with involuntary disclosure. In some cases, the HIV status of a colleague is revealed with no malicious intent. The person may be trying to encourage others to be more supportive toward their colleague who is HIV-positive or may be seeking support for his or her own distress about a friend's status. Nevertheless, disclosing someone's HIV status without his or her permission is a severe breach of confidentiality and should be treated as such.

Supportive legislation is key to ensuring confidentiality and prohibiting non-voluntary disclosure. As a proactive measure, education sector staff at all levels should be informed of what HIV-related information qualifies as confidential and of their organisation's policies and procedures around the issue. This will help to avoid unintentional involuntary disclosure. Disciplinary and grievance procedures should be in place as a means of recourse for people living with HIV whose status is disclosed without permission. The specifics of such policies and procedures will vary somewhat,

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- Cornu, C. (2006). *Enhancing the Greater Involvement of People Living With HIV/AIDS (GIPA) in NGOs/CBOs in India.* New Delhi: International HIV/AIDS Alliance & India HIV/AIDS Alliance.
- EI, WHO, & EDC. (2007). *Inclusion is the Answer: Unions involving and supporting educators living with HIV. A toolkit for educators and their unions.* http://www.ei-ie.org/efaids/en/documentation_ei.php
- ILO & UNESCO. (2006). *An HIV and AIDS workplace policy for the education sector in Southern Africa.* Paris: UNESCO. Available from http://unesdoc.unesco.org/images/0014/001469/146933E.pdf
- Stephens, D. (2004). *Out of the shadows: Greater Involvement of People Living With HIV/AIDS (GIPA) in policy, POLICY Working Paper Series No. 14.* Washington, DC: POLICY Project. Available from http://www.policyproject.com/pubs/workingpapers/WPS14.pdf

depending on an individual country's legislation and pre-existing education sector policies. In the ILO and UNESCO Southern Africa workplace policy, for example, if people in the education sector refuse to work or interact with a colleague who is HIV-positive, they will first be offered educational counselling. If, however, after this step they still refuse to work with the person living with HIV, disciplinary measures will be taken.[29]

SECTION 6 Operationalising the principles of GIPA

Both the education sector and networks of people living with HIV should recognise that they can learn from each other. This section therefore examines the strategic partnerships that should be embraced to successfully operationalise the principles of GIPA principles. It addresses resource mobilisation by providing guidance on conducting a resource gap analysis, or needs assessment, as well as developing an action plan to operationalise the GIPA principles in the education sector. It also includes establishing a **Memorandum of Understanding** (MOU) to formalise agreements that clearly define joint planning strategies, procedures, and shared roles and responsibilities in programme planning and evaluation, consistent with incorporating GIPA principles into a comprehensive approach.

What you need to know

What is a partnership?

A partnership is a strategic alliance or relationship between two or more people or organisations. Partnerships can be formal, where each party's roles and obligations are spelled out in a written agreement, or informal, where the roles and obligations are assumed or agreed verbally.

Partnerships are often necessary when working toward a common goal that is more likely to be achieved collaboratively than alone. Successful partnerships are often based on trust, equality, and mutual understanding and obligations. Working with a partner has its challenges and limitations as well as its benefits, since different partners bring different perspectives and expectations. It is important that both parties be open-minded and accepting of each other's differences. There must be a willingness to learn and adapt. Partners must be willing to exchange their technical knowledge and to relate as equals in a shared vision.

Building Partnerships

Each partner can benefit by:

- » Sharing and creating knowledge
- » Pooling resources
- » Building capacity within each organisation
- » Public recognition of partnerships

What is a Memorandum of Understanding?

A Memorandum of Understanding (MOU) is an agreement between two parties in the form of a legal document. It is not fully binding in the way that a contract is, but it is stronger and more formal than a traditional agreement. Sometimes MOU is used as synonym for a letter of intent, particularly in private law.[30] A letter of intent expresses an interest in performing a service or taking part in an activity, but does not legally obligate either party.

What is resource mobilisation?

Resource mobilisation is a comprehensive process that involves strategic planning for programme funding, communication and effective negotiation with donors, sound management of resources, improving image and credibility of the organisation, and ensuring good coordination among all partners.[31]

Resource mobilisation has become an increasingly important activity for operationalising the GIPA principles, particularly at a time when GIPA partners are expected to undertake a variety of activities for operationalising the principles of GIPA in the education sector. In order

to effectively operationalise the GIPA principles in any sector, one needs to know as much as possible about the HIV response in the sector, and then create approaches that change the knowledge, beliefs, attitudes, and structures related to the problem. To accomplish this, it is necessary to conduct a mapping or charting exercise to help us identify the gaps in service and knowledge of the sector/organisation in which you will work. Conducting a resource gap analysis, or needs assessment, together with developing an action plan with clear goals and activities, will serve as the starting point; it will show us where our GIPA efforts should or could be directed, and ultimately increase the likelihood of a successful strategy for operationalising the principles of GIPA.

Activity 6.1 will allow participants to brainstorm potential partners, share any experiences they have had in collaborating, and conduct a resource gap analysis to identify where further collaboration in HIV work might be desirable.

Activity 6.2 will help participants to learn the skills of organising an action plan, based on the resource gap analysis, and composing an MOU to operationalise the GIPA principles in the education sector.

Facilitation tips

Ideally, Activities 6.1 and 6.2 would be conducted in sequence.

If there seems to be a need to review basic information about HIV and AIDS (including how HIV is spread, common behaviours that lead to HIV infection, and HIV treatment) please refer to the handouts and facilitator resources provided for Activity 1.1.

Facilitation tip for MOE personnel

MOE may wish to partner closely with MOH counterparts and the representatives of the network of people living with HIV to jointly work through these activities.

Tips for people living with HIV

People living with HIV may want to highlight the need for this partnership and how beneficial it will be to their communities.

When discussing the various elements of this session, do not hesitate to highlight the added value of GIPA in comparison to a context where GIPA principles would not be integrated.

Facilitation tip for MOH personnel

MOH personnel may wish to partner closely with their MOE counterparts and the representatives of the network of people living with HIV to jointly work through these activities.

MOH may want to share with the participants the new and emerging challenges posed by HIV and AIDS, necessitating the need for a multisectoral response to HIV and AIDS.

ACTIVITY 6.1

Building partnerships: identifying partners and conducting a resource gap analysis

Goal: To identify partners and to facilitate collaboration and priority-setting for operationalising the principles of GIPA in the education sector through a gap analysis

Target audience: Education sector, other line ministries involved with HIV work, networks of people living with HIV, National AIDS Committee

Time: 2 hours 40 min

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

» Identify and describe a variety of partners to operationalise the principles of GIPA in the education sector *(cognitive)*
» Demonstrate a sensitivity to embracing all partners to the GIPA principles *(affective)*
» Conduct a resource gap analysis for mobilisation of human and financial resources to operationalise the principles of GIPA in the education sector *(cognitive)*

Preparation: *Prepare in advance:*

» 4 sets of flipchart papers with the template of Handout C (one for each of the components of a comprehensive approach) for each of the groups

Prepare the following materials to be used during this activity:

» Activity 6.1—PPT Presentation (included on CD-ROM)
» Handout A: List of potential partners to operationalise the principles of GIPA in the education sector
» Handout B: Identifying partners for collaboration in HIV work
» Handout C: Resource gap analysis
» Blank sheets of paper, pens, pencils, markers, flipchart paper, flipchart

Familiarise yourself in advance with:

» Facilitator Resource A: Partnerships
» Facilitator Resource: Resources and resource mobilisation

Methods: Brainstorm, group work, discussion, planning analysis, group discussions and presentations, writing

Introduction — 5 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. “Tips for facilitators”).

Introduce the session by telling participants that they will spend some time brainstorming partners for the advancement of GIPA in the education sector. They will also be introduced to gap analysis to help with identifying human and financial resource needs. The session will start with a short quiz.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 5 min

Ask participants to offer their own definitions of what a partnership is. Then clarify the meaning of the word ‘partnerships’ in the GIPA context. (Refer to Facilitator Resource A: “Partnerships”.)

Step 3 — 15 min

Ask participants to break into groups of 3 or 4 and brainstorm a list of partners that are currently involved with HIV work in their sectors/organisations. Record the list of partners on flipchart. Distribute Handout A (“List of potential partners to operationalise the principles of GIPA in the education sector”), and ask participants to compare this list to what they just brainstormed.

To assist participants in establishing a better understanding of who are the partners that can collaborate to operationalise the principles of GIPA in the education sector, engage them in a short discussion on ways partners can work together. (Refer to Facilitator Resource A: “Partnerships”.)

Step 4 — 45 min

Distribute Handout B (“Identifying partners for collaboration in HIV work”). Instruct the groups to fill out the form to describe three HIV activities in which they are presently involved, recording name of activity, duration, target audience, present partners, and potential partners. Ask participants to include activities that address some of the components of a comprehensive response to HIV and AIDS in education.

After 15–20 minutes, ask groups to place the handouts on walls of room. Have each group choose a recorder and presenter to report in plenary. Each group will present and discuss findings.

Step 5 — 10 min

In preparing participants for the gap analysis exercise, explain the words 'resource' and 'resource mobilisation.' (Refer to Facilitator Resource B.) Ask participants to give examples of these, and record responses on flipchart.

Explain that the next activity will help participants to assess the current state of resource availability and implementation, as well as to identify areas of need within the education sector.

Step 6 — 1 hour

Distribute Handout C ("Resource gap analysis") to each participant. Then distribute a set of flip-chart papers with the template from Handout C for each of the four components of a comprehensive approach to each group. Instruct the groups to fill out the templates according to the instructions on the first page of the handout.

When finished, ask groups to choose two resource categories, while considering all components, that they feel require the greatest attention due to their calculated priority scores. Have each group choose a recorder and presenter to report on these areas in plenary. Each group will present and discuss findings.

Closure — 20 min

Ask participants to think of important aspects of partnerships that they have learned from the activity and write down at least four. Ask volunteers to share.

Highlight some of the key issues that were routinely selected during the gap analysis activity. Summarise by saying that partner organisations may enter into a written MOU which outlines the roles, responsibilities, and commitments of the partner organisations in working together to advance the common goal of operationalising the GIPA principles in the education sector. This will be the focus of Activity 6.2.

Use the PPT presentation (Activity 6.1—PPT Presentation, included on CD-ROM) to review some of the important concepts for this activity.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

» Record the number participants and their affiliations.

Outcome:

- » Compare responses from the pre- and post-quizzes.
- » Record responses of participants in Step 3.
- » Record responses to Handout C: “Resource gap analysis.”
- » Collect or report response of participants to closure activity (what they have learned).

Quiz answers

1. b

2. a. 1
   b. 4
   c. 3
   d. 2

3. a. True
   b. False
   c. True
   d. True
   e. False

4. d

ACTIVITY 6.1

Quiz questions

1. Which of the following is not an essential resource for ensuring that the planning and implementation of a programme are successful?

   a. Human resources (people involved in the project)
   b. Common ethnic background and language
   c. Financial resources
   d. Goods and services (such as equipment, computers, etc.)
   e. Time
   f. All of the above

2. Order the following ways organisations and their constituents can work together by degree of interaction (1=Lowest degree of interaction; 4=Highest degree of interaction):

   a. ______Networking
   b. ______Collaborating
   c. ______Cooperating
   d. ______Coordinating

3. True or False: Individuals, groups, and organisations can benefit from partnerships by

a.	. . . sharing and creating knowledge.	True	False
b.	. . . taking credit for the work that others accomplish.	True	False
c.	. . . pooling or sharing resources.	True	False
d.	. . . building capacity within each organisation.	True	False
e.	. . . keeping the partnership secret.	True	False

4. Which of the following is one of the primary purposes of a resource gap analysis?

   a. Helps to understand and interpret the goals and objectives that have been previously determined through preliminary assessments
   b. Helps to understand what some of the drawbacks have been when evaluating a programme's effectiveness
   c. Helps to sensitise individuals to HIV and AIDS and why the GIPA principles are important
   d. Helps to identify the areas where service and knowledge are lacking in the sector or organisation in which a programme will be implemented

ACTIVITY 6.1

HANDOUT A: List of potential partners to operationalise the principles of GIPA in the education sector

1. Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC)
2. Caribbean Community (CARICOM)
3. Caribbean Education Sector HIV&AIDS Coordinator Network (EduCan)
4. Caribbean Regional Network of People Living with HIV/AIDS (CRN+)
5. Education Development Center, Inc. (EDC)
6. Inter-Agency Task Team (IATT)
7. Local network of people living with HIV, such as The Bahamas National Network for Positive Living (BNN+) or the Jamaican Network of Sero-positives (JN+)
8. Ministry of Education (MOE)
9. Ministry of Health (MOH)
10. National AIDS Programme (NAP)
11. Pan Caribbean Partnership Against HIV/AIDS (PANCAP)
12. Partnership for Child Development (PCD)
13. United Nations Educational, Scientific and Cultural Organization (UNESCO)
14. United Nations Children's Fund (UNICEF)
15. Joint United Nations Programme on HIV/AIDS (UNAIDS)

ACTIVITY 6.1

HANDOUT B: Identifying partners for collaboration in HIV work

A table is provided on the following page to help you to identify individuals, organisations, and other institutional partners for collaboration in your HIV and AIDS work. Consider activities that address any of the components of a comprehensive approach in the education sector to HIV and AIDS (for a model of a comprehensive approach, see Activity 2.1, Handout A), and write the component in the first column. In the second column, think about some corresponding strategies that might be employed within to adequately address these components.

For these strategies (selected from the second box below, or alternatives that you propose), go into greater detail by describing a specific HIV activity for each component that you are presently involved in. Then, for each activity, add the information for the remaining columns as named: how long is the activity expected to last, what persons are being targeted, who is presently working on the activity, and who else could be working on the activity.

Make multiple copies of this worksheet to capture all the HIV and AIDS activities in which you are currently involved.

Components of a comprehensive approach:

- Workplace policy on HIV and AIDS
- Healthy psychosocial and physical environment
- Skills-based HIV and AIDS education
- HIV and AIDS services, care, and support

Strategies to implement the components:

- Policy, management, and systems
- Quality education
- Content, curriculum, and learning materials
- Educator training and support
- Approaches and illustrative entry points

Component	Strategy and de-scription of activity	Timeframe (start & duration)		Target audience	Present partners*	Potential partners*

*Partners may include:
Gov't: Government
MOE: Ministry of Education
MOH: Ministry of Health
UN: United Nations
CBO: Community-based organisation
FBO: Faith-based organisation
PLHIV: People living with HIV
NGO:Non-governmental organisation
INGO: International non-governmental organisation

ACTIVITY 6.1

HANDOUT C: Resource gap analysis

This worksheet will help facilitate discussion and assessment of available resources and needs for the four components and five strategies that guide efforts to operationalise the GIPA principles.

Components of a comprehensive approach:

» Workplace policy on HIV and AIDS
» Healthy psychosocial and physical environment
» Skills-based HIV and AIDS education
» HIV and AIDS services, care, and support

1. Fill out a separate worksheet for each of these components. For every category of resources (see definitions discussed earlier), brainstorm several indicators for what ideal conditions, situations, personnel levels, etc. would look like.
2. Discuss with your group how you would rank each of these indicators in terms of their importance for achieving effective implementation of the component. Enter the consensus into the column marked “Ranking” according to the following code:

   1 = not at all important   2 = somewhat important   3 = very important

3. Under the “Current status” heading, describe in detail what current availability of resources, or current implementation of resources, could help to realise the indicators established earlier.
4. With your group, assess the degree to which “Current Status” approaches the “Indicators of Effectiveness.” Enter the consensus into the column marked “Rating” according to the following code:

   - 1 = indicator has been achieved, or there are sufficient resources available to do so
   - 2 = progress is being made, but many resources are not available or being used
   - 3 = little or no evidence of the indicator and there are insufficient resources

5. To determine the priority ranking, multiply the “Ranking” numbers by the “Rating” numbers. Use these “Priority” numbers to guide further discussion and prepare for the action planning exercise.

Component of a comprehensive approach:

____

Indicators of effectiveness	Ranking	Current status	Rating	Priority
Human resources				
Financial resources				
Goods and services				
Time				

ACTIVITY 6.1
FACILITATOR RESOURCE A: Partnerships

MOEs and networks of people living with HIV should generate *partnerships* and *formalised agreements* that clearly define joint planning strategies, procedures, and shared roles and responsibilities in programme implementation. Countries may want to consider establishing a GIPA committee that includes a cross-section of stakeholders. Such a committee could stem from an existing structure and would potentially facilitate partnerships. Working with people living with HIV networks, as opposed to only individuals, is an effective strategy for operationalising the principles of GIPA. A group opinion represents the voices of many individuals and thus benefits from strength in numbers when advocating for GIPA policies and practices. Also, groups involved in HIV and AIDS work often include both infected and affected people. When someone from the group speaks out, it does not necessarily mean that he or she is HIV-positive, which alleviates some of the pressures of stigma and discrimination.

Why collaborate?

Collaborative efforts offer many benefits to individuals, their organisations, and what they ultimately produce, including:

- Better use of scarce resources
- Ability to create something that could not have been created in isolation
- Higher quality outcomes and results, better able to provide integrated services to those in need
- Potential for organisational and individual learning

In a successful collaboration, each organisation contributes resources that other partners may lack. Examples of resource types include knowledge, staffing, physical property, access to people, money, and skills. Each organisation can focus on and contribute from its areas of strength, while avoiding unnecessary overlap of activities. The most important benefit to collaboration, however, is its potential to help organisations better achieve their goals and objectives, with higher quality and more efficiency.

What are some of the ways in which partners work together?

There are four main ways organisations and their constituents can work together:

1. **NETWORKING:** exchanging information for mutual benefit. Networking is the least formal of the inter-organisational linkages and often reflects an initial level of trust, limited time availability, and a reluctance to share turf.

2. **COORDINATING:** exchanging information and altering activities for mutual benefit and to achieve a common purpose. Coordinating requires more organisational involvement than networking; it is a very crucial change strategy. Compared to networking, coordinating involves more time, higher levels of trust, yet little or no access to each other's turf.
3. **COOPERATING:** exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose. Cooperating requires greater organisational commitments than networking or coordinating and may, in some cases, involve written (perhaps, even legal) agreements. Cooperating can require a substantial amount of time, high levels of trust, and significant access to each other's turf.
4. **COLLABORATING:** exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose. The qualitative difference between collaborating and cooperating in this definition is the willingness of organisations (or individuals) to enhance each other's capacity for mutual benefit and a common purpose. In this definition, collaborating is a relationship in which each organisation wants to help its partners become the best that they can be at what they do.

Who are our partners for the advancement of GIPA in the education sector?

Partnerships should be embraced and allies sought to successfully operationalise the principles of GIPA. Operationalising the principles of GIPA should be understood to be a mutually beneficial process, and people living with HIV should be treated as *equal partners* in HIV and AIDS efforts.

Both the education sector and networks of people living with HIV should recognise that they can learn from each other. The knowledge, experiences, and cultures of people living with HIV should be valued and respected; their first-hand knowledge of HIV and of the social conditions surrounding the topic will bring expertise to the work.

Therefore, their involvement must be incorporated into the progression of GIPA activities, both at the outset and throughout. The education sector should also be aware that, over time, networks of people living with HIV will assume increasing responsibility of GIPA activities and funds, and the education sector should not resist this power shift. Both parties should work to understand their fears and prejudices.

Principles and practices for effective working relationships

The following list provides principles and practice guidelines to ensure effective and long-lasting working relationships:

- » Individuals who become involved should be properly matched to positions or tasks based on their skills, interests, and abilities. A self-assessment of interests and abilities can help to facilitate a good match.
- » Do not over-generalise the points of view of a few to all people living with HIV. One cannot assume that those who have disclosed their HIV-positive status represent the diversity that exists among networks of people living with HIV.
- » Use appropriate language. In a workshop in which some participants have disclosed their HIV status, it is appropriate to ask how they would like to be addressed (e.g., people living with HIV, PLHIV, people living with HIV/AIDS).
- » Partnerships will be improved by the presence of education sector ***guidelines*** on recruitment and training, remuneration, job descriptions, and performance reviews for people living with HIV. Establishing practices and procedures will foster more consistent and equitable involvement of people living with HIV.

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ACTIVITY 6.1

FACILITATOR RESOURCE B: Resources and resource mobilisation

What are resources and resource partners?

Invariably the term 'resources' is understood to mean only funds, especially within the context of resource mobilisation. It is therefore useful to define 'resources' and 'resource partners'.

Resources

Resources include money, people, goods, and services. Within the context of programme planning and implementation, resources can be grouped within the following categories (UNAIDS, 2000):

» **Human resources:** refer to the people required to design, implement, monitor, and evaluate programmes. They will require a range of appropriate skills and know-how to carry out specific tasks within assigned roles and responsibilities. Their services could be paid or voluntary on a full-time or part-time basis. Alternatively, persons can be seconded from government bodies or international agencies

» **Financial resources:** refer to money, which may come from a wide variety of sources such as government (including World Bank Credit Budget), grants from International Development Agencies (IDAs), NGO budgets, and the private sector.

» **Goods and services:** includes equipment, computers, office space, technical support, vehicles, training services, training materials, meeting places, and event venues. All of these maybe provided at a reduced cost or in-kind.

» **Time:** is an important resource, which is often overlooked, but is very important to various aspects of HIV work.

Resource partners

Resource partners include non-governmental organisations, international development agencies, institutions in the United Nations system, donors from the private sector, and communities. They all play a vital role and make significant contributions to successful national responses.[31]

What is resource mobilisation?

Resource mobilisation is a comprehensive process that involves strategic planning for programme funding, communication and effective negotiation with donors, sound management of resources, improving image and credibility of the organisation, and ensuring good coordination among all partners.

What is the purpose of resource mobilisation?

- How can an organisation raise the human or financial resources needed to carry out its mission?
- Where are the required resources?
- How do you sustain your organisation and work?

These key questions confront organisations when they consider how to maintain their work and strengthen organisational sustainability.

Developing needs assessment/resource gap analysis and action plan can lead to creative efforts to gain support for organisational sustainability. Needs assessments can help organisations consider alternative and efficient resources for proposed project implementation. In the process one may rediscover innovative solutions by mapping traditional technologies and practices. For example, being aware of community members' skills, one might be able to use a local resident or a person living with or affected by HIV to deliver services or training, rather than hiring an external consultant. Additionally, knowing one another's assets could also help to build relationships among local residents, people living with or affected by HIV, associations, and institutions

While mobilising additional resources is important, maximising existing resource is equally important. In so doing, the following questions are asked:

- Is the current response still relevant?
- Are current responses effective and cost-effective?
- Are there opportunities for reallocation and/or reprogramming of resources?
- Where are the priorities now?

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ACTIVITY 6.2

Resource mobilisation: organising an action plan and composing an MOU to operationalise the GIPA principles in the education sector

Goal: To move from identifying partners and the available resources and needs to developing an operational action plan and formalising GIPA in the education sector

Target audience: Education sector, other line ministries involved with HIV work, networks of people living with HIV, National AIDS Committee

Time: 2 hours

Objectives: *At the end of the session, participants will be able to:*

- Explain how to develop an action plan ***(cognitive)***
- Demonstrate appreciation for utilising information gathered through a gap analysis to inform the action plan to operationalise the GIPA principles in the education sector ***(affective)***
- Develop an action plan to use in their sector/organisation for operationalising the GIPA principles ***(behavioural)***
- Formalise partnerships through the composition of an MOU ***(behavioural)***

Preparation: *Prepare the following materials to be used during this activity:*

- Activity 6.2—PPT Presentation (included on CD-ROM)
- Handout A: Steps for determining involvement of people living with HIV
- Handout B: Action plan: operationalising the principles of GIPA in the education sector
- Handout C: Template for Memorandum of Understanding
- Blank sheets of paper, pens, pencils, markers, flipchart paper, flipchart, index cards

Familiarise yourself in advance with:

- Completed handouts from previous exercises (Activity 6.1)

Methods: Brainstorm, group work, planning analysis, group discussions and presentations, individual writing

Introduction — 5 min

Introduce yourself as facilitator, ask participants to briefly introduce themselves, review the objectives of the session, and state ground rules (see Appendix 1. “Tips for facilitators”).

Explain to participants that in this session they will participate in three activities that will help them apply the resource gap analysis findings to the development of an action plan to operationalise GIPA principles. As time permits, each participant will have the opportunity to expand and deepen his/her own action plan for his/her sector/organisation. The session starts with a short quiz.

Step 1 — 5 min

Distribute the Activity Quiz to participants, and ask them to fill it out individually. Collect responses.

Step 2 — 10 min

Distribute blank sheets of paper and ask participants to write down the answers to the following questions:

- What do you know about action planning?
- Have you ever been engaged in an action-planning activity?

Give each person 1 minute to write the response. Go around the room and ask participants to share at random.

Step 3 — 15 min

Use the PPT presentation (Activity 6.2—PPT Presentation, included on CD-ROM) to give a 5–10 minute overview on action planning. After the presentation, allow time for questions and answers.

Step 4 — 30 min

Distribute Handout A (“Steps for determining involvement of people living with HIV”) and ask participants to break up into groups of 3 or 4 (for example, groups of potential partners). Instruct participants to read the instructions quietly, and state that this will serve as an introduction to action planning.

Once they have finished reading, ask groups to fill out the handout. After 10 minutes, ask groups to report, and discuss.

Step 5 — 45 min

Distribute Handout B (“Action plan: operationalising the principles of GIPA in the education sector”). Instruct the participants to use the data gathered in Handouts A and B from the previous activity as well as Handout A in this activity for filling out in greater detail Handout B.

After participants have spent some time in groups filling out the action plan in Handout B, ask some volunteers to share. Explain that by using these materials and those from the previous activity (Activity 6.1: "Building partnerships: identifying partners and conducting a resource gap analysis") they should be able to convene a working group at their organisation to develop a specific GIPA action plan for resource mobilisation.

Step 6 — 15 min

Upon completion of the task, say, "Having looked at the potential partners and identified their roles of involvement, it might be necessary to have an agreement between the parties that are involved. This is called a *Memorandum of Understanding*." (Refer to definition in the introduction to this section.)

Emphasise once more the importance of the Memorandum of Understanding. It formalises the current arrangement in terms of which partner organisations with expertise in the field of HIV and human rights render assistance to other partners in the form of training, materials development, and distribution. Through this partnership the wealth of experience and expertise of the partner organisation can be harvested to more effectively promote a human-rights-based response for operationalising the GIPA principles in the education sector.

Distribute Handout C ("Template for Memorandum of Understanding"), and ask participants to use the information from the tables they filled out in Handouts A and B to give an example of how partnerships can be formalised for operationalising the GIPA principles in the education sector. Reconvene the whole group to share and discuss their ideas.

Closure — 10 min

Give a brief wrap-up of the session, saying, "Today you have focused on developing an action plan based on a resource gap analysis and other assessments. The strategies you have just learned will help you to assist your organisation in becoming GIPA-ready. I challenge you to follow through on the immediate next steps of having your organisation assess its GIPA status and develop a GIPA action plan."

Ask participants to commit to two or three next steps that they will follow, and have them write these down on an index card.

If desired, distribute another copy of the Activity Quiz, and collect it once completed.

Monitoring and evaluation

Process:

» Record the number participants and their affiliations.

Outcome:

- Compare responses from the pre- and post-quizzes.
- Record responses of participants in Step 4 (Steps for developing GIPA action plan).
- Record responses of participants in Step 5 (Action plan: operationalising the principles of GIPA in the education sector).
- Collect or report response of participants to closure activity (commitment to next steps).

Quiz answers

1. a

2. d, e, f

3. a, c, e, f

4. a. False
   b. True
   c. True
   d. True

ACTIVITY 6.2

Quiz questions

1. Which of the following defines Memorandum of Understanding?

   a. An agreement between two parties in the form of a legal document; it is not fully binding in the way that a contract is, but it is stronger and more formal than a traditional agreement
   b. A verbal communication, such as a speech or other announcement, that is an attempt to create unity among a diverse set of constituents
   c. Guidance that is uncomplicated and easy to interpret

2. Which of the following are necessary steps in developing an action plan? (Circle your selections.)

   a. Delaying compensation for staff to ensure sustainability
   b. Creating a budget for each planned activity
   c. Translating the document into English, Spanish, and French
   d. Developing a time frame outlining roles and responsibilities
   e. Developing goals and objectives that are achievable
   f. Describing the expected outcomes

3. Which of the following is a characteristic of a good action plan?

   a. Focuses on a significant problem/concern
   b. Prioritises problems that seem unfeasible
   c. Considers causes, factors, and solutions
   d. Involves waiting for others to solve problems
   e. Indicates potential partnerships
   f. Considers available interventions and strategies

4. True or False: Action planning is…

   a. . . . a process that should be kept private and only discussed with individuals/organisations selectively. True False
   b. . . . usually the process that takes place after the needs assessment/resource gap analysis is conducted. True False
   c. . . . a powerful tool for goal-based achievement. True False
   d. . . . deciding the “who, what, and when” for an organisation to reach its overall goals and objectives. True False

ACTIVITY 6.2

HANDOUT A: Steps for determining involvement of people living with HIV

The involvement of people living with HIV is both an individual and organisational process. Research indicates that many people living with HIV tend to move along a continuum from access to inclusion to participation to involvement.

Having identified some of the resource gaps, you should do the following:

1. Assess the organisation's GIPA status. Consider the following questions:
    - Are you satisfied with the involvement of people living with HIV and infected communities in your organisation? If not, what is the problem? Remember that 'more' in numbers does not necessarily mean 'more' in terms of quality of involvement.
    - Do you think there is the opportunity to improve the meaningful participation of people living with HIV? How would you start to involve people living with HIV—in what roles in the organisations would they be most valuable?
2. List and prioritise the actions that the organisation intends to take related to the components of a comprehensive approach to addressing HIV and AIDS in the education sector.
3. Use information from the table to form the basis for developing goals and objectives
4. Circulate the draft plan to all staff and volunteers for comments before finalisation and adoption.
5. Display the plan in a prominent place in the organisation.
6. Send a copy to partner organisations and donors.
7. As with all plans, review it regularly.

Components of a comprehensive approach:

- Workplace policy on HIV and AIDS
- Healthy psychosocial and physical environment
- Skills-based HIV and AIDS education
- HIV and AIDS services, care, and support

Strategies to implement the components:

- Policy, management, and systems
- Quality education
- Content, curriculum, and learning materials
- Educator training and support
- Approaches and illustrative entry points

• Chong, S. & Gray, G. (2005). *"Valued voices" GIPA toolkit: A manual for the Greater Involvement of People Living With HIV/AIDS.* Bangkok: Asia Pacific Network of People Living With HIV/AIDS (APN+) & Asia Pacific Council of AIDS Service Organisations (APCASO).

Component	Challenge	Action	Priority	Timeframe
Examples: *Services*	No VCT services offered	Provide access to VCT	Medium	6 months
Education	No PLHIV involved in teaching about HIV and AIDS	Engage PLHIV to teach about HIV-related stigma and discrimination	High	3 months

ACTIVITY 6.2

HANDOUT B: Action plan: operationalising the principles of GIPA in the education sector

The previous handouts asked you to fill in information on the potential partners that could operationalise the principles of GIPA in the education sector (Activity 6.1, Handout A) and to identify gaps in resources (Activity 6.1, Handout C), as well as to identify areas for the involvement of people living with HIV (Activity 6.2, Handout A). Now use this form to extend your action plan to incorporate GIPA at a greater level, based on the information you have gathered.

On this form, record one of your actions for achieving GIPA and one activity that you have selected to meet this goal. Identify the steps needed to achieve each objective, the timeframe, target audience, partners or person(s) responsible, resources required, and indicators for monitoring and evaluation. Make additional copies of this page to create an action plan for additional activities.

Action:

Objective:

Activity to be implemented	Timeframe	Target Audience	Partners/ person(s) responsible	Resources required	Indicators for monitoring and evaluation

Sample

Action:

Objective:

Activity to be implemented	Timeframe	Target Audience	Partners/ person(s) responsible	Resources required	Indicators for monitoring and evaluation
Voluntary counselling and testing	6 months (January to June 20xx)	MOE staff and family	MOH, Network Counselling Services, PLHIV networks	MOH: provide testing kits and human resources to do blood work; follow up treatment and care for HIV-positive people Network Counselling Services: provide counselling to MOE HIV-positive staff and family members MOE: promote VCT; provide private space to offer confidential VCT; develop HIV workplace policy PLHIV networks: provide prevention education, counselling	The # and % of partners who worked together over a 3-month period to support VCT of MOE staff and family members The # and % of PLHIV providing a service to MOE staff and family members The # and % of referrals made to Network Counselling Services

ACTIVITY 6.2

HANDOUT C: Template for Memorandum of Understanding

Memorandum of Understanding

Between *[your organisation's name]* and *[partnering organisation's name]*

For Application to *[specific programme, if necessary]*

This Memorandum of Understanding (MOU) establishes a *[type of partnership]* between *[Your Organisation's Name]* and *[Partnering Organisation's Name]*.

I. MISSION

[Brief description of your organisation's mission. Brief description of partnering organisation's mission. You might want to also include a sentence about the specific programme if applicable.]

Together, the Parties enter into this Memorandum of Understanding to mutually promote *[Describe efforts that this partnership will promote (e.g., health care or workforce development)].* Accordingly, *[Your Organisation's Name]* and *[Partnering Organisation's Name]*, operating under this MOU agree as follows:

II. PURPOSE AND SCOPE

[Describe the intended results or effects that the organisations hope to achieve, and the area that the specific activities will cover]

1. *Why are the organisations forming a collaboration? Benefits for each organisation?*
2. *Who is the target population?*
3. *How does the target population benefit?*

Include issues of funding if necessary (e.g., each organisation of this MOU is responsible for its own expenses related to this MOU, there will / will not be an exchange of funds between the parties for tasks associated with this MOU)

III. RESPONSIBILITIES

Each party will appoint a person to serve as the official contact and coordinate the activities of its own organisation in carrying out this MOU. The initial appointees of each organisation are: *[List contact persons with address and telephone information]*

The organisations agree to the following tasks for this MOU:

[Your Organisation's Name] will:

» *[List tasks of your organisation as bullet points]*

[Partnering Organisation's Name] will:

» *[List tasks of partner organisation as bullet points]*

[Your Organisation's Name] and *[Partnering Organisation's Name]* will:

» *[List shared tasks as bullet points]*

IV. TERMS OF UNDERSTANDING

The term of this MOU is for a period of ***[Insert length of MOU (e.g., 1 to 3 years)]*** from the effective date of this agreement and may be extended upon written mutual agreement. It shall be reviewed at least ***[Insert how often (e.g., 1 to 3 years)]*** to ensure that it is fulfilling its purpose and to make any necessary revisions. Either organisation may terminate this MOU upon thirty (30) days' written notice without penalties or liabilities.

AUTHORISATION

The signing of this MOU is not a formal undertaking. It implies that the signatories will strive to reach, to the best of their ability, the objectives stated in the MOU. On behalf of the organisation I represent, I wish to sign this MOU and contribute to its further development.

[Your Organisation completes below]

Name ______________________________ Date ________________________
Title ____
Organisation ____

[Partnering Organisation completes below]

Name ______________________________ Date ________________________
Title ____
Organisation ____

• Neighborhood Networks. (2002). *Sample memorandum of understanding*. Washington, DC: U.S. Department of Housing and Urban Development. Available from http://www.hud.gov/offices/hsg/mfh/nnw/partnerships/partnershipsresources/nnwpartnermou.pdf

MONITORING AND EVALUATION

Monitoring and evaluation are important in order to determine how well the activities are being conducted (monitoring or process evaluation) and whether they achieve the GIPA principles in a comprehensive approach of the education sector to HIV and AIDS (outcome evaluation).

Process and outcome evaluation measures are provided at the end of each activity in this toolkit. These are intended to be used near the time that the activity is conducted, to evaluate short-term outcomes. The outcome evaluation methods and questions described in this section are to be considered in the longer term as part of a broader evaluation of the implementation of a comprehensive approach to HIV and AIDS in the education sector that purposely involves people living with HIV.

Monitoring (process evaluation)

Monitoring, or process evaluation, keeps track of what has been done, by measuring the outputs of the activities. This type of evaluation is concerned with the process rather than the change itself. Observations, interviews, and review of records are effective methods for process evaluation. Process evaluation may include recording of:

» The number of activities (e.g., workshops) conducted
» The number of participants in each activity or coverage (proportion of the targeted group), which can be recorded by age, gender, professional affiliation (e.g., MOE, MOH, people living with HIV, principal, teacher, student), location, and other characteristics
» Whether participants understood the key message, which can be ascertained through short questions at the end of the sessions.

Process evaluation is helpful in monitoring whether and to what extent activities are reaching the intended audience. Furthermore, it can be used to inform and modify programmes and activities, especially if it is found that activities did not reach the audience or convey the intended message.

This type of information may be collected during and/or immediately after each activity, by the person(s) responsible for conducting the activity. Ideally, the collected data should be entered into a central data collection system, which may include an Excel spreadsheet.

Outcome evaluation

Outcome evaluation measures the actual changes, or outcomes, that have taken place toward achieving the objectives that this toolkit seeks to accomplish. Surveys before and after the intervention, gathering numeric (quantitative) data, and interviews with participants, gathering stories of changes in persons or organisations (qualitative data), might be used as part of a mixed-methods approach. Surveys should be conducted before the activities are implemented, and may be re-

peated annually. If indicators have been measured over a period of time (e.g., years), percentages of changes can be calculated. Interviews can reveal stories of how individuals have changed their attitudes and behaviour.

The overall outcome measures may include:

- Number or percentage or stories of people living with HIV who are involved in decision-making positions in the education sector.

The information should be broken down according to age and sex or interest group (e.g., women, young people, and marginalised populations). It would also be useful, where possible, to record the level of participation and authority of these individuals at different levels of the decision-making process.[6]

This type of information is helpful in order to show whether the activities are effective, to provide data that can support policy development, to contribute to the knowledge base (e.g., through publication of the data), and to re-apply for funding to sustain effective programmes.

If resources are available, we recommend utilising an evaluator who can design and conduct a rigorous outcome evaluation, using a controlled design (such as pre/post design, or quasi-experimental design). If no evaluator is available, it is important to establish an evaluation plan, with timelines, so as to keep track of the evaluation effort and to ensure data collection will be done in a timely manner. Pre-intervention data should be collected before any of the activities have been conducted. Post-intervention data should be collected from the same pool of people who participated in the pre-intervention data collection and participated in the activity.

Ensure the best possible quality of outcome evaluation by using mixed methods, consisting of both quantitative and qualitative data:

- Surveys (useful for quantitative data collection): if possible, use pre-tested survey questionnaires and statistical data analysis software, such as SAS or SPSS.
- Interviews (useful for qualitative data collection): use interview protocols with a script (e.g., why is the interview being conducted, for what purpose, how long will it take, how is confidentiality assured) and include open-ended questions (e.g., questions that require more than a one word response). Analyze by looking for patterns and commonalities, if possible, with qualitative data analysis software such as Atlas.ti or NVivo.

Other potential tools to supplement these standard methods of outcome evaluation include:

- Case studies of how people living with HIV and MOE staff have been involved in joint activities, as an example of good practice and to contribute to reducing stigma and discrimination

- Reports of programmes being implemented, with what impacts and outcomes, driven by people living with HIV
- Stories of activities that children and staff have conducted to reduce stigma and discrimination, based on interaction with people living with HIV
- Numbers/rates and examples of people living with HIV involved in the education sector at various levels of authority (define specific activities and skills, levels of participation and authority), which may involve those who have already worked in the education sector and have newly disclosed and/or members of networks of people living with HIV who have become newly involved in the education sector

Monitoring and evaluation matrix worksheets

A series of worksheets are provided on the following pages that address each of the six objectives outlined in the *Goal and objectives of the toolkit* section. Sample process and outcome measures are provided for each objective and related activities. For each activity that you conduct, select from these sample measures or provide your own.

Next, determine the mechanisms needed to assess these indicators. For process indicators, these might include: number and type of activities (including location and duration), number of participants (recorded by gender and professional affiliation), and answers to short questions at the end of sections (and how these will be analyzed). Various mechanisms for measuring outcome indicators (such as surveys and interviews) have already been discussed above. A good practice that will support the monitoring and evaluation effort is to develop a data collection system using Microsoft Excel or other software.

After the indicators and mechanisms for measuring them have been chosen, establish clear timeframes. During process evaluation, the timeframe will usually be during and/or immediately after each activity. For outcome evaluation, depending on the information of interest, the evaluation efforts may be undertaken 6 months or more following the toolkit implementation.

Last, identify the individuals who will be responsible for conducting the monitoring and evaluation components. For process evaluation, these people may be facilitators or others involved in administering the toolkit activities. For outcome evaluation, however, recruiting an evaluator would be ideal. With the support of a professional evaluator, survey and interview questions may be prepared and piloted well in advance and monitoring and evaluation efforts will be much more rigorous and informative.

Following these worksheets is a list of suggested sources from which additional survey questions, measures, and indicators may be taken. Many of the sample outcome measures provided in the worksheets come from these sources and are referenced.

Activities	Measures		Mechanism	Timeframe	Person responsible
Objective 1: Deepen appreciation and awareness of HIV and AIDS and the GIPA principles					
Activity 1.1 Sensitisation session: What are HIV and AIDS? *Activity 1.2* Sensitisation session: What is GIPA?	**Process**	*Sample process measures:* » # of participants and their affiliations » Responses to “Closure” questions in Activities 1.1 and 1.2			

	Outcome	*Sample outcome measures*[5, 8]*:*
		» Explanation of the relationship between HIV and AIDS
		» # of participants who say that people can protect themselves from contracting HIV by abstaining from sex, using condoms, or having sex only with one faithful, uninfected partner
		» # of respondents who correctly reject the two most common local misconceptions about HIV transmission or prevention
		» # of respondents who know that a healthy-looking person can have HIV
		» # of respondents who report that they feel it is important to:
		  » Ask people living with HIV how services could be better tailored to meet their needs
		  » Involve people living with HIV in policy development and planning			

Activities	Measures		Mechanism	Timeframe	Person responsible
Objective 2: Increase awareness of incorporating GIPA principles in a comprehensive education sector response					
Activity 2.1 Sensitisation session: What is a comprehensive approach to HIV and AIDS in the education sector? *Activity 2.2* Ways to incorporate GIPA in a comprehensive response to HIV and AIDS in the education sector	**Process**	*Sample process measures:* » # of participants and their affiliations » Responses to questions about comprehensive approach » # of pledge cards gathered » Responses regarding the benefits of incorporating the GIPA principles » # of completed action plans			
	Outcome	*Sample outcome measures[1]:* » Explanation of the relationship between the four components and five strategies of a comprehensive approach » Ideas and suggestions offered regarding ways to achieve the GIPA principles in the education sector » Possible NGO and civil society processes and activities that are identified to potentially assist in this effort » Existence of barriers that limit the ability of people living with HIV to participate in government processes that are designed to assist them in particular			

Activities	Measures		Mechanism	Timeframe	Person responsible
Objective 3: Build capacity of the education sector, people living with HIV, and other partners to apply the GIPA principles in a comprehensive approach to HIV and AIDS in the education sector					
Activity 3.1 Training workshop: advocacy for GIPA	**Process**	*Sample process measures:* » # of participants and their affiliations » Responses to “Closure” questions in Activity 3 » # of completed handouts collected			
	Outcome	*Sample outcome measures[6]:* » Reported knowledge of the goals and objectives of a campaign » Examples and mechanisms provided by participants regarding the ways in which change might occur (e.g., change in ordinance, change in policy, funding for policy, enforcement of existing policy) » # and type of partners identified who will collaborate to achieve the outcomes chosen in this activity » Descriptions about how to develop an effective advocacy message, including references to the major steps of the advocacy wheel » Sample advocacy messages provided by participants in relation to implementing the GIPA principles			

Activities	Measures		Mechanism	Timeframe	Person responsible
Objective 4: Reduce HIV and AIDS-related stigma and discrimination					
Activity 4.1 Sensitisation session: stigma and discrimination *Activity 4.2* Workshop: voluntary disclosure versus exposure	**Process**	*Sample process measures:* » # of participants and their affiliations » # of completed write-ups collected at end of activities » Responses recorded during discussion sections			
	Outcome	*Sample outcome measures[1, 3, 5]:* » Respondents who report a supportive attitude toward, and willingness to: » Care for an HIV-positive family member who becomes sick » Buy fresh vegetables from a vendor whom they know to be HIV-positive » Allow a female teacher who is HIV-positive to continue teaching in school » Keep the HIV-positive status of a family member a secret » Reported changes or trends (and in what direction) in attitudes and behaviours directed toward people living with HIV, over a certain time period » Reported changes or trends (and in what direction) in stigma and discrimination directed toward people living with HIV, over a certain time period			

Activities	Measures		Mechanism	Timeframe	Person responsible
Objective 5: Create supportive and enabling environments that facilitate the collaboration of people living with HIV at all levels of the education sector					
Activity 5.1 Sensitisation workshop addressing confidentiality and a supportive and enabling environment	**Process**	*Sample process measures:* » # of participants and their represented groupings » Responses recorded for case studies » Responses recorded for role plays » Responses recorded in the checklist » # of index cards with commitments collected			
	Outcome	*Sample outcome measures* [1, 5, 8]*:* » Reasons stated for why people living with HIV should or should not be allowed to disclose or keep their status private » # of participants who believe that people living with HIV should be allowed to continue to work in the education sector » # of participants who believe that people living with HIV would feel comfortable talking about their status or experiences in their workplace » Reported actions against people living with HIV that violate their right of personal liberty and security » Reported cases where people living with HIV experienced discrimination in the workplace			

Activities	Measures		Mechanism	Timeframe	Person responsible
Objective 6: Identify and strengthen structures that help operationalise the GIPA principles in a comprehensive response					
Activity 6.1 Building partnerships: identifying partners and conducting a resource gap analysis *Activity 6.2* Resource mobilisation: organising an action plan and composing an MOU to operationalise the GIPA principles in the education sector	**Process**	*Sample process measures:* » # of participants, and their affiliations » Lists of potential partners » # of completed resource gap analyses collected » Responses recorded for the "Steps" exercise in Activity 6.1 » # of completed action plans collected » # of cards with commitments collected			
	Outcome	*Sample outcome measures* [9, 11]*:* » # of partnerships formalised and roles of each partner defined to implement GIPA in the education sector » Involvement of multiple government agencies/ministries in HIV and AIDS response » Roles specified for MOE, MOH, and other agencies in HIV and AIDS response » # of people involved in action planning based on needs assessment » # of MOE sector mobilisation strategies defined and implemented			

Suggested sources for developing additional survey questions, measures, and indicators

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Appendix 1. Tips for Facilitators

General tips for facilitators

» The key to successfully completing these activities is thorough preparation. Proper planning must be done ahead of time for the effective facilitation of the exercises. This includes preparing copies of handouts, flipcharts with markers, index cards, sign-in sheets, name-tags, etc.

» Select a facility or place that comfortably accommodates the number of participants. It should have adequate space (to conduct the exercises), available parking, and restrooms. Make sure that there is easy access for persons with disabilities. Ensure that snacks or meals are available for the participants at the end of the exercises.

» We recommend that activities be co-facilitated. Facilitators should be quite knowledgeable about HIV and AIDS as a topic and about the participants in the workshop; they should be prepared to answer questions from the participants.

» In addition, facilitators should carefully reflect on the community attitude toward people living with HIV and other marginalised groups; they should be clear about their own attitudes and values, possess adequate training skills, and be comfortable with conducting group exercises and building synergy in making groups a safe place.

» The number of participants should not exceed 25 people.

» Begin each activity with a short introduction of your name, your organisation, and your work in HIV and AIDS. Ask each participant to offer the same information. This will assist in "breaking the ice."

» Identify some ground rules and ask participants to add more if necessary, for example:

- Turn off cell phones
- Respect each other's opinions
- Work as a team
- Listen to each other
- Keep personal information confidential, and do not share with others outside of this training

» Facilitators may wish to let the wide cross-section of participants know that the group will share ideas and learn from each other and that no one's suggestions are incorrect. The stress should be on working collaboratively, as groups will be mixed for activities. It would be useful to remind participants that this is exactly what GIPA is about, pooling ideas together.

» Create an atmosphere in which participants will feel they are being heard, cared for, and respected, with constructive and effective feedback; this includes clarifying any misunderstandings, correcting false information, and discouraging prejudiced information.

» The introduction to a topic must be made by taking the ideas of the participants rather than by telling them all that you know.

- » Give simple instructions:
    - If these are oral, speak slowly and clearly.
    - If the instructions are written, read through them. Ensure that the content is suitably matched to the literacy capability of the participants.
- » Presentations should be in orderly fashion, with no interruptions.
- » Give sufficient time for completing the task. Check to make sure that groups are on task, understand the instructions, and are conscious of the time.
- » Facilitate group work by walking through the room, answering any questions that the groups have, and making sure they are on task.
- » Always give feedback on reports. Begin with constructive comments, and then share any corrections.

Additional tips for facilitating the processing of activities that include role plays

EXPERIENTIAL LEARNING CYCLE

Trainers can use the experiential learning cycle to help participants process their training experience and become able to apply what they have learned in training to "real-life" situations. The stages of the experiential learning cycle are:

Experiencing: to generate individual data from one or more of the sensing, thinking, feeling, wanting, or doing modes. The experiencing stage refers to the training activity itself.

Sharing: to report the data generated from the experience.

Interpreting: to make sense of the data generated for both individuals and the group.

Generalizing: to develop testable hypotheses and abstractions from the data.

Applying: to bridge the present and the future by understanding and/or planning how these generalisations can be tested in a new place.

Source: The Experiential Learning Cycle (University Associates, 1979)

The following sample questions, when combined with the facilitator's summarising and reflecting, aid the group in moving either more deeply into the stage at hand or on to another stage.

It is obvious that many of these questions focus on and will elicit similar responses; (i.e., they overlap in content and meaning). However, for the skilled facilitator, variations on the same theme offer more than one road to arrive at the same place.

NOTE: The experiencing phase is the activity itself, and needs to be set up appropriately, with instructions and other information, but is not included in the "questioning."

SHARING

In stage two, *the sharing phase*, participants have completed the experience. Questions are directed toward generating data.

- » Who would volunteer to share? Who else?
- » What went on/happened?
- » How did you feel about that?
- » Who else had the same experience?
- » Who reacted differently?
- » Were there any surprises/confusing issues?
- » How many felt the same?
- » How many felt differently?
- » What did you observe?
- » What were you aware of?

INTERPRETING

In stage three, *the interpreting phase*, participants have acquired data. Questions are directed toward making sense of that data for the individual and the group.

- » How did you account for that?
- » What does that mean to you?
- » How was that significant?
- » How was that good/bad?
- » What struck you about that?
- » How do those fit together?
- » How might it have been different?
- » Do you see something operating there?
- » What does that suggest to you about yourself/your group?
- » What do you understand better about yourself/your group?

GENERALISING

In stage four, *the generalising phase*, participants work toward abstracting from the specific knowledge they have gained about themselves and their group to super-ordinate principles. Questions are directed toward promoting generalisations.

- » What might we draw/pull from that?
- » Is that plugging in to anything?
- » What did you learn/relearn?
- » What does that suggest to you about—in general?
- » Does that remind you of anything?
- » What principle/law do you see operating?

- Does that remind you of anything? What does that help explain?
- How does this relate to other experiences?
- What do you associate with that?
- So what?

APPLYING

In stage five, *the* ***applying phase***, participants are concerned with utilising learning in their real world situation. Questions are directed toward applying the general knowledge they have gained to their personal and/or professional lives.

- How could you apply/transfer that?
- What would you like to do with that?
- How could you repeat this again?
- What could you do to hold on to that?
- What are the options?
- What might you do to help/hinder yourself'?
- How could you make it better?
- What would be the consequences of doing/not doing that?
- What modifications can you make work for you?
- What could you imagine/fantasise about that?

Processing the Entire Experience

A final stage can be added here, that of ***processing*** the entire experience as a learning experience. Questions are aimed at soliciting feedback.

- How was this for you?
- What were the pluses/minuses?
- How might it have been more meaningful?
- What's the good/bad news?
- What changes would you make?
- What would you continue?
- Any suggestions?
- If you had it to do over again, what would you do?
- What additions/deletions would help?

Adapted from: Gaw, B. A. (1979) Processing questions: An aid to completing the learning cycle. In Jones, J. E. & Pfeiffer, J. W. (Eds.) *The 1979 annual handbook for group facilitators*. La Jolla, California, University Associates.

Appendix 2. Glossary

Below are definitions of many words and concepts presented in this toolkit. The page number that follows each of the terms in the first column refers to the first time that the term is mentioned in the text, where it also appears in bold.

Access to services (6)	The ability of an individual or a population to obtain and make use of needed resources or services (such as health care). This may be impacted by physical availability and by financial and organisational factors, as well as by social or cultural barriers. *(For more on this topic, please refer to Activity 1.1, Handout B)*
Action plan (13)	The organisation of activities and strategies into an outline that includes duration, target audience, and monitoring and evaluation, for the purpose of achieving a clear set of objectives or goals. *(For more on this topic, please refer to Activity 6.2 – PPT Presentation, as well as Activity 2.2, Handout D)*
Advocacy (8)	The work of trying to bring about certain political, economic, or social outcomes that directly impact people's lives, by identifying a cause, creating a message, and putting strategies into action. *(For more on this topic, please refer to Activity 3.1)*
AIDS (27)	(Acquired Immunodeficiency Syndrome) The condition in which a body's immune system has been significantly weakened by HIV and is vulnerable to life-threatening conditions, such as infections and cancers. *(For more on this topic, please refer to Activity 1.1)*
Antiretroviral (27)	A medication that interferes with the ability of a retrovirus, such as HIV, to make more copies of itself. *(For more on this topic, please refer to Activity 1.1)*
Capacity (8)	The ability of an organisation, or group of individuals, to achieve their goals and objectives and to ensure that their efforts are sustainable. *(For more on this topic, please refer to Section 3)*
Collaboration (28)	Exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose. *(For more on this topic, please refer to Activity 6.1)*
Community outreach (7)	The work of connecting an organisation's mission, goals, and objectives to the efforts and interests of community members, in an effort to engage them and invite their support and participation.
Complementary (55)	Resources committed to one area may be called to bear on another area. *(For more on this topic, please refer to Section 2)*

Comprehensive approach to HIV in the education sector (6)	Using all means at the education sector's disposal to promote and protect the health of students and staff and to mitigate the impact of HIV and AIDS on the system itself. A comprehensive approach includes: (1) adopting an overarching workplace policy on HIV and AIDS; (2) creating a healthy psychosocial and physical environment, free from stigma, discrimination, gender inequity, sexual harassment, fear of same-sex relationships, and violence; (3) implementing skills-based HIV and AIDS prevention curricula; and (4) enhancing HIV and AIDS-related treatment education, services, care, and support for learners and educators living with HIV. *(For more on this topic, please refer to Section 2)*
Confidentiality (13)	The non-disclosure of any information (often medical) related to a particular individual by a third party that has been permitted to know this information through writing or oral communication. *(For more on this topic, please refer to Activity 5.1)*
Disclosure (9)	Sharing information related to one's HIV status. *(For more on this topic, please refer to Activity 4.2)*
Discrimination (6)	Any form of arbitrary distinction, exclusion, or restriction based on a stigmatised attribute. Discrimination violates individuals' rights. *(For more on this topic, please refer to Activity 4.1)*
Empowerment (8)	The process whereby an organisation or individual improves its own social, political, or economic strength and confidence.
Epidemic (6)	An infection or disease that has spread rapidly through a segment of the human population in a given geographic area.
Exposure (13)	The involuntary disclosure of another's HIV status. While this information may not have been revealed out of malice, disclosing someone's HIV status without his or her permission is a severe breach of confidentiality and should be treated as such. *(For more on this topic, please refer to Activity 4.2)*
Fair employment policies (6)	Laws that protect individuals from employment discrimination based on race, age, sex, religion, or HIV status. They also prohibit an employer from taking retaliatory action against an individual for opposing or complaining about unlawful employment practices. *(For more information, please visit: http://www.equalrightscenter.org)*
Gender differences (8)	Differences between men and women that are the result of biology, social and political status, the availability of opportunities, and even the security of human rights. In cases where gender inequity and inequality are severe, the health and well-being of women require increased attention. *(For more on this topic, please refer to Activities 1.1 and 1.2)*
GIPA principles (5)	(Greater involvement of people living with or affected by HIV and AIDS) A series of principles that promote involving people living with HIV fully in decision-making, formulation, and implementation of programmes and policies. *(For more on this topic, please refer to Activity 1.2)*

HIV (8)	(Human Immunodeficiency Virus) The virus that causes AIDS. Two types have been identified: HIV-1 and HIV-2. HIV-1 is responsible for most HIV infections throughout the world, whereas HIV-2 is found primarily in West Africa. *(For more on this topic, please refer to Activity 1.1)*
Immune system (27)	The parts of the body that fight germs in order to maintain health. *(For more on this topic, please refer to Activity 1.1)*
Intervention (9)	A programme or course of action that seeks to promote or produce a positive behaviour or outcome, or is intended to prevent poor behaviours or outcomes.
Levels of involvement of people living with HIV (10)	Levels of responsibility at which people living with HIV can be involved in HIV and AIDS activities. The goal is to achieve higher levels of involvement. In increasing order of responsibility, the levels of involvement are: target audiences >> contributors >> speakers >> implementers >> experts >> decision-makers. *(For more on this topic, please refer to Activity 2.2, Handout B)*
Marginalised populations (7)	Those groups, of individuals or communities, whose social standing, power, or rights have been reduced to extremely low levels, often resulting in exclusion from beneficial services, programmes, or policies. Marginalisation unfairly limits access to food, shelter, and other human necessities.
Memorandum of Understanding (155)	An agreement between two parties in the form of a legal document. It is not fully binding in the way that a contract is, but it is stronger and more formal than a traditional agreement. *(For more on this topic, please refer to Activity 6.2, Handout C)*
Monitoring and evaluation (8)	Otherwise called process and outcome evaluation, these tools help to keep track of what has been done by measuring the outputs of the individual activities as well as the actual changes, or outcomes, which have taken place toward achieving a set of objectives. *(For more on this topic, please refer to "Monitoring and evaluation," p.8)*
Operationalising (8)	The process of clearly outlining and implementing the steps needed to ensure that an activity will appropriately address particular goals and objectives.
Participatory (55)	Students, teachers, parents, and community members are actively engaged. *(For more on this topic, please refer to Section 2)*
Partnerships (8)	A strategic alliance or relationship between two or more people or organisations. Partnerships can be formal, where each party's roles and obligations are spelled out in a written agreement, or informal, where the roles and obligations are assumed or agreed to verbally. *(For more on this topic, please refer to Activity 6.1)*

Resource gap analysis (13)	The systematic process of organising the availability of particular kinds of resources (such as human, financial, goods and services, or time) and identifying the areas where they are lacking, in order to prioritise where energy and attention must be directed for the programme to be successful. *(For more on this topic, please refer to Activity 6.1, Handout C)*
Resource mobilisation (8)	A comprehensive process involving strategic planning for programme funding, communication and effective negotiation with donors, sound management of resources, improving image and credibility of the organisation, and ensuring good coordination among all partners. *(For more on this topic, please refer to Activity 6.2)*
Same-sex relationships (8)	Those relationships, based on sexual behaviour or attraction, that exist between individuals of the same biological sex.
Sensitisation (14)	The process whereby an individual's understanding or awareness of a particular issue is deepened by addressing his or her psychological or emotional response.
Sex work (8)	The "exchange of money or goods for sexual services, either regularly or occasionally, involving female, male, and transgender adults, young people, and children, where the sex worker may or may not consciously define such activity as income-generating." *(For more information, please visit: http://www.unfpa.org/hiv/docs/factsheet_genderwork.pdf)*
Sexuality (8)	According to the American Psychological Association, the term "refers to an individual's sense of personal and social identity" based on their emotional, romantic, and/or sexual attractions or "behaviours expressing them and membership in a community of others who share them." More broadly, sexuality refers to the way in which individuals express themselves sexually. *(For more information, please visit: http://www.apa.org/topics/topicsbehavior.html)*
Social norms (6)	The standard, often unwritten, customs or conditions of a society or culture that guide social behaviour and influence the ways in which individuals interact. These customs or conditions include values, beliefs, attitudes, and behaviours.
Stigma (6)	The process of devaluing people and viewing them negatively on the basis of a particular attribute, for example, their HIV status, gender, or sexuality. *(For more on this topic, please refer to Activity 4.1)*
Strategic planning (7)	The process of defining the strategy or future direction for an organisation or programme, often involving an analysis regarding the resources available and needed. *(For more on this topic, please refer to Activity 6.1)*
Supportive environment (10)	A setting, such as a school or other workplace, that offers protection from harmful issues (including stigma and discrimination, and gender inequity). *(For more on this topic, please refer to Section 5)*

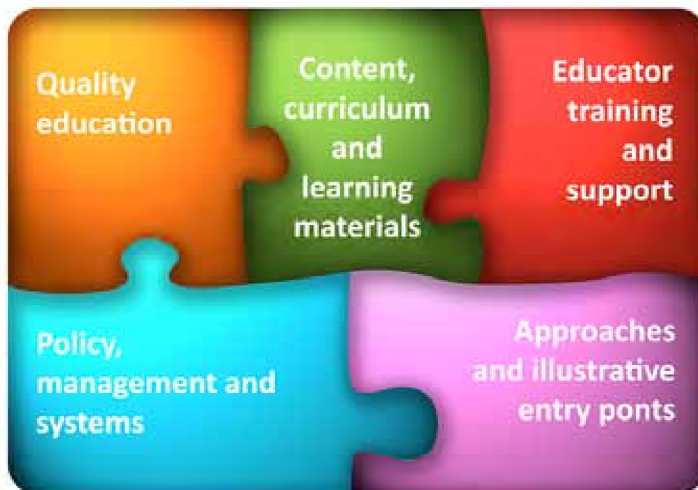
Sustainable (8)	The capacity to maintain a programme or intervention at a certain state or level indefinitely. Often this entails the self-generation or recycling of various resources.
Universal precautions (37)	Safety measures to prevent transmission of HIV and other blood-borne germs when providing first aid or health care. This involves wearing protective barriers such as gloves.
Unprotected sex (27)	Any kind of sexual activity that puts the participating individuals at risk for HIV or other infection because of not using a condom or other prophylaxis. *(For more on this topic, please refer to Activity 1.1)*

Appendix 3. GIPA Declarations

Declaration of Commitment on HIV/AIDS (6)	The June 2001 Declaration by the United Nations General Assembly that expanded on the recommendations made during the 1994 Paris AIDS Summit by emphasising the importance of including people living with HIV in the design, planning, implementation, and evaluation of programmes and policies targeting the epidemic. This further stressed the need to actively engage those *affected* by HIV and AIDS, such as family members and caregivers. *(For the declaration, please visit: http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf)*
Denver Principles (6)	The recommendations made in Denver, Colorado (United States) in 1983 at the Second National AIDS Forum at the National Lesbian and Gay Health Conference by a small group of people living with HIV, regarding their human rights as citizens and their right to involvement in the HIV and AIDS response. These principles laid the groundwork for later annunciation of the GIPA principles. *(For the Denver Principles, please visit: http://www.napwa.org/whoweare/denver-principles.shtml)*
Paris AIDS Summit (6)	The 1994 meeting at which the GIPA principles were formally outlined. There, 42 countries agreed to support an initiative to "strengthen the capacity and coordination of networks of people living with HIV and community-based organisations" to ensure "the creation of supportive political, legal and social environments." *(For more on this topic, please refer to "Origins and history of GIPA" p.6)*
Port-of-Spain Declaration (7)	Following the UN Declaration of Commitment on HIV/AIDS in 2001, a high-level meeting of MOEs and national AIDS authorities of CARICOM developed and endorsed this new declaration in 2006, which signified a renewed commitment to efforts aimed toward enhancing the education sector response to HIV and AIDS in the Caribbean. *(For the declaration, please visit: http:// www.caricom.org/jsp/communications/meetings_statements/port_of_spain_declaration_hiv_aids.jsp)*
Roseau Declaration (7)	In 2007, MOEs of the Organisation of Eastern Caribbean States (OECS) reaffirmed their commitment to the Port-of-Spain Declaration and issued this statement regarding the critical role of the education sector in response to HIV and AIDS. *(For the declaration, please visit: http://portal.unesco.org/es/files/36735/1709848049Roseau__DECLARATION.pdf/Roseau%2B%2BDECLARATION.pdf)*

Appendix 4. Additional models for a comprehensive approach to HIV and AIDS

EDUCAIDS Framework for Action §



A *comprehensive* education sector response means to move away from programming HIV and AIDS on a project–by-project basis, and toward a holistic, sector-wide view of the impacts and challenges of HIV, and the deployment of all components, modalities, and capacities of the education sector system to address and mitigate those impacts.

Comprehensive education sector responses comprise *five essential components*. All of these components need to be in place and working well to ensure optimal success in the response to the epidemic.

Policy, management, and systems

Elements of HIV and AIDS policy, management, and systems for the education sector include:

- Inclusion of the education sector response in the national HIV and AIDS strategy
- Sectoral policies and strategies on HIV and AIDS integrated into the national education plan
- HIV and AIDS workplace policies that ensure supportive and safe environments for educators and learners
- HIV and AIDS management structures or committees to guide and monitor the sector's response

§ UNESCO & UNAIDS. (2008). EDUCAIDS: Framework for Action. Geneva: UNESCO. Available from http://unesdoc.unesco.org/images/0014/001473/147360E.pdf

- Education management information systems, situation analyses, and needs assessments
- Planning for human capacity, impact assessment, and projection models
- Strategic partnerships for coordination, advocacy, and resource mobilisation
- Monitoring, evaluating, and assessing outcomes and impact

Quality education

Quality HIV and AIDS education embodies a number of cross-cutting principles, including:

- Rights-based, learner-centred, and inclusive
- Gender-responsive
- Scientifically accurate
- Culturally sensitive
- Age-specific
- Delivered in safe and secure learning environments
- Focused on and tailored to various groups, including key populations vulnerable to HIV
- Promoting the involvement of people living with HIV

Access to educational opportunities is widely recognised as an effective means for reducing vulnerability of children and young people to HIV. UNESCO supports efforts to ensure that all learners are reached with relevant and appropriate learning opportunities of good quality.

Content, curriculum, and learning materials

The content of HIV and AIDS curricula should:

- Be adapted and appropriate for various ages, levels, and settings (including formal and non-formal)
- Be integrated into the national curriculum
- Begin early, before the onset of sexual activity
- Build knowledge and skills to adopt protective behaviours and reduce vulnerabilities
- Focus on prevention, while also including relevant care, treatment, and support issues
- Address stigma and discrimination, gender inequality, and other structural drivers of the epidemic
- Involve communities in curriculum development and revisions to ensure ownership and support

Educator training and support

The following are key aspects of educator training and support:

- Pre- and in-service programmes for teachers and support for non-formal educators
- Deepening educators' technical knowledge on HIV and AIDS, confidence, and experiences in interactive and participatory learning methodologies

- Addressing educators' own vulnerabilities to HIV infection and the impact of HIV and AIDS
- Complemented by appropriate learning and teaching materials and aids
- Reinforced through supervision, peer coaching, and mentoring by experienced teachers
- Involving communities to share knowledge, build support, and encourage dialogue
- Support for HIV-positive educators through teachers' unions and networks for teachers who are living with HIV

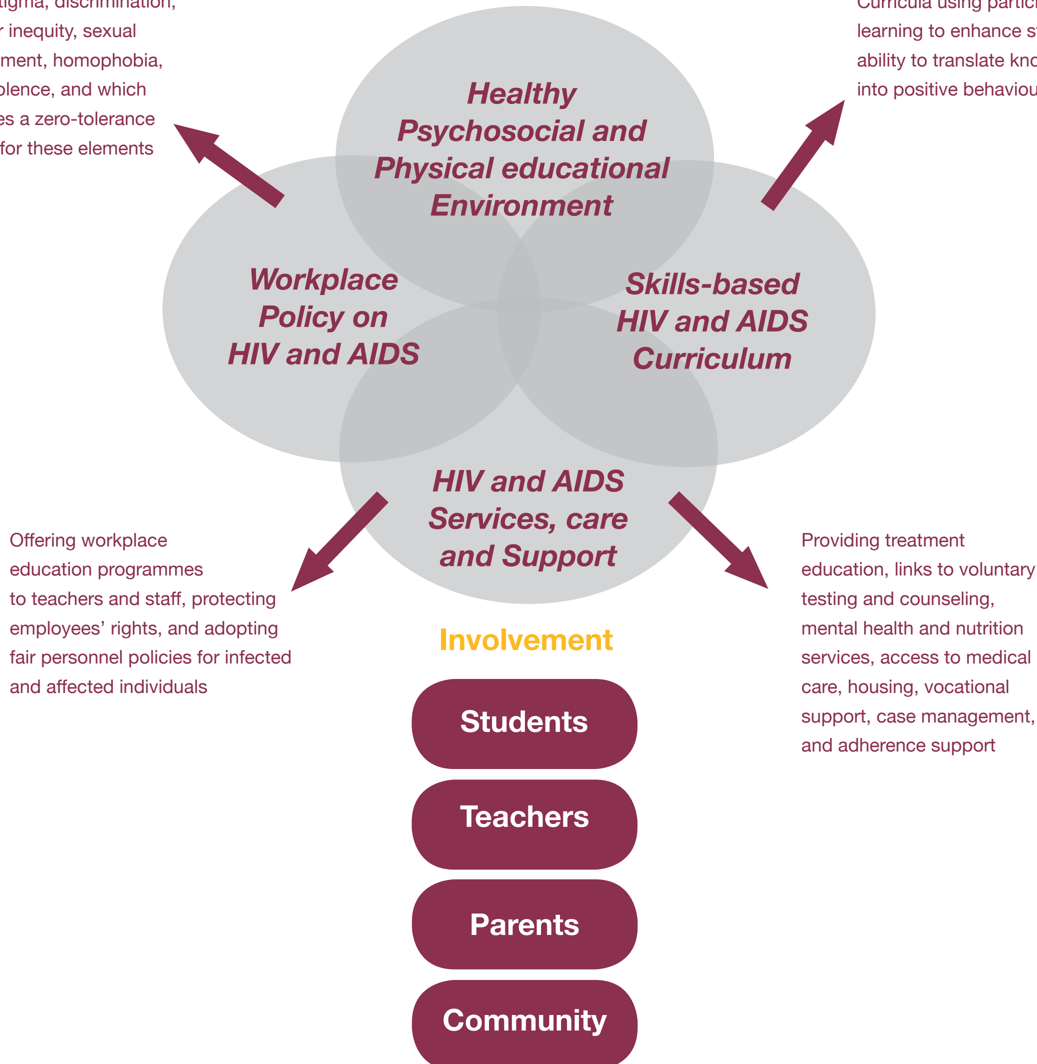
Approaches and illustrative entry points

A holistic approach, which maximises the use of opportunities and entry points in different contexts, is essential. The following are examples of varying approaches and illustrative entry points:

- Sex, HIV, and relationships education
- School health and school feeding programmes
- Peer education
- Communications and media
- Community-based learning and outreach, including for out-of-school young people
- Life skills education
- Adult education and literacy
- HIV and AIDS treatment education

EDUCAIDS implementation support tools related to all five essential components are available from: http://unesdoc.unesco.org/images/0015/001584/158428E.pdf

A Comprehensive Approach to HIV and AIDS in the Education Sector §



A comprehensive approach goes beyond implementing an HIV and AIDS prevention curriculum in the classroom. To have a real impact on HIV and AIDS, the education sector must address its other challenges as well, including the need for workplace policies and training programmes for teachers and staff, a safe and secure learning environment for working and learning, and links to services for those living with HIV. The UNESCO/EDC model, introduced in 2005, identifies four primary components for a comprehensive approach to HIV and AIDS in the education sector.

§ UNESCO & EDC. (2005). *Leading the way in the education sector: Advocating for a comprehensive approach to HIV and AIDS in the Caribbean.* Newton, MA: EDC. Available from http://www.caribbeanleaders.org/advocacy/PDFs/Advocacy%20and%20Leadership%20Workbook.pdf

Workplace policy on HIV and AIDS

According to the International Labour Organization (ILO), a workplace policy provides a framework for action to reduce the transmission of HIV and manage the impact of AIDS. Supportive workplace policies in schools include:

- HIV prevention training education for all school personnel
- Required coordination between health and education authorities at local and district levels in planning and implementing HIV interventions in schools
- Policies for students and school personnel that support privacy, attendance, employment and infection control
- Policies that support HIV prevention and other health interventions at all levels of schooling, starting in the earliest grade and continuing through the last grade
- Designation of a school-level coordinator with the responsibility and authority to deal with health issues
- A code of professional ethics that protects students, teachers, and staff from sexual harassment and abuse[†]

Healthy psychosocial and physical educational environment

A healthy educational environment goes beyond academic outcomes, ensuring that learners and educators know that they will be "safe from harm, cared for equally, and treated with respect."‡ Creating a healthy environment involves the following actions:

- Establish clear regulations about stigma and discrimination, confidentiality, gender equity and equality, violence, and sexual harassment, bullying, and attitudes toward same-sex relationships.
- Ensure that every educational institution and setting offers a welcoming atmosphere for individuals living with HIV.
- Make sure that every educational institution and setting implements a zero-tolerance policy for discriminatory or stigmatising actions, violence, sexual harassment and exploitation—by students, teachers, and staff.
- Take steps to ensure that every pupil and staff member (1) has sufficient knowledge of HIV and AIDS to dispel common fears and prejudices and (2) recognises that there are no grounds for stigmatising any infected or affected person, in school or elsewhere.‡
- Ensure that the physical school environment, including structures, drinking water, and sanitation facilities, is safe and consistently monitored.

[†] WHO. (1999). *Preventing HIV/AIDS/STI and related discrimination: An Important responsibility of Health-Promoting Schools; WHO Information Series on School Health 6.* Geneva: WHO. Available from: http://www.who.int/school_youth_health/media/en/90.pdf

[‡] Kelly, M., & Bain, B. (2005). *Education and HIV/AIDS in the Caribbean.* Paris: UNESCO. Available from: http://www.unesco.org/iiep/PDF/pubs/KellyCarib_web.pdf

Skills-based HIV and AIDS curriculum

A skills-based HIV and AIDS prevention curriculum focuses on the development of "abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life."* The goal is not only to change students' level of knowledge but also to enhance their ability to translate that knowledge into specific behaviour. Such a curriculum has the following elements:

» Learning activities that target communication skills, refusal skills, decision-making skills, and emotional coping skills
» Participatory, interactive teaching and learning methods, including role plays, brainstorming, and small-group work
» Learning activities that are culturally relevant and gender sensitive

An abstinence-only curriculum is one approach to addressing HIV and AIDS in schools, and is developmentally appropriate for students who are not yet sexually active. However, given the young age of first intercourse in the Caribbean, students also need skills and services for protection. Any curricula should be supplemented by the Health and Family Life Education (HFLE) curriculum, which is a skills-based curriculum addressing many aspects of healthy lifestyles.

HIV and AIDS services, care, and support

HIV and AIDS services include the following:

» Education, empowerment, and voluntary counselling and testing for individuals who may be at risk of infection
» Mental health (e.g., psychosocial counselling) and nutrition services for those living with HIV
» Access to medical care, including antiretroviral treatment
» Housing, vocational support
» Case management and adherence support

A key factor in enhancing care, support, and services related to HIV and AIDS is to ensure that students and educators know and trust that their HIV status or the status of a loved one will always remain confidential. If people do not believe that information about HIV status will be kept confidential, they will not be willing to disclose their status and get the help they need. National HIV and AIDS workplace policies for the education sector must include rules and regulations that protect private and confidential information disclosed by students, teachers and staff related to HIV and AIDS.

* EDC, EI, & WHO. (2005). *Teachers' Exercise Book for HIV Prevention; (WHO Information Series on School Health 6.1).* Geneva: WHO. Available from: http://www.who.int/school_youth_health/resources/sch_document61_HIV_prevention_env2.pdf

The toolkit aims to assist education sector staff, networks of people living with HIV (PLHIV), and others to apply the principles for the greater involvement of people living with or affected by HIV and AIDS (GIPA) to a comprehensive approach to the education sector's response to HIV and AIDS.

The toolkit includes step-by-step lesson plans, handouts, and resources for 10 activities including tips for facilitators and suggestions for monitoring and evaluation. The activities introduce the concept of GIPA and detail how its principles can be incorporated into the education sector's planning of HIV and AIDS initiatives. Stigma and discrimination, and issues related to confidentiality and disclosure are addressed, and there are case studies and role plays.

The publication is intended for persons involved in HIV response programming: policy and decision-makers, persons in the education sector, and networks of people living with HIV.

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