2019

Youth Engaging for Success (YES)—Youth peer mentor pre-service training: Youth peer mentor guide

Project SOAR

Youth Engaging for Success (YES)

Youth Peer Mentor Pre-Service Training

Youth Peer Mentor Guide

PEPFAR

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PROJECT SOAR SUPPORTING OPERATIONAL AIDS RESEARCH

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Acronyms and Definition of Key Terms

3TC	Lamivudine – a type of Antiretroviral drug.
ABC	Abacavir – a type of Antiretroviral drug.
ADCH	Arthur Davison Children's Hospital
Adherence	The degree to which a patient follows directions given by a health care worker. Taking medicine exactly as directed by a health care worker, including the number of pills and when and how to take them.
AIDS	Acquired Immunodeficiency Syndrome – the late stage of HIV disease. People are diagnosed with AIDS when they have fewer than 200 CD4 cells, or they have experienced certain illnesses.
ALHIV	Adolescents living with HIV
Antibody	Y-shaped proteins (also known as immunoglobulins) produced by the immune system to help stop intruders such as viruses, bacteria or chemicals, from harming the body.
Antiretroviral Drug	Medications used to control HIV virus by making it difficult for it to make copies of itself (replicate).
ART	Antiretroviral Therapy – a treatment for HIV using antiretroviral medications.
ARV	Antiretroviral drugs
ARV drug classes	Antiretroviral drugs are grouped into classes depending on how they work to fight the virus.
ATV	Atazanavir – a type of Antiretroviral drug.
AZT	Zidovudine – a type of Antiretroviral drug.
cART	Combination ART
CD4 cells	A type of immune system cell that fights certain infections. These cells are the primary target of HIV. The number of CD4 cells in the system determines how well the immune system is functioning.
Discrimination	Denying someone opportunities based on some attribute.
ECP	Emergency contraceptive pills – oral contraceptives that can be used to prevent pregnancy following unprotected sexual intercourse.
EFV	Efavirenz – a type of Antiretroviral drug.
FDC	Fixed dose combination – combining different medications into one tablet.
First-line treatment	The combination of medications that is usually used first with ART.
FTC	Emtricitabine – a type of Antiretroviral drug.
HIV	Human Immunodeficiency Virus – the virus that causes AIDS.

HPV	Human papillomavirus
HSV	Herpes simplex virus
HTS	HIV testing services – the full range of services provided with HIV testing, including counselling; linkage to appropriate HIV prevention, treatment, and care, and other clinical services; and coordination with laboratory services to ensure delivery of accurate results.
IDU	Intravenous drug use
Immune system	The systems in the body that work to fight off infection.
Infection	An infection is caused by a bacteria or virus entering the body. The body can naturally fight off some infection, while others cause illnesses.
IUD	Intrauterine device – a small T-shaped device inserted into the uterus to provide protection against pregnancy.
LPV	Lopinavir – a type of Antiretroviral drug.
MTCT	Mother-to-child transmission
NAT	Nucleic Acid Test – a virological testing technology used for early infant HIV diagnosis.
NCH	Ndola Central Hospital
NNRTI	Non-nucleoside reverse transcriptase inhibitors – a classification of ARV drugs.
NRTI	Nucleoside reverse transcriptase inhibitors – a classification of ARV drugs.
NVP	Nevirapine – a type of Antiretroviral drug.
OI	Opportunistic Infection – an infection that occurs in a person with a weak immune system.
PCP	Pneumocystis pneumonia
PCR	Polymerase Chain Reaction – a test done to detect HIV-specific genetic material that indicates the presence of HIV.
PEP	Post-exposure prophylaxis – a short-term course of Antiretroviral drugs given to HIV-negative people who have been exposed to HIV to reduce their risk of HIV infection.
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention – an HIV prevention strategy among people living with HIV (PLHIV) that focuses on risk reduction, ART adherence, correct condom use, family planning, STI screening, and partner HIV testing.
PI	Protease inhibitors – a classification of Antiretroviral drugs.

PITC	Provider Initiated Testing and Counselling – when health care providers recommend HIV testing to patients attending facilities.
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis – ARV drugs given to an HIV-negative person to reduce the risk of HIV infection in cases where the person is in a relationship with an HIV-positive person who refuses cART, or if the person is engaged in high-risk activities.
PST	Pre-service training
-r	Ritonavir – a type of ARV drug (- indicates a low dose of the drug).
Resistance	The ability of the HIV virus to change and resist the capacity of some medications to work against it.
Second-line treatment	The combination of medications that is usually used to treat HIV once first-line medications have failed.
Self-stigma	Accepting or internalising negative feelings about oneself due to a real or perceived difference about oneself.
Side effect	A symptom or problem caused by taking a medication.
SOAR	Supporting Operational AIDS Research
SRH	Sexual reproductive health – health and well-being in matters related to sexual relations, pregnancies, and childbirth.
STI	Sexually transmitted infection
Stigma	Seeing someone negatively due to a real or perceived difference.
Stigma by association	Seeing someone negatively due to that person's relationship to someone seen as different.
TB	Tuberculosis
TB/HIV co-infection	Infection with both TB and HIV.
TDF	Tenofovir – a type of ARV drug.
Third-line treatment	The combination of medications that is usually used to treat HIV once second-line medications have failed.
USAID	United States Agency for International Development
Viral load	The amount of HIV virus in the blood.
Viral replication	When a virus makes more copies of itself.
Voluntary disclosure	When an HIV-positive person voluntarily shares his or her HIV status with someone else.
Window period	The time it takes for HIV antibodies to be detectable after infection.
YES	Youth Engaging for Success
YPLHIV	Young people living with HIV
YPM(s)	Youth peer mentor(s)

Training Schedule

Day 1

Session 1: Opening Session (2 hours) ..... 08h30 – 10h30
Tea Break ..... 10h30 – 10h45
Session 2: Project YES Overview (2 hours and 30 min) ..... 10h45 – 13h00
Lunch Break ..... 13h00 – 14h00
Session 3: Life Lessons (1 hour and 15 min) ..... 14h00 – 15h30
Tea Break ..... 15h30 – 15h45
Session 3: Life Lessons continued (1 hour and 5 min) ..... 15h45 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 2

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 4: HIV Basics (2 hours) ..... 08h40 – 10h40
Tea Break ..... 10h40 – 10h55
Session 4: HIV Basics continued (2 hours) ..... 10h55 – 12h55
Lunch Break ..... 12h55 – 13h55
Session 5: Treatment and Adherence (1 hour and 30 min) ..... 13h55 – 15h25
Tea Break ..... 15h25 – 15h40
Session 5: Treatment and Adherence continued (1 hour and 10 min) ..... 15h40 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 3

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 5: Treatment and Adherence continued (40 min) ..... 08h40 – 09h20
Session 6: Sexual Reproductive Health (1 hour) ..... 09h20 – 10h20
Tea Break ..... 10h20 – 10h35
Session 6: Sexual Reproductive Health continued (2 hours) ..... 10h35 – 12h35
Lunch Break ..... 12h35 – 13h35
Session 7: Stigma and Discrimination (1 hour) ..... 13h35 – 14h35
Session 8: Disclosure (1 hour) ..... 14h35 – 15h35
Tea Break ..... 15h35 – 15h50
Session 8: Disclosure continued (1 hour) ..... 15h50 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 4

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 9: Healthy Living (2 hours) ..... 08h40 – 10h40
Tea Break ..... 10h40 – 10h55
Session 9: Healthy Living continued (2 hours and 20 min) ..... 10h55 – 13h15
Lunch Break ..... 13h15 – 14h15
Session 10: Effective Communication (1 hour and 20 min) ..... 14h15 – 15h35
Tea Break ..... 15h35 – 15h50
Session 10: Effective Communication continued (1 hour) ..... 15h50 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 5

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 10: Effective Communication (2 hours) ..... 08h40 – 10h40
Tea Break ..... 10h40 – 10h55
Session 11: Mentoring Skills (2 hours) ..... 10h55 – 12h55
Lunch Break ..... 12h55 – 13h55
Session 11: Mentoring Skills continued (1 hour and 40 min) ..... 13h55 – 15h35
Tea Break ..... 15h35 – 15h50
Session 11: Mentoring Skills continued (1 hour) ..... 15h50 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 6

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 12: Facilitating Client Meetings (2 hours) ..... 08h40 – 10h40
Tea Break ..... 10h40 – 10h55
Session 12: Facilitating Client Meetings continued (2 hours and 5 min) ..... 10h55 – 13h00
Lunch Break ..... 13h00 – 14h00
Session 12: Facilitating Client Meetings continued (1 hour and 30 min) ..... 14h00 – 15h30
Tea Break ..... 15h30 – 15h45
Session 12: Facilitating Client Meetings continued (1 hour and 5 min) ..... 15h45 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 7

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 12: Facilitating Client Meetings continued (2 hours) ..... 08h40 – 10h40
Tea Break ..... 10h40 – 10h55
Session 12: Facilitating Client Meetings continued (2 hours and 15 min) ..... 10h55 – 13h10
Lunch Break ..... 13h10 – 14h10
Session 12: Facilitating Client Meetings continued (1 hour and 30 min) ..... 14h10 – 15h40
Tea Break ..... 15h40 – 15h55
Session 12: Facilitating Client Meetings continued (55 min) ..... 15h55 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 8

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 12: Facilitating Client Meetings (2 hours) ..... 08h40 – 10h40
Tea Break ..... 10h40 – 10h55
Session 13: Facilitating Youth Group Meetings (2 hours and 5 min) ..... 10h55 – 13h00
Lunch Break ..... 13h00 – 14h00
Session 13: Facilitating Youth Group Meetings continued (1 hour and 30 min) ..... 14h00 – 15h30
Tea Break ..... 15h30 – 15h45
Session 14: Practicum (1 hour and 5 min) ..... 15h45 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 9

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 14: Practicum continued (1 hour and 40 min) ..... 08h40 – 10h20
Tea Break ..... 10h20 – 10h35
Session 14: Practicum continued (2 hours and 25 min) ..... 10h35 – 13h00
Lunch Break ..... 13h00 – 14h00
Session 14: Practicum continued (2 hours) ..... 14h00 – 16h00
Tea Break ..... 16h00 – 16h15
Session 14: Practicum continued (35 min) ..... 16h15 – 16h50
Daily Summary and Closure (10 min) ..... 16h50 – 17h00

Day 10

Homework Review and Daily Preview (10 min) ..... 08h30 – 08h40
Session 15: Project Partners and Resources (1 hour) ..... 08h40 – 09h40
Session 16: Closing (1 hour and 20 min) ..... 09h40 – 11h00
Tea Break ..... 11h00 – 11h15
Health Care Workers Working Session (1 hour and 45 min) ..... 11h15 – 13h00
Working Lunch Break and Room Prep for Graduation ..... 13h00 – 14h00
Session 16: Closing continued (1 hour) ..... 14h00 – 15h00

Session 1: Opening Session

Total Session Time: 2 hours

OBJECTIVES:

By the end of the session participants will be able to

- acquaint themselves with the other participants and training facilitators,
- discuss the goal and objectives of the pre-service training (PST),
- address questions and expectations about the PST,
- establish ground rules for working together, and
- obtain baseline measurement of pre-training knowledge on HIV-related topics.

SESSION OVERVIEW

Learning Activity	Time
Welcome	30 min
Getting to Know You	30 min
PST Overview	30 min
Knowledge Assessment Pre-Test	30 min

LEARNING ACTIVITIES

Getting to Know You

Introductions

- Fold your paper in half length-wise to form a name tent, and write the name you wish to be called in the middle of the bottom half of the page.
- Open the paper back up and write why you wanted to become a youth peer mentor (YPM) across the top of the page.
- Across the bottom of the page, write one thing you are really good at.
- Choose three words that describe positive things about you and scatter those around the page.

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PST Overview

Expectations and Questions

- Write at least one expectation you have for this PST on a sticky note. If you have more than one expectation, write each one on a sticky note.
- Write at least one question you have about this PST on a sticky note. If you have more than one question, write each one on a sticky note.

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PST Goal

The overall goal of this PST is to build the capacity of young adults living with HIV, who have successfully transitioned to self-management and adult HIV care and treatment, to deliver peer mentoring services to improve HIV-related outcomes, including viral suppression, among young people living with HIV (YPLHIV) as they transition to self-management and adult HIV care and treatment.

PST Objectives

The specific objectives of this PST are to enable participants to

- serve as youth peer mentors (YPMs) and act as empowered role models for healthy living and successful self-management of HIV,
- provide education and mentoring to YPLHIV ("clients") through one-on-one and youth group meetings,
- support involvement of client caregivers,
- assist clients and their caregivers to access available health and wellness-related services in the health facility and community,
- work effectively as part of a facility-based health care team to reinforce medical messages, support adherence to prescribed treatments, and serve as an early warning system for identifying clients who may need additional support, and
- assess and improve uptake of recommended healthy living practices.

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Session 2: Project YES Overview

Total Session Time: 2 hours and 15 minutes

OBJECTIVES:

By the end of the session participants will be able to

- describe the goals of Project YES,
- identify project team members and resources,
- define peer mentoring,
- describe the role of YPMs in meeting project goals, and
- discuss the benefits and limitations of peer mentoring.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Project YES Overview	60 min
Peer Power	70 min

LEARNING ACTIVITIES

Project YES Overview

Background: _____

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Project goals and objectives: _____

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Expected outcomes: _____

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Project team members and resources: _____

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Recruitment and intake process:_____

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How would you describe Project YES to a friend in your own words? _____

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Notes: _____

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Peer Power

A *peer* is a person of the same age, status, or ability as another specified person, and a *mentor* is an experienced and trusted advisor (Oxford Living Dictionaries, 2017).

Youth Peer Mentors are an essential part of the Project YES team and their essential job functions are to

- work with identified youth, clinic staff, and, when possible, the youth's caregiver(s), to identify key areas of interest and need and develop a personalized action plan,
- hold individual education and psychosocial support meetings with youth on a monthly basis,
- work with clinic staff to facilitate six monthly education and psychosocial support group meetings for HIV+ youth,
- work with clinic staff to co-facilitate up to three education and psychosocial support group meetings for interested caregivers,
- attend all required training workshops and meetings,
- document activities on identified monitoring and evaluation tools and submit reports as required, and
- support the clinic with administrative tasks as needed.

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Benefits of Peer Approach	
For Clients	**For YPMs**

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YPMs	
ARE:	**Are NOT:**

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Boundaries

Boundaries are rules or limits we set to protect ourselves from being manipulated, used, or violated by others.

People have boundaries that can be

- rigid – where they keep people at a distance physically or emotionally,
- diffuse – where they are overinvolved with others and never say "No" regardless of their needs or wants, and/or
- healthy – where they are open to close and intimate relationships, but are also comfortable saying "No" when appropriate.

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YPM Boundaries		
Appropriate	**Inappropriate**	**Needs Guidance**

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Session 3: Life Lessons

Total Session Time: 2 hours and 35 minutes

OBJECTIVES:

By the end of the session participants will be able to

- identify lessons learned from their own experiences with HIV that could benefit their clients,
- identify issues that may be triggered during client interactions,
- identify resources for dealing with emotional issues and triggers, and
- identify future ambitions and set goals for reaching them.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Life Lessons	150 min

LEARNING ACTIVITIES

Life Lessons

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Session 4: HIV Basics

Total Session Time: 4 hours

OBJECTIVES:

By the end of the session participants will be able to

- describe the difference between HIV and AIDS,
- explain how HIV can affect the immune system and physical health,
- define Opportunistic Infection (OI),
- list common OIs,
- explain how HIV is transmitted,
- explain how HIV transmission can be prevented,
- discuss benefits of HIV testing,
- describe HIV tests used for adults and infants,
- define what HIV sero-concordance and sero-discordance means in a couple, and
- respond to common HIV misbeliefs.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
HIV & AIDS	60 min
HIV Transmission	60 min
HIV Prevention	40 min
HIV Testing	30 min
Fiction to Fact	45 min

LEARNING ACTIVITIES

HIV & AIDS

HIV

HIV stands for Human Immunodeficiency Virus. This virus attacks a person's immune system, making it difficult for the person's body to fight off various infections and diseases.

HIV cannot be cured yet, but it can be treated and managed to control the amount of damage done to the immune system. People living with HIV (PLHIV) who get proper care and treatment can live long and healthy lives; however, left untreated and unmanaged, HIV can lead to AIDS and ultimately death.

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AIDS

AIDS stands for Acquired Immunodeficiency Syndrome, where

- *acquired* means something that is passed from one person to another,
- *immune* refers to the system in the body that protects against infections and diseases,
- *deficiency* refers to impairment of the immune system, and
- *syndrome* means a collection of infections and diseases, not just one.

AIDS is the advanced stage of the disease when the immune system has been damaged to the point it can no longer protect the body.

AIDS is a medical diagnosis based on the health of the immune system or the presence of specific diseases and infections. Left untreated and unmanaged, most people infected with HIV will develop AIDS in ±10 years; however, the goal of treatment and management is to stop the progression of the disease before it gets to the point of AIDS.

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HIV's Impact on the Body

Once HIV enters the body, it starts looking for cells it can hijack in order to replicate and survive. Unfortunately, the cells HIV hijacks are a very important part of the immune system called the *CD4 cells*.

CD4 cells are like a general in a defence force, as they direct the immune system where to attack when it is invaded. Once HIV is inside a CD4 cell, it takes over and turns it into a factory to make more copies of the HIV virus, which are then released into the body to take over other CD4 cells.

This HIV life cycle takes only 2.5 days from when it takes over a CD4 cell to the time it kills the cell and releases the new HIV copies.

When first infected with HIV, some people experience flu-like symptoms, while others do not. It takes a while for the immune system to recognize HIV as a threat and start making *antibodies*. The time between when HIV enters the body and the time when HIV antibodies can be detected is called the *window period*.

The window period for most people is between three and twelve weeks. During this window period where the immune system is not fighting back, the amount of HIV in the body, called the *viral load,* goes up, and the number of CD4 cells, called the *CD4 count,* goes down because the cells are being destroyed.

When a person's CD4 count falls below 200, or the person develops *Opportunistic Infections* (OIs) that are not seen in people with healthy immune systems, then the person is considered to have AIDS.

OIs are infections or diseases that attack or take advantage of the body when it is weak – much like the way rain enters a house when its roof is falling apart.

Common OIs	
Type of OIs	**Signs and Symptoms**
Tuberculosis	Cough lasting over three weeks, coughing blood, night sweats, weight loss, fever
Candidiasis (thrush in the mouth, throat, vagina)	Oral/throat: pain when swallowing, sore mouth or tongue, whitish patches on the palate or sides of the mouth Vagina: burning, itching, soreness, thick vaginal discharge, pain during sexual intercourse
Meningitis (fungal type)	Fever, frequent and severe headaches, vision problems, nausea and vomiting, stiff neck, feeling more and more tired
Pneumonia (PCP)	Difficulty breathing, especially when climbing stairs, fever or chills, weight loss
Kaposi's sarcoma (skin cancer)	Skin lesions (rash) that may appear dark; non-itchy and painless lumps, which can affect any part of the body.
Herpes zoster (shingles)	Very painful blistery rash, fever
(Ministry of Community Development Mother and Child Health, 2014)	

It is not the role of the YPM to try to diagnose a client who talks about signs or symptoms that may indicate an OI, but rather to serve as an early warning system and refer those clients to health care workers so they can be properly assessed.

Clients should be urged to report even mild signs and symptoms to their healthcare workers to avoid progression to serious health problems.

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Review Points

The difference between HIV and AIDS: _____

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Immune system: _____

CD4 cell: _____

CD4 count: _____

Viral load: _____

Antibody: _____

Window period: _____

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HIV Transmission

In order for there to be a risk of HIV transmission there must be

- *exposure* to a body fluid infected with HIV, and
- a way for that fluid to have *access* into the body.

Exposure refers to the presence of an HIV-infected body fluid. Those fluids that contain enough HIV to pose a risk are

- blood, which will typically have the highest concentration of HIV,
- semen, which will typically have the second highest concentration of HIV,
- vaginal fluid, which will typically have the third highest concentration of HIV, and
- breast milk, which will typically have the lowest concentration of HIV.

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Access refers to a way for the HIV-infected fluid to enter the bloodstream, which includes through

- cuts or sores in the skin,
- injections through the skin, and
- mucosal surfaces ("soft skin"), including the lining of the vagina, tip and foreskin of the penis, rectum, and mouth.

The three types of activities that give an HIV-infected fluid access to the bloodstream are

- sexual transmission – the main mode of transmission in Zambia,
- mother-to-child transmission (MTCT) – the second highest mode of transmission in Zambia, and
- blood contact transmission.

In order for there to be a risk of transmission, both exposure and access have to be present.

Viral load is one of the most important factors in HIV transmission. When viral load is low, the risk of transmission drops considerably.

Viral load is one of the most important factors in HIV transmission

Exposure and Access in Sexual Transmission

Vaginal sex: The vagina contains a large concentration of immune cells to protect from infection, and microscopic tears in the vagina during intercourse can provide access to HIV-infected semen.

Anal sex: The anus has a very thin lining and no natural lubrication, which can result in tears in the lining, which can provide access to HIV-infected semen.

Oral sex: Small cuts or sores in the mouth can provide access to HIV-infected semen or vaginal fluids. Sores, dental work, or damage to the mouth can result in blood in the saliva.

Exposure and Access in MTCT

Mothers and babies do not share blood, but HIV can be transmitted during pregnancy if the mother's blood crosses into the baby's blood due to damage to the placenta or other infections.

HIV can be transmitted when the baby has contact with the mother's blood and vaginal fluids during labour and when the baby passes through the vagina during delivery.

HIV can also be transmitted to the infant through breastfeeding.

Exposure and Access in Blood Contact

HIV-infected blood can access the bloodstream through cuts or sores in the skin or through sharing sharp instruments, such as razors or needles.

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HIV Prevention

The Exposure + Access = Risk formula also applies to prevention strategies, as the goal is to remove or limit exposure, access, or both.

While the ultimate goal is eliminating risk completely, there will be circumstances where that is not realistic, so reducing the risk is the next best option.

Preventing Sexual Transmission

Strategies for preventing or reducing the risk of sexual transmission of HIV include

- abstinence – 100% effective; however, it may not be a realistic choice for many,

- being faithful – to one partner whose HIV status you know and with whom you have an agreement you trust on safer sex practices,
- condoms – consistently and correctly using male or female condoms provides a high level of protection, but not 100%, and
- adhering to prescribed care and treatment to keep viral load as low as possible.

Other risk reduction strategies include

- substituting risky practices with non-penetrative practices, such as hugging, massaging, dry rubbing, or masturbation,
- early diagnosis and treatment of sexually transmitted infections,
- delaying sexual debut,
- reducing the number of sexual partners,
- male circumcision (circumcised men are less likely to get HIV from HIV-positive partners), and
- disclosing HIV status so other prevention strategies can be discussed and used.

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Preventing MTCT

Strategies for preventing or reducing the risk of MTCT of HIV include

- preventing HIV infection in women of childbearing age,
- utilising recommended family planning methods to prevent unintended pregnancies,
- providing ARV drugs to mothers and babies,
- encouraging delivery in a facility where safer delivery practices can be used, and
- following recommended infant feeding practices.

With current recommended treatment and management practices, the risk of HIV-positive pregnant women passing HIV to their infants can be reduced from as high as 40% to less than two percent (UNAIDS, 2011).

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Preventing Blood Contact Transmission

Strategies for preventing or reducing the risk of blood contact transmission of HIV include

- putting a barrier between you and blood, such as wearing gloves if cleaning up a blood spill or bandaging someone's cut,
- not sharing any sharp instruments, such as razors, or properly sterilising them if they must be shared, and
- not sharing needles and only taking injections when proper safety measures have been followed.

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HIV Testing

HIV testing is important for many reasons, including

- most people who have HIV look and feel healthy in the early stages,
- the earlier HIV infection is detected, the easier it is to treat and manage,
- people who know of their HIV status can take steps to protect their own health and ensure they do not transmit HIV to others,
- pregnant women who know of their HIV status can take steps to reduce significantly the risk of passing HIV to their infants,
- couples who know their HIV status and wish to have children can take steps to plan pregnancies for the healthiest outcomes for both mother and infant, and
- early detection of HIV in infants is key to child survival, as most HIV-positive children die before age 2 without comprehensive care and treatment.

The two main types of HIV tests used are

- those that look for HIV antibodies (e.g., antibody or serologic tests), and
- those that look for the virus (e.g., polymerase chain reaction [PCR] or nucleic acid test [NAT]).

Antibody tests will not be effective if the person is in the window period, or in the case of infants under the age of 18 months born to an HIV-positive mother, as the infants will have their mother's HIV antibodies.

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HIV Testing Recommendations

Current recommendations under the Zambia Consolidated Guidelines (Directorate of Clinical Care and Diagnostic Services, 2016) relevant to YPM activities are as follows:

- The five essential C's of HIV testing services (HTS) include informed Consent; Confidential, high quality pre-test information and post-test Counselling; provision of Correct test results; and linkage to Care, prevention, and treatment services.
- Provider Initiated Testing and Counselling (PITC) should be offered to all clients at all service points.
- Sexually active adolescents (10-19 years) and their partners should be offered HTS at first contact, re-testing at 3 months if negative and then every 6 months.
- Community-based testing embraces a family-centered approach, where all family members of an HIV-positive person are offered testing regardless of age or risk factors to facilitate early diagnosis of HIV and prompt linkage to care and treatment.

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HIV Status of Couples

Sero-concordant and *sero-discordant* are terms used to describe the HIV status of a couple where

- *sero* refers to HIV status,
- *concordant* means the same, and
- *discordant* means different.

If a couple is sero-concordant, it means that they have the same HIV status, which can be either positive or negative.

If a couple is sero-discordant, it means that one partner is HIV-positive while the other is HIV-negative.

In many settings in sub-Saharan Africa, up to half of PLHIV are in a sero-discordant relationship (Chemaitelly, Cremin, Shelton, Hallett, & Abu-Raddad, 2012).

Safer sex practices are very important in sero-discordant couples to protect the HIV-negative partner, but they are also very important in sero-concordant couples to protect both partners from HIV reinfection and infection with other sexually transmitted infections (STIs).

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Fiction to Fact

Translating Fiction into Fact	
Fiction	**Fact**

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Session 5: Treatment and Adherence

Total Session Time: 3 hours and 20 minutes

OBJECTIVES:

By the end of the session participants will be able to

- explain what antiretroviral (ARV) drugs are and how they are used for treatment and prevention,
- describe the effects ARV drugs have on HIV,
- list ARV drugs commonly used in Zambia,
- recognize first-line treatment for adolescents and adults in Zambia,
- explain the importance of adherence to ARV drugs and other prescribed medications, and
- discuss common adherence challenges and identify strategies for overcoming them.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Antiretroviral Drugs	85 min
Adherence	110 min

LEARNING ACTIVITIES

Antiretroviral Drugs

ARV drugs are used to control the HIV virus by making it difficult for HIV to make copies of itself (replicate).

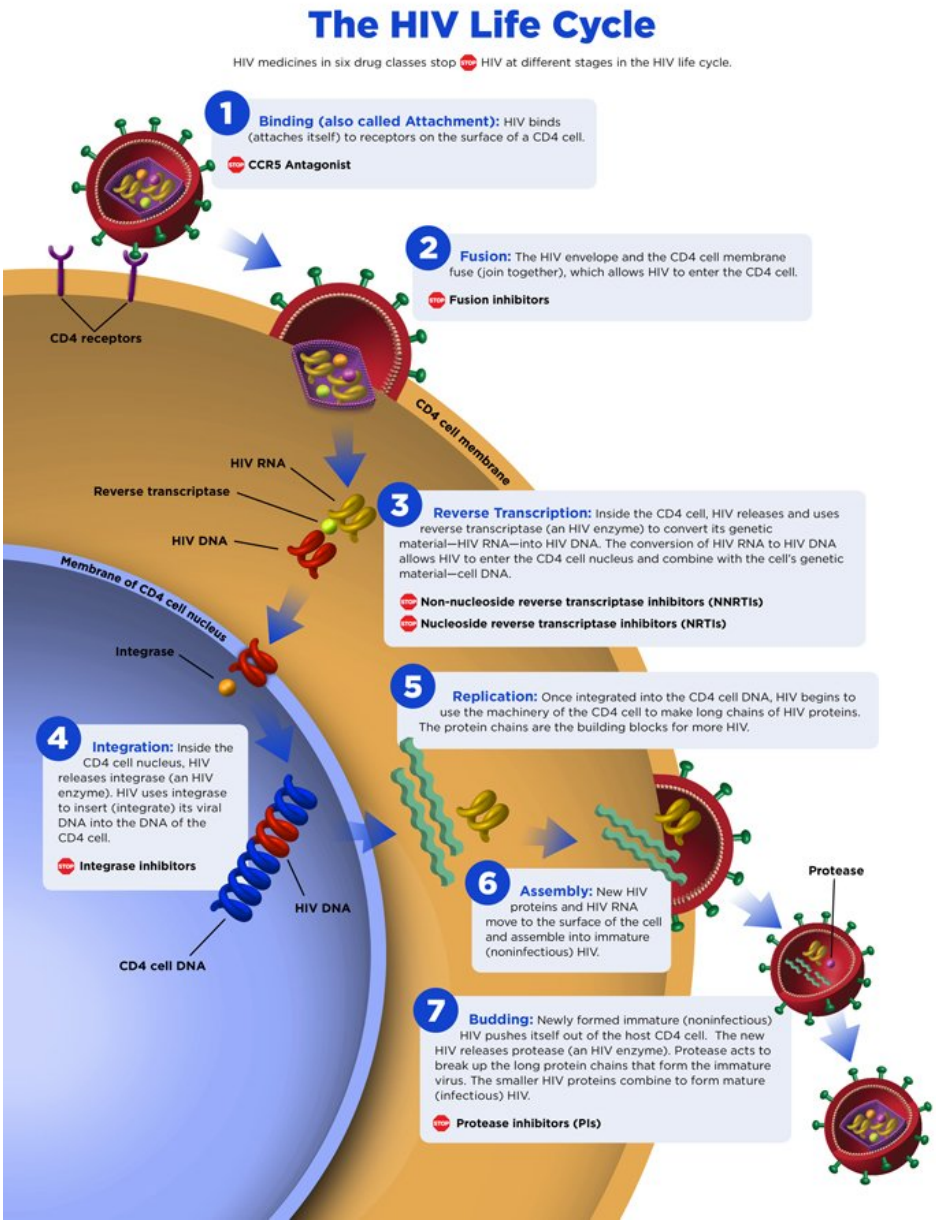
When ARV drugs are working properly to achieve viral suppression, fewer CD4 cells are destroyed so the CD4 count starts to increase, the person's immune system gets strong enough to once again fight off infections and diseases, and the person's overall health improves. A low viral load also reduces the risk of transmitting HIV to partners or infants.

In some cases, the viral load becomes so low it becomes *undetectable* which means that it cannot be measured with current tests; however, it does not mean the person has been cured.

If the ARV drugs are not suppressing viral replication, that is called *treatment failure*. Poor adherence is the most common cause of treatment failure.

The most common cause of treatment failure is poor adherence

ARV drugs work by disrupting or blocking HIV replication at different stages as illustrated in the following graphic (AIDS Info, 2017). Using a combination of ARV drugs is most effective because it works on multiple stages to achieve viral suppression.



As HIV replicates, it changes (mutates) and can become resistant to ARV drugs, which means that ARV drugs are no longer effective at viral suppression.

Using a combination of ARV drugs reduces the risk of ARV drug resistance in addition to being most effective at achieving viral suppression.

Testing the viral load is one of the main ways to measure how effective the ARV drugs are in suppressing viral replication, where

- a viral load under 20 copies/ml means the ARV drugs are effectively suppressing HIV replication,
- a viral load between 20 and 1,000 copies/ml (where the patient is adhering properly) means the ARV drugs may not be working effectively and must be assessed, and
- a viral load of over 1,000 copies/ml (where the patient is adhering properly) means the ARV drugs are failing to suppress replication.

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ARV Drugs

ARV Drugs Commonly Used in Zambia	
Classification	**Abbreviation (Generic Name)**
Nucleoside Reverse Transcriptase Inhibitors (NRTI or "nukes")	ABC (Abacavir)
	3TC (Lamivudine)
	FTC (Emtricitabine)
	AZT (Zidovudine)
	TDF (Tenofovir)
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI or "non-nukes")	EFV (Efavirenz)
	NVP (Nevirapine)
Protease Inhibitors (PIs)	LPV-r (Lopinavir + Ritonavir)
	ATV-r (Atazanavir + Ritonavir)
(Republic of Zambia Ministry of Health, 2017)	

ARV drugs are given as

- lifelong treatment to PLHIV who meet the qualifications, and
- preventative measures, called prophylaxis, to HIV-negative people at risk of HIV exposure.

<table>
<tr><th colspan="2">Qualifications for Lifelong Treatment and Prophylaxis</th></tr>
<tr><th>Lifelong ARV Treatment</th><th>ARV Prophylaxis</th></tr>
<tr><td rowspan="3">All HIV-positive adults, adolescents, and children, regardless of staging or CD4 count
Rationale for early initiation includes the following:
• Reduced rates of HIV-related diseases and death
• Reduced MTCT (in pregnant and breastfeeding women)
• Potential reductions in the incidence and severity of chronic conditions (e.g., renal disease, liver disease, certain cancers, and neurocognitive disorders)
• Reduction in infectious complications (e.g., Tuberculosis [TB])
• Reduced rates of sexual transmission</td><td>HIV-exposed infants for a defined period of time</td></tr>
<tr><td>Post-exposure prophylaxis (PEP) - short-term course of ARV drugs given to HIV-negative people who have been exposed to HIV to reduce their risk of HIV infection (e.g., health care worker who gets a needle-stick injury, or a person who has been sexually assaulted based on assessed risk of the exposure). PEP must be started within 72 hours after exposure, but the sooner it is started the better.</td></tr>
<tr><td>Pre-exposure prophylaxis (PrEP) - ARV drugs given to HIV-negative people to reduce their risk of HIV infection in cases where they are in a relationship with an HIV-positive person who refuses cART or if they are engaged in high-risk activities.</td></tr>
<tr><td colspan="2">(Directorate of Clinical Care and Diagnostic Services, 2016)</td></tr>
</table>

YPMs should always refer clients back to their health care workers if they have specific questions about their ARV drugs or treatment plans.

Preferred First-Line ARV Drugs for Adolescents and Adults

Table 10: Preferred first-line cART and alternative regimens by specific populations

Specific Populations	Description	Preferred 1st line cART	Alternative regimen
Pregnant & Breastfeeding Women [b]	ARV naïve or Sure of tail coverage	TDF + XTC + EFV[b]	TDF + XTC + NVP [c] or ABC + 3TC + EFV
	Previous sdNVP exposure; or NVP monotherapy exposure (NVP without 7 days of AZT+ 3TC cover); or: Unsure of tail coverage	TDF + XTC + LPV-r	TDF + XTC + LPV-r or ATV-r
Children (0-2 weeks)	All	AZT + 3TC + NVP	Consult or refer to expert opinion
Children (2 weeks to < 5 years old)	All	ABC + 3TC + LPV-r	AZT + 3TC + LPV-r
	HIV and TB co-infection	ABC + 3TC + EFV	After completion of ATT, substitute to preferred 1st line with LPV-r
Children (5 to <10 years old)	ARV naïve	ABC + 3TC + EFV	AZT + 3TC + EFV or ABC + 3TC + NVP
	History of maternal sdNVP; maternal NVP monotherapy; mother unsure of tail coverage[d]	ABC + 3TC +LPV-r	AZT + 3TC + LPV-r or ATV-r
Adolescents (10 to <19 years old) weighing <35kg	NO history of maternal sdNVP; maternal NVP monotherapy; mother sure of tail coverage	TDF + XTC + EFV (weight-based dosing)	TDF + XTC* + NVP[i] ABC + 3TC + EFV (weight-based dosing)
	History of maternal sdNVP, unsure of tail coverage; maternal NVP monotherapy	TDF + XTC + LPV-r	TDF + XTC + LPV-r or ATV-r
Adults	All	TDF + XTC + EFV [a]	TDF + XTC + NVP or ABC + 3TC + EFV

Note: These first-line protocols are for people who are just being initiated onto ARV drugs. People already on ARV drugs may be taking different combinations.

(Directorate of Clinical Care and Diagnostic Services, 2016)

Health care workers have to consider a number of factors when determining which ARV drugs to prescribe, including

- patients who have a different strain of HIV called HIV2, and
- patients who acquired HIV at birth where, to avoid potential drug resistance, clinicians have to consider what ARV drugs the mother has used.

Health care workers may also have specific criteria to guide switching patients to different combinations which will include how effective their current regime is at suppressing the virus, how well the patient is tolerating the treatment, and severity of any side effects.

Second- and third-line treatments are alternative lines of treatment in cases where first- or second-line treatment fails. These lines may be more complicated and/or have more side effects.

Treatment and other protocols will change as new data or options become available, or as supplies of drugs and equipment change, which is another reason why it is important for YPMs to always refer clients to health care workers if they have specific questions about their treatment plans.

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Side Effects

Some people who take ARV drugs experience signs or symptoms called side effects. In most cases side effects are mild and disappear over time; however, some can be life-threatening so clients should be encouraged to report them to health care workers.

Examples of side effects include

- nausea or vomiting,
- diarrhoea,
- abdominal pain, distension, and bloating,
- headaches,
- fatigue or weakness,
- muscle pain, and
- central nervous system effects – vivid dreams, dizziness, drowsiness, and mood disturbance.

More severe side effects that need immediate attention from a health care worker can include

- severe skin rash, blisters around the mouth, or peeling skin,
- yellow colouring to the skin (jaundice), yellowing whites of the eyes, and dark urine,
- pins and needles, numbness, or burning feelings in the feet, and
- sudden onset or severe loss of appetite, nausea, vomiting, diarrhoea, or back pain.

It is not the role of the YPM to try to diagnose a client who talks about signs or symptoms that may indicate a side effect, but rather to serve as an early warning system and refer those clients to health care workers so they can be properly assessed.

Clients should be urged to report even mild side effects to their healthcare workers.

In addition to reporting any side effects, people on ARV drugs should always check with a health care worker before taking any other medication to ensure that it does not adversely impact their ARV drugs, including

- other prescription drugs like contraceptives,
- over-the-counter drugs from the chemist,
- herbal or traditional medicines, or
- street drugs.

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Adherence

Adherence means taking medicine exactly as directed by health care workers, including the number of pills and when and how to take them.

Adherence also means going to all scheduled clinic appointments and getting all monitoring tests to
make sure ARV drugs are working.

Poor adherence can take many forms, including

- skipping a dose,
- taking a dose at the wrong time,
- not following instructions for taking a medication,
- running out of medication, and
- not keeping to the recommended schedule of follow-up clinic appointments and monitoring tests.

Consequences of poor adherence can include

- incomplete viral suppression,
- drug resistance,
- progression of disease,
- emergence of resistant viral strains that can be transmitted to others,
- treatment options becoming more limited, often more difficult to take, and having greater side effects – where eventually treatment options may run out,
- increased risk of OIs resulting in poor health and AIDS, and
- higher viral loads, which increase the risk of transmitting HIV to partners and infants if pregnant.

At least 95% adherence is required to prevent HIV from becoming resistant to the ARV drugs being taken, which translates into missing no more than 1 dose every 3 weeks.

Preventing drug resistance requires at least 95% adherence

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Strategies that health care workers may use to improve client adherence (Directorate of Clinical Care and Diagnostic Services, 2016) include

- establishing trust and making sure the patient feels he or she is there to help manage and solve problems,
- involving the patient in developing a plan for taking the drugs that is simple and works with the patient's daily activities,
- educating the patient about the goals of therapy, possible side effects, and what will happen if the patient does not take all the drugs,
- treating depression or substance abuse issues, which can interfere with good adherence,
- treating and managing side effects,
- monitoring adherence at each visit, and
- reinforcing importance of adherence at each follow-up visit.

A key part of the YPM role is to encourage and support good adherence by reinforcing adherence strategies, helping clients problem-solve adherence challenges, and sharing lessons learned from the YPM's own adherence experiences.

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Supporting Adherence

Supporting Adherence	
Challenges	**Strategies**

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Session 6: Sexual Reproductive Health

Total Session Time: 3 hours

OBJECTIVES:

By the end of the session participants will be able to

- describe common sexually transmitted infections (STIs) and how they are transmitted,
- describe how STIs can be prevented,
- demonstrate correct use of male and female condoms,
- discuss strategies for negotiating safer sex practices,
- define family planning and explain benefits,
- describe modern contraceptive methods commonly used in Zambia, and
- define dual protection and its benefits.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Defining Sexual Reproductive Health	5 min
Sexually Transmitted Infections	20 min
Safer Sex Practices	80 min
Safer Sex Negotiation	40 min
Family Planning	30 min

LEARNING ACTIVITIES

Defining Sexual Reproductive Health

Sexual and reproductive health (SRH) is a broad concept encompassing health and well-being in matters related to sexual relations, pregnancies, and childbirth.

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Sexually Transmitted Infections

STI True or False	
Statements	**Answers**
STI stands for sexually transmitted infection.	
HIV is an STI.	
All people with an STI will have symptoms.	
People with another STI are more vulnerable to getting HIV.	
If both partners are HIV-positive there is no need to use condoms.	
Some STIs are spread even without sexual intercourse.	
Condoms are the most effective protection against getting an STI.	

Sexually Transmitted Infections						
STI/STD	**Cure (C) or Manage (M)**	**Transmission Routes**				
		Vaginal & Anal Sex	**Oral Sex**	**Infected Skin or Sore Contact**	**Blood Contact**	**MTC**
Chlamydia	C	X	X			X
Gonorrhea	C	X	X			X
Hepatitis B	M	X	X		X	X
Genital Herpes (HSV)	M	X	X	X		X
HIV	M	X	X		X	X
Genital Warts/HPV	M	X	X	X		Rare
Syphilis	C	X	X	X	Rare	X
(Adapted from Public Health Agency of Canada, 2017)						

The presence of another STI increases the risk of transmitting HIV through sexual contact as sores, blisters, and rashes from the STI can provide openings for HIV to enter the system.

STIs put additional stress on the immune system, so PLHIV who get another STI are more likely to get sick more frequently and develop AIDS more rapidly.

Common signs and symptoms of STIs can include

- fluid, sores, or bumps on vagina or penis,
- swelling or pain in stomach or groin,
- a burning feeling when urinating or having sex. and
- unusual discharge from vagina or penis.

It is not the role of the YPM to try to diagnose a client who talks about signs or symptoms that may indicate an STI, but rather to serve as an early warning system and refer those clients to health care workers so they can be properly assessed.

Clients should be urged to report even mild signs and symptoms to their healthcare workers.

Some people with STIs, especially women, may not have any signs or symptoms, so testing is the only way to know for sure.

In addition to increasing the risk for other infections, possible dangers from untreated STIs include

- infertility,
- cancer, and
- miscarriages, premature births, and birth defects.

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Safer Sex Practices

Safer sex practices are ways to eliminate or reduce the risk of transmitting HIV or other STIs through sexual contact.

While a focus of safer sex practices is on reducing the risk of transmitting HIV to negative partners, it is also critical for protecting the health of PLHIV from HIV reinfection or infection with other STIs.

Viral load is one of the most important factors in HIV transmission. One of the reasons Zambia decided to start all HIV-positive individuals on cART early was to significantly reduce the risk of HIV transmission (Directorate of Clinical Care and Diagnostic Services, 2016).

Other factors that can reduce overall risk of sexual transmission of HIV include

- delaying sexual debut,
- reducing number of sexual partners,

- being in a monogamous relationship (only one partner), where both partners know their own status for HIV and other STIs and that of their partner, both partners agree on and consistently use safer sex practices and neither partner has sex outside that relationship,
- male circumcision – circumcised men are less likely to get HIV from HIV-positive partners,
- prompt diagnosis and treatment of other STIs,
- substituting higher risk activities with non-insertive activities, such as hugging, massaging, dry rubbing, or masturbation, and
- disclosing HIV status to partners to facilitate open discussion and agreement on safer sex practices.

Reducing Risk of HIV Transmission through Vaginal and Anal Sex

Strategies for reducing the risk of HIV transmission through vaginal and anal sex include

- adhering to ARV drugs to achieve viral suppression,
- consistently and correctly using condoms,
- not reusing condoms,
- using appropriate lubrication, and
- male circumcision (reduces risk for insertive partner, but not receptive partner).

Reducing Risk of HIV Transmission through Oral Sex

Strategies for reducing the risk of HIV transmission through oral sex include

- adhering to ARV drugs to achieve viral suppression,
- using male condoms for oral sex on males or dental dams for oral sex on females,
- ejaculating outside of the mouth, and
- abstaining from performing oral sex in the presence of open sores or cuts in the mouth.

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Male Condoms

Male condoms are a thin covering worn on the penis during sex to reduce the risk of STI transmission and pregnancy.

Male condoms are made of latex, polyurethane, or natural membrane. Only latex or polyurethane condoms block HIV and other STIs. Latex condoms provide the best protection against HIV. Polyurethane condoms are an option for people with latex allergies but do break more often than latex.

Using an appropriate lubricant with a male condom can reduce the risk that the condom will break or slip. Water or silicone-based lubricants can be used with both latex and polyurethane condoms. Oil-based lubricants can be used with polyurethane condoms, but not latex condoms as they can cause them to break.

Steps for Correct Use of Male Condoms	
1	The condom should be put on after the penis becomes hard (erect) and before any genital contact.
2	Always use a new condom every time you have penetrative sex.
3	Check the packet – including the date on the condom. If the packet is ripped or damaged in any way, or if the use-by date has passed, use a new condom.
4	Tear open the condom packet and remove the condom. Do not use your teeth to open the packet, and be careful of long nails or jewelry damaging the condom.
5	Check which side rolls down and then hold the tip of the condom between your finger and thumb to leave space at the tip to collect semen.
6	With your other hand, put the condom on the end of the penis and unroll it down the length by pushing down the round rim of the condom.
7	When the rim of the condom is at the base of penis (near the pubic hair) penetration can begin.
8	After ejaculation, withdraw the penis while it is still hard, holding the bottom rim of the condom to prevent it from slipping off the penis.
9	Do not let the penis go soft inside your partner because the condom may slip off and spill semen in or near the vagina.
10	Slide the condom off the penis and tie a knot to prevent semen from escaping.
11	Wrap the used condom in waste paper before disposing of it safely in a trash bin (preferably one with a closed lid).
(Ministry of Community Development Mother and Child Health, 2014)	

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Female Condoms

Female condoms are a pouch that is inserted in the vagina during sex to reduce the risk of STI transmission and pregnancy.

Female condoms are made of polyurethane, which means any type of lubricant can be used with them.

Female condoms have some unique features male condoms do not, including they

- can be worn up to eight hours before sexual intercourse,
- do not require that the male have a full erection to be effective,
- can be relubricated, and
- conduct body heat better so may feel more natural to the male partner.

Steps for Correct Use of Female Condoms	
1	The condom can be inserted up to eight hours before sex or immediately beforehand.
2	Check the packet – including the date on the condom. If the packet is ripped or damaged in any way, or if the use-by date has passed, use a new condom.
3	Tear open the condom packet and remove the condom. Do not use your teeth to open the packet, and be careful of long nails or jewelry damaging the condom.
4	The condom has two plastic rings – a loose, smaller inner ring at the closed end, which is inserted into the vagina; and a firm, larger ring at the open end which stays outside the vagina.
5	Hold the condom by the inner ring (closed end) and squeeze it between your thumb and middle fingers to make a figure 8.
6	Find a comfortable position – either squatting, lying down, or with one foot on a chair – and insert the inner ring into the vagina.
7	Put your index finger inside the condom and push the inner ring up inside your vagina. The condom is in place when you can feel the inner ring pushing against your cervix – your cervix feels like the tip of your nose.
9	When your partner penetrates, you may need to guide his penis into the condom – the outer ring should remain flat against your vagina, and you should not be able to feel the condom during sexual intercourse.
10	Your partner does not need to remove his penis immediately after ejaculation – the condom can be removed when you are both ready.
11	To remove the condom, twist the outer ring (to keep the semen inside), and gently pull the condom from the vagina.
12	Wrap the used condom in waste paper before disposing of it safely in a trash bin (preferably one with a closed lid).
(Ministry of Community Development Mother and Child Health, 2014)	

Other tips for using condoms include

- never using more than one condom at a time (e.g., not using two male condoms at once, or using a male and female condom at the same time), as that can increase friction which can cause condom breakage, and
- storing them in a cool, dry place.

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Safer Sex Negotiation

Barriers to Safer Sex Practices

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Negotiating Safer Sex Scenarios	
Scenario	**Negotiation Strategies**
1. You are a 15-year-old young woman who is being pressured by your 15-year-old boyfriend to have sexual intercourse. You are not ready to take that step yet, but do want to try to maintain the relationship.	
2. You are a 17-year-old young woman in a relationship with a 19-year-old young man who does not like the way male condoms feel and refuses to use them. You want to use condoms for both infection and pregnancy prevention.	

Other recommendations related to safer sex negotiation are as follows:

- Consider that, if you are not ready to talk to a partner about safer sex practices, you may not be ready to have sex with that person or at all.
- Do not wait to have the conversation about safer sex right before you start having it – introduce the conversation ahead of time.
- Be clear about your boundaries and state them in a clear and firm manner, avoiding language that is open to interpretation (e.g., saying "I'd prefer to use condoms" may make it seem like you are willing to NOT use them while "I will not have sex without a condom" is very clear).
- Do not make it all negative, but also talk about what you ARE willing to do (e.g., "While I am not willing to have sex without a condom, I am willing to give you pleasure with my hand.").
- Suggest trying female condoms, as many males who do not like male condoms because of how they feel do not have the same issue with female condoms.
- Use of drugs and alcohol can impair good decision-making and interfere with using condoms correctly.

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Family Planning

Family planning involves choosing the number of children desired, planning when to have them, and using appropriate contraceptives to prevent unplanned pregnancies.

Research has highlighted many benefits of family planning (Smith, Ashford, Gribble, & Clifton, 2009), as follows:

- Spacing births at least two years apart is healthiest for the mother, the infant, and other children.
- The health of the woman is protected, reducing maternal mortality due to pregnancy-related health risks and the demand for unsafe abortions.
- The health and well-being of the infant and other children in the family are protected, and infant mortality related to closely spaced and ill-timed pregnancies is reduced.
- Greater educational and employment opportunities (especially for girls) become available, as do higher investments and savings and reduced public expenditures for education, health, and other social services.

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Types of Contraceptives Available in Zambia		
Type	**Description**	**STI Protection**
Oral contraceptives	Pills which are highly effective when taken as prescribed and are effective within 24 hours. They must be taken daily to be effective.	NO
Injectables	Shots which are highly effective and provide protection against pregnancy for 2-3 months.	NO
Implants	Small matchstick-size rods which are highly effective and provide protection against pregnancy for 5 years. They require a minor surgical procedure for insertion and removal.	NO
Intrauterine devices (IUDs)	Small T-shaped devices inserted into the uterus which are highly effective and provide protection against pregnancy for up to 10 years. They must be inserted and removed by trained health care workers in settings with infection prevention procedures.	NO
Sterilisation	A surgical procedure that provides permanent protection against pregnancy and is considered irreversible. In males it is called a *vasectomy* and involves cutting or blocking the tubes which release sperm into the semen. In females it is called *tubal ligation* and involves blocking the tubes which carry eggs from the ovaries to the uterus.	NO
Emergency contraceptive pills (ECP)	Oral contraceptives that can be used to prevent pregnancy following unprotected sexual intercourse. They are only effective when used within 72 hours following unprotected sex.	NO
Condoms	Male and female condoms which are highly effective when used consistently and correctly.	YES
Dual protection	Use of male or female condom in addition to another modern form of contraception.	YES
Natural family planning	People who reject modern contraceptives (for example due to cultural or religious beliefs) may be trained in natural family planning methods, which vary in their effectiveness.	NO
(Republic of Zambia Ministry of Health, 2006)		

Women living with HIV have special needs related to contraception and planning pregnancies in order for both mother and infant to be as safe as possible, thus family planning is even more important for them.

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Session 7: Stigma and Discrimination

Total Session Time: 1 hour

OBJECTIVES:

By the end of the session participants will be able to

- explain the difference between stigma and discrimination,
- discuss different types of stigma and its potential effects, and
- identify strategies to address stigma and discrimination.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Stigma and Discrimination	55 min

LEARNING ACTIVITIES

Stigma and Discrimination

Stigma is seeing someone negatively due to a real or perceived difference, and discrimination is denying someone opportunities based on some attribute (Oxford Living Dictionaries).

UNAIDS definitions of HIV-related stigma and discrimination (UNAIDS, 2003) include the following:

- HIV-related stigma can be described as a ”process of devaluation” of people either living with or associated with HIV. This stigma often stems from the underlying stigmatisation of sex and intravenous drug use – two of the primary routes of HIV infection.
- Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma and discrimination breach fundamental human rights and can occur at a number of different levels, including political, economic, social, psychological, and institutional.
- When stigma exists people often prefer to ignore their real or possible HIV status. This can lead to the risk of faster disease progression for themselves and also to the risk of them spreading HIV to others.

Common underlying causes of stigma in sub-Saharan Africa (Ogden & Nyblade, 2005) include

- lack of understanding of how HIV is transmitted combined with fear of death and disease, which helps perpetuate beliefs in casual transmission, which results in avoidance of those with HIV,

- prevailing sexual norms, combined with knowledge that HIV can be transmitted sexually, which leads to perceptions that those with HIV have behaved "improperly," and
- lack of recognition of stigma in general and words or actions that can be stigmatising.

The main forms of stigma are

- physical and social isolation from family, friends, and community,
- shaming and blaming, and
- depriving people of their rights.

Stigma can also include

- self-stigma when people blame and isolate themselves, and
- stigma by association when the family and friends of PLHIV are stigmatised.

Possible effects of stigma can include

- discrimination which results in loss, including rights, freedoms, housing, schooling, employment, and support,
- reduced likelihood of people learning their HIV status or seeking treatment,
- poor adherence, as PLHIV may be afraid to take ARV drugs in certain settings for fear of exposing their HIV status,
- fear of sharing status and insisting on safer sex practices, which increases risk of HIV transmission and the risk of HIV reinfection and/or infection with other STIs, and
- shame, denial, self-isolation, neglect, loss of hope, depression, alcoholism, self-rejection, anger, and/or violence.

Some strategies for combating stigma (Kidd & Clay, 2010) are as follows:

- Create a sense of community and build openness and safety to talk about HIV and AIDS, stigma, sex, injecting drug use, and death.
- Name the problem: get people to describe how stigma occurs in different contexts.
- Help people read and reflect on their own words, attitudes, and actions towards PLHIV.
- Help people see the effects of stigma on PLHIV, their families, children, and communities – how it directly hurts those stigmatised and indirectly hurts those who are stigmatising.
- Address fears and misconceptions about getting HIV through casual contact.
- Help PLHIV overcome self-stigma, and build up self-esteem and skills to provide leadership on anti-stigma action.
- Help family members learn the attitudes and skills to provide support and care for PLHIV and children living with HIV.

Notes: _____

Session 8: Disclosure

Total Session Time: 2 hours

OBJECTIVES:

By the end of the session participants will be able to

- define disclosure,
- discuss benefits and risks of disclosing,
- discuss aspects to consider when preparing to disclose, and
- practice supporting a client with disclosure preparation.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
HIV Disclosure	55 min
Supporting Disclosure	60 min

LEARNING ACTIVITIES

HIV Disclosure

Disclosure in the context of HIV means sharing one's HIV status with someone.

Disclosure

- should always be voluntary,
- is a process, not a one-time event, and
- can have many benefits, but also has some risks that need to be considered.

Properly preparing for disclosure gives a person a chance to think about what to say and how to say it and plan for possible reactions.

Barriers to Disclosure

Disclosure Benefits and Risks	
Benefits	**Risks**

Notes: _____

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Supporting Disclosure

When exploring the question of disclosure it can be helpful to use a framework of questions that can guide the discussion, such as

- Who – Who do you want to tell about your HIV status, or who do you think needs to know?
- What – What do you want to say, and what level of detail are you comfortable sharing?
- Why – Why are you telling this person, and what do you hope to achieve or gain?
- When – When would be the best time to have this conversation?
- Where – Where would be a safe and comfortable place to have the conversation?
- How – How do you think this person will respond? How prepared are you to answer questions that may come up?

General tips for disclosure include

- keeping it simple and not over-explaining when you start,
- giving the person a chance to ask questions,
- testing the waters first by asking the person about an HIV-related topic in the news to gauge the person's reaction to the topic, and
- being prepared for any reaction.

Notes: _____

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Session 9: Healthy Living

Total Session Time: 4 hours and 20 minutes

OBJECTIVES:

By the end of the session participants will be able to

- discuss the dimensions of healthy living,
- identify actions PLHIV can take to protect their physical health,
- identify warning signs of possible mental health issues and suicidal thoughts,
- discuss issues related to grief and bereavement,
- discuss issues related to safety, including gender-based violence,
- discuss risks associated with drug and alcohol abuse for PLHIV,
- identify referral resources for healthy living services, and
- use self-reflection activity to assess their own healthy living practices.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Healthy Living	30 min
Protecting Physical Health	80 min
Fostering Mental Health	60 min
Promoting Safety	40 min
Addressing Substance Abuse	30 min
Healthy Living Assessment	15 min

LEARNING ACTIVITIES

Healthy Living

The World Health Organization (2017) defines healthy living as a dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity.

Promoting Healthy Living			
Physical	**Mental**	**Spiritual**	**Social**

Notes: _____

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Protecting Physical Health

In addition to general population recommendations for protecting physical health, PLHIV have some additional factors they should consider.

Health Considerations for PLHIV

Nutrition is a very important topic for PLHIV, and research conducted in Zambia found that malnutrition among PLHIV was much higher than in the general population (Republic of Zambia Ministry of Health, 2011).

Malnutrition means not getting enough nutrients, while undernutrition means not getting enough food.

The relationship between HIV and malnutrition can be a vicious cycle, as malnutrition can weaken the immune system. This can worsen the effects of HIV, including susceptibility to OIs, which can further increase the likelihood of malnutrition. PLHIV also have an increased risk of malnutrition because they may not eat enough, and even when they do, they may not absorb or utlise the nutrients as well (World Health Organizaton, Food and Agriculture Organization of the United Nations, 2002).

Good Nutrition for PLHIV	
Challenges	**Benefits**

The nutrients the body needs to function are

- water,
- carbohydrates,
- proteins,
- fats,
- vitamins, and
- minerals.

Carbohydrates, proteins, and fats are needed in large amounts, and are referred to as *macronutrients*. Vitamins and minerals are needed in smaller amounts, and are referred to as *micronutrients*.

Recommendations from the Ministry of Health (Republic of Zambia Ministry of Health, 2011) for insuring adequate nutrient and energy intake for PLHIV include

- eating smaller meals more frequently throughout the day, and not skipping meals,

- eating a variety of foods at every meal to get the necessary nutrients,
- eating meals that contain a staple food, such as nshima (a thick porridge made from maize meal), potatoes, rice, cassava, or sweet potatoes; meat, fish, beans, or kapenta (dried fish); vegetables such as ibondwe (amaranthus), sweet potato leaves, or cassava leaves; and fruits in season, such as mangoes, guavas, pawpaw, masuku (a wild fruit), apples, and oranges,
- eating snacks of fruit, cooked or roasted groundnuts or porridge at least twice a day to increase energy and nutrient intake,
- eating fermented foods, such as maheu, chibwantu, munkoyo, sour milk, or yoghurt, to prevent the growth of diarrhoea-causing germs,
- eating germinated foods to activate proteins and essential fatty acids, and
- eating fortified foods, such as vitamin A-fortified household sugar and iodised salt to improve micronutrient intake.

In addition to eating well, it is important to drink plenty of clean water and to practice food safety, which includes

- washing hands before preparing or eating food,
- keeping food-preparation tools and storage areas clean,
- keeping raw and cooked foods separate,
- not eating mouldy or rotten fruits and vegetables, and not buying cracked eggs or meat or fish with past sell-by dates,
- not eating raw or undercooked eggs, meat, or fish, and
- reheating previously cooked foods thoroughly.

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Fostering Mental Health

The World Health Organization (2017) defines mental health as a state of well-being in which every individual realises his/her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her/his community.

Everyone struggles with emotions at times and can have periods where they are grieving a loss or feeling depressed or anxious, but when those periods become prolonged or the feelings become severe, it is important that the person be referred to a health care worker so he/she can be properly assessed.

PLHIV may be more likely to experience serious depression or anxiety and YPLHIV may be at an even greater risk, as many common mental health issues like depression and anxiety do not present in people until they enter adolescence.

Signs and symptoms that may indicate the presence of a mental health issue (Duffy, Bergmann, & Sharer, 2014) include

- flat affect,
- dramatic changes in appearance and self-care patterns,
- irritability,
- behavioral problems,
- difficulty concentrating,
- difficulty sleeping,
- decreased socialization with peers and others, and
- poor school performance.

Another common emotion PLHIV may be dealing with is grief or bereavement, which is the emotional suffering felt when someone or something important is lost. This could include the death of someone close to them, or the loss of the life they knew before they learned they have HIV.

Common emotions experienced during the grieving process (Kubler-Ross, 2005) include

- denial,
- anger,
- bargaining,
- depression, and
- acceptance.

Severe emotional suffering can cause people to consider suicide as a way to escape their pain and distress. Signs that can indicate someone may be considering suicide (U.S. Department of Health and Human Services, 2017) include

- talking about wanting to die or to kill oneself,
- looking for a way to kill oneself,
- talking about feeling hopeless or having no reason to live,
- talking about feeling trapped or in unbearable pain,
- talking about being a burden to others,
- increasing the use of alcohol or drugs,
- acting anxious or agitated or behaving recklessly,
- sleeping too little or too much,
- withdrawing or feeling isolated,
- showing rage or talking about seeking revenge, and
- displaying extreme mood swings.

The role of the YPM is not to try to diagnose a client as having a mental health issue or being suicidal, but to notice changes in a client's mood or behavior that could indicate the presence of a mental health issue that needs professional support.

Here are three questions YPMs can ask if they are concerned a client might be thinking of hurting or killing himself or herself.

- Are you thinking of hurting/killing yourself?
- Do you have a plan?
- Do you have a way to carry out the plan?

While YPMs should refer all clients who exhibit any mood or behavior changes anyone who answers yes to any of the three questions needs to be referred immediately and not left alone.

Actions that can help someone dealing with emotional or mental health issues can include

- individual and family counselling,
- medications which can help manage symptoms,
- lifestyle changes like diet and exercise,
- talking to trusted listeners like YPMs,
- attending support groups, and
- helping others.

Notes: _____

Promoting Safety

Three main categories of violence are

- physical (e.g., slapping, hitting, kicking, beating),
- emotional (e.g., intimidation, constant belittling, humiliation), and
- sexual (e.g., forced intercourse, other forms of sexual coercion).

Consequences of violence for people in general can include

- poorer physical and mental health,
- risk for re-victimisation,
- higher likelihood of depression, aggression, and/or alcohol abuse,
- lower likelihood of undertaking safe sexual practices, and
- lower likelihood of completing school.

Factors that may make some groups more vulnerable to violence include

- age,
- gender,
- stigma associated with some health conditions like HIV,
- socio-economic status, and
- cultural norms.

Gender-Based Violence

Sex is a term for sexual intercourse. It also refers to the biological differences between males and females. For example, a female has a vagina and a male has a penis.

Gender refers to the roles and behaviors that society views as appropriate for males and females.

Gender-based violence refers to any form of harm directed at an individual because of his/her biological sex or gender identity.

Vulnerable Populations

Youth, in general, may have a higher risk of experiencing gender-based or other forms of violence (e.g. violence from a parent/caregiver).

PLHIV may be at higher risk of experiencing gender-based or other forms of violence than the general population because

- HIV stigma is strong and violence is used to blame a person for having the disease,
- violence can happen as an immediate reaction to HIV disclosure, or
- HIV infection can make an individual weak, leaving the person more vulnerable to violence.

In addition to the general consequences of violence, PLHIV may also experience

- poorer adherence to antiretroviral therapy, and
- lower CD4 count.

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Addressing Substance Abuse

Abusing drugs or alcohol is not a healthy living practice for anyone, but PLHIV may be more likely to experience negative effects, especially once they are on ARV drugs, which can include

- toxic reactions causing sickness and even death,
- reduced level of ARV drugs in the blood, which can inhibit viral suppression and lead to resistance and treatment failure,
- increased damage to liver and kidneys, which have to process ARV drugs and alcohol or drugs, and
- reduced likelihood of using safer sex practices at all or using them correctly.

Alcohol use has also been linked to poorer rates of adherence, including one study which found that youth who reported alcohol use in the previous month were significantly more likely to have a 48-hour treatment gap than their peers who did not consume alcohol (Denison, et al., Factors Related to Incomplete Adherence to Antiretroviral Therapy among Adolescents Attending three HIV Clinics in the Copperbelt, Zambia, n.d.)

Signs and symptoms that could indicate that someone has a substance abuse problem may include

- feeling a need to use the substance regularly or to manage situations or feelings, and failing in attempts to stop using,
- devoting a lot of time to thinking about and planning how to get the substance,
- spending money budgeted for necessities like food on the substance,
- doing things outside of normal behaviour to obtain the substance, such as stealing or trading sex,
- taking risks, such as driving under the influence of the substance,
- neglecting responsibilities, such as chores or homework, and relationships with family and friends, and
- passing out or not remembering things you have done when under the influence of the substance.

Adolescent Drug and Alcohol Abuse	
Risk Factors	**Strategies**

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Session 10: Effective Communication

Total Session Time: 4 hours and 20 minutes

OBJECTIVES:

By the end of the session participants will be able to

- discuss the two dimensions of communication,
- describe aspects of verbal and nonverbal communication and ways to improve them,
- identify common communication barriers and strategies for addressing them,
- discuss common communication tools and when and how to use them, and
- practice using effective communication skills during a role play.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Dimensions of Communication	55 min
Communication Barriers	20 min
Communication Tools	180 min

LEARNING ACTIVITIES

Dimensions of Communication

Face-to-face communication involves both *verbal* and *nonverbal* dimensions.

Verbal Communication Involves	Nonverbal Communication Involves

Research has shown that when communication is about feelings and attitudes, nonverbal communication is more important than verbal, especially if the messages are inconsistent (Merabain & Ferris, 1967).

Communication is not just about speaking, as it also involves how a message is received and then interpreted by the other person. Factors that can influence how a message is received and/or interpreted can include

- inconsistencies in verbal and nonverbal messages,
- level of knowledge on the topic.
- beliefs or opinions about the topic or the speaker,
- previous experiences, and
- emotional reaction to the topic or speaker.

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Communication Barriers

Communication barriers are things that get in the way of effective communication.

Barriers to Effective Communication	
Barriers	**Strategies**

Notes: _____

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Communication Tools

In addition to attending to our verbal and nonverbal messages, there are other tools we can use to make our communication more effective, including

- active listening,
- questioning,
- paraphrasing,
- reframing,
- normalising statements,
- "I" statements,
- summarising, and
- feedback.

Active Listening

Active listening is a way to show the person speaking that you are interested in what he or she is saying and want to understand what the person means by using verbal and nonverbal cues to demonstrate interest, such as saying "uh huh" or nodding.

It also involves paying close attention to what the other person is saying, both verbally and nonverbally, and not just focusing on your response.

Active listening can include asking clarifying questions and rephrasing what the person said to ensure understanding. It can also include mirroring the speaker's body language. For example, leaning in towards the speaker when the speaker is leaning in.

Questioning

Questioning is a way to gain information from and understanding of another person. Questions can be closed- or open-ended.

Closed-ended questions can be answered with a one-word answer, including "Yes" or "No" and are useful when specific information is needed. For example, "Did you take your pills today?"

Open-ended questions require more of a response and are useful when you want more information. For example, "How did you feel after disclosing to your friend?"

Open-Ended Questions

Paraphrasing

Paraphrasing is using your own words to repeat back to a speaker what you understand the speaker to be saying, and is useful in avoiding conflicts which can arise when assumptions are made. Paraphrasing can make the speaker feel listened to and validated. For example, "So what I think I heard you say was that you feel your best friend may reject you if you disclose your status – is that right?"

Reframing

Reframing is looking at an experience, event, or emotion in another way, often to find an alternative or more positive interpretation, and can be useful when someone feels stuck and cannot see past a situation or emotion. For example, "You've said that you don't think your mother trusts you because she holds on to your medication. That's one way of looking at it. What might be another way?"

Normalising Statements

A normalising statement is one that creates a space for the person to feel that he or she is not alone in his/her actions, thoughts, or beliefs, and can be useful when someone feels his or her reactions, emotions, circumstances, etc. are bad or wrong or completely different from anyone else's. For example, "Many people feel anger when they lose someone they love – it's a normal part of the grieving process."

"I" Statements

"I" statements provide a way to take responsibility for one's personal opinions, experiences, or thoughts, and can be useful in diffusing situations where someone is feeling blamed or attacked.

Using an "I" statement is also a way of acknowledging similar experiences or expressing empathy without presuming to know exactly how the other person feels. For example, "I feel like you're avoiding the subject."

"I" Statements	
Statement	**"I" Statement**
You are really frustrating me because we've talked so much about the importance of adherence and you still keep missing doses.	
I know exactly how you feel!	
You let me down when you didn't show up for our appointment – why did you skip it?	

Summarisation

Summarisation is a way to bring together the points of what has been discussed in order to confirm understanding. It can also be useful before moving into problem-solving an issue that is being shared, or to close a session. For example, "So, today we've focused on brainstorming ways you can remember to take your pills, and you've decided you'd like to try setting alarms on your phone this week. If that doesn't work, you'll ask your cousin if she can also set an alarm to help support you."

Feedback

Feedback is an observation communicated from one person to another and can be positive or negative. When done skillfully, feedback can be very constructive, and when done poorly it can be very destructive.

Feedback is also useful in giving a person a different viewpoint so that he or she can make corrections, improvements, or decisions. For example, "I know you've shared you really want to take on more self-management of your treatment, but when you skip doses the way you've been doing, it makes it hard for your caregiver and health care team to feel you're ready for that."

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Session 11: Mentoring Skills

Total Session Time: 4 hours and 40 minutes

OBJECTIVES:

By the end of the session participants will be able to

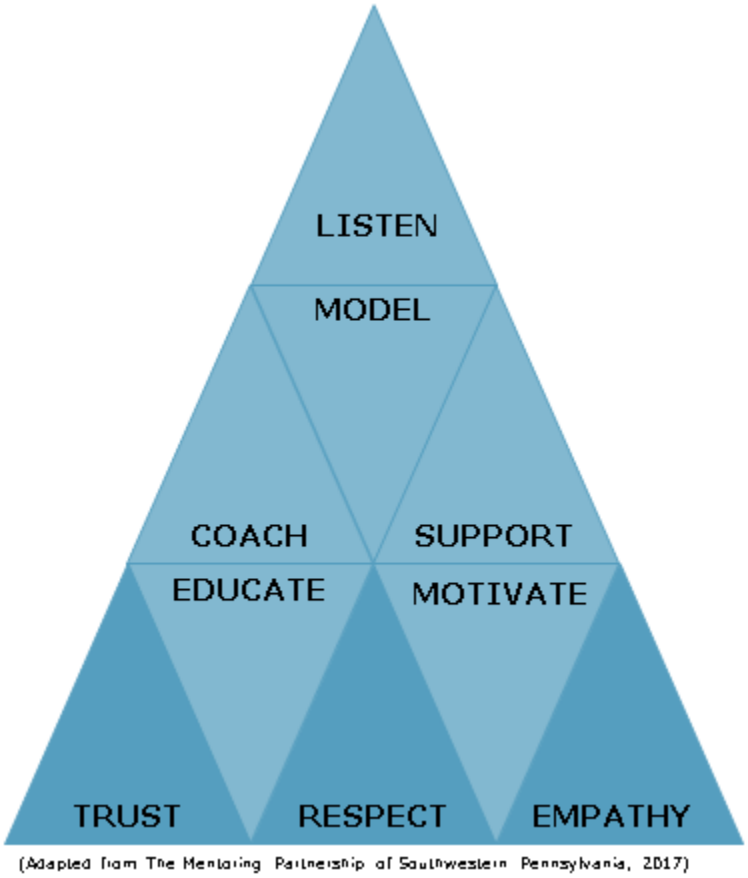
- discuss the peer mentoring framework,
- give examples of ways YPMs can demonstrate peer mentoring activities, and
- describe developmental needs of adolescent clients.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Peer Mentoring Framework	220 min
Mentoring Adolescents	55 min

LEARNING ACTIVITIES

Peer Mentoring Framework



(Adapted from The Mentoring Partnership of Southwestern Pennsylvania, 2017)

Listen

Model

Coach

Support

Educate

Motivate

Trust

Respect

Empathy

Mentoring relationships will go through several steps over time (The Mentoring Partnership of Southwestern Pennsylvania, 2017), including the following:

- **Building** the relationship – initial meetings are important for establishing trust and boundaries and learning about the client and his/her needs.
- **Enhancing** the relationship – as the relationship develops, the focus can shift towards setting goals and problem-solving challenges the client has identified.
- **Sustaining** the relationship – can be a challenge after the newness of the meetings has worn off and may require resetting expectations for the meetings or establishing new boundaries.
- **Transitioning** the relationship – at the conclusion of the project period, clients need to be prepared to transition out of meetings or into more limited ones, which may involve finding other resources to continue supporting unmet needs.

Special Needs of Adolescent Clients

The World Health Organization defines adolescents as people between 10 and 19 years of age (United Nations General Assembly, 1989). It is one of the most rapid phases of human development and is characterized by a period of tremendous physical, emotional, and social change and growth.

Adolescents are not all alike and the needs of two adolescents of the same age could vary widely based factors, such as their

- stage of development,
- gender,
- home and family situation,
- educational level, and
- relationship status.

Common Adolescent Challenges

Common YPLHIV Challenges

Notes: _____

Session 12: Facilitating Client Meetings

Total Session Time: 15 hours and 20 minutes

OBJECTIVES:

By the end of the session participants will be able to

- discuss elements of client meetings,
- identify tools used in each client meeting,
- participate in a client meeting demonstration,
- practice facilitating client meetings, and
- practice completing meeting tools.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Introduction to Client Meetings	25 min
Facilitating Client Meetings	890 min

LEARNING ACTIVITIES

Introduction to Client Meetings

One of the core Project YES interventions is one-on-one meetings between clients and YPMs. These meetings will be guided by an outline that provides some structure for the YPM, while still providing enough flexibility to meet the needs of the client.

Client Meetings	
Meeting	**Notes**
Orientation Meeting	
1st Creating a Life you Love	
2nd Healthy Living	

3rd – 5th Preparing for Safer Sex and Healthy Babies	
3rd – 5th Dealing with Stigma and Preparing for Disclosure	
3rd – 5th Healing From Loss & Grief	
6th Closure and Transition	

Notes: _____

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Facilitating Client Meetings

Client Meetings	
Meeting	**Notes**
Orientation Meeting Demo	

Orientation Role Plays	
1st Client Meeting Demo	
1st Client Meeting Role Play	
2nd Client Meeting Demo	
2nd Client Meeting Role Play	
3rd Client Meeting Demo	

3rd Client Meeting Role Play	
4th Client Meeting Demo	
4th Client Meeting Role Play	
5th Client Meeting Demo	
5th Client Meeting Role Play	
6th Client Meeting Demo	

6th Client Meeting Role Play	

Notes: _____

Session 13: Facilitating Youth Group Meetings

Total Session Time: 3 hours and 35 minutes

OBJECTIVES:

By the end of the session participants will be able to

- discuss elements of a youth group meeting,
- identify tools used in youth group meetings, and
- participate in a youth group meeting demonstration.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Introduction to Youth Group Meetings	30 min
Facilitating Youth Group Meetings	180 min

LEARNING ACTIVITIES

Introduction to Youth Group Meetings

Another core Project YES intervention is youth group meetings facilitated by YPMs that are open to all clients at that facility.

For the purpose of this project, youth group meetings are intended to provide clients with information and emotional support and will be

- closed, meaning only those invited may attend,
- ~90 minutes in duration, and
- co-facilitated by YPMs utilising guest speaker subject matter experts when needed.

These meetings will also be guided by an outline that provides some structure for the YPM, while still providing enough flexibility to meet the needs of the clients.

Youth Group Meetings	
Meeting	**Notes**
1st Getting Started	

2nd HIV & AIDS Basics	
3rd Flourishing with HIV	
4th Sexual Reproductive Health	
5th Stigma, Discrimination & Disclosure	
6th Closure and Transition	

Support Group Facilitation	
Challenges	**Strategies**

Notes: _____

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Facilitating Youth Group Meetings

Client Meetings	
Meeting	**Notes**
1st Getting Started Demo	
2nd HIV & AIDS Basics Review	
3rd Flourishing with HIV Review	
4th Sexual Reproductive Health Review	
5th Stigma, Discrimination & Disclosure Review	

6th Closure and Transition Review	

Notes: _____

Session 14: Practicum

Total Session Time: 7 hours and 45 minutes

OBJECTIVES:

By the end of the session participants will be able to

- practice planning and facilitating a youth group meeting,
- practice facilitating a client meeting, and
- practice completing client and youth group meeting tools.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Youth Group Meetings	250 min
Client Meetings	2 min

LEARNING ACTIVITIES

Youth Group Meetings

Notes: _____

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Client Meetings

Notes: _____

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Session 15: Project Partners and Resources

Total Session Time: 1 hour

OBJECTIVES:

By the end of the session participants will be able to

- describe roles and responsibilities of team members, and
- discuss available services in the health facility and community.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Health Care Teams	25 min
Community Services	30 min

LEARNING ACTIVITIES

Health Care Teams

Health Care Team Members	
Team Member	**Roles and Responsibilities**
Physicians	
Clinical Officers	
Nurses	
Counsellors	
Pharmacists	
Nutritionists	

Notes: _____

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Community Resources

Notes: _____

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Session 16: Closing

Total Session Time: 2 hours and 20 minutes

OBJECTIVES:

By the end of the session participants will be able to

- obtain follow-up measurement of knowledge on HIV-related topics,
- provide feedback on the training course, and
- obtain certificates of completion.

SESSION OVERVIEW

Learning Activity	Time
Session Overview	5 min
Knowledge Assessment Post-Test	30 min
Training Course Evaluation	15 min
Coming to Closure	30 min
Graduation	40 min

LEARNING ACTIVITIES

Coming to Closure

Notes: _____

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Appendix

Session 11: Stages of Adolescent Development

Stages of Adolescent Development			
Category	**EARLY 10-15 years**	**MIDDLE 14-17 years**	**LATE 16-19 years**
Physical Growth	• Secondary sexual characteristics appear • Rapid growth reaches a peak	• Secondary sexual characteristics advance • Growth slows down • Has reached approximately 95% of adult growth	• Physically mature
Cognition	• Uses concrete thinking ("here and now") • Does not understand how a present action affects the future	• Thinking can be more abstract (theoretical) but goes back to concrete thinking under stress • Better understands results of own actions • Very self-absorbed	• Most thinking is now abstract • Plans for the future • Understands how choices and decisions have an effect on the future
Psychological and Social	• Spends time thinking about rapid physical growth and body image (how seen by others) • Frequent changes in mood	• Develops body image • Thinks a lot about impractical or impossible dreams • Feels very powerful • Experiments with sex, drugs, risks, etc.	• Plans and follows long term goals • Usually comfortable with own body image • Understands right from wrong (morally and ethically)
Family	• Struggles with rules related to independence • Argues and is disobedient	• Argues with people in authority	• Moving from a child-parent/guardian relationship to a more equal adult-adult relationship
Peer Group	• Important for self-development • Intense friendships with same sex • Contact with opposite sex in groups	• Strong peer friendships • Peer group most important and determines behaviour	• Decisions/values less influenced by peers than by individual friendships • Selection of partner based on individual choice rather than what others think
Sexuality	• Self-exploration and evaluation	• Forms stable relationships	• Mutual and balanced sexual relations
(Adapted from World Health Organization, 2017)			

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