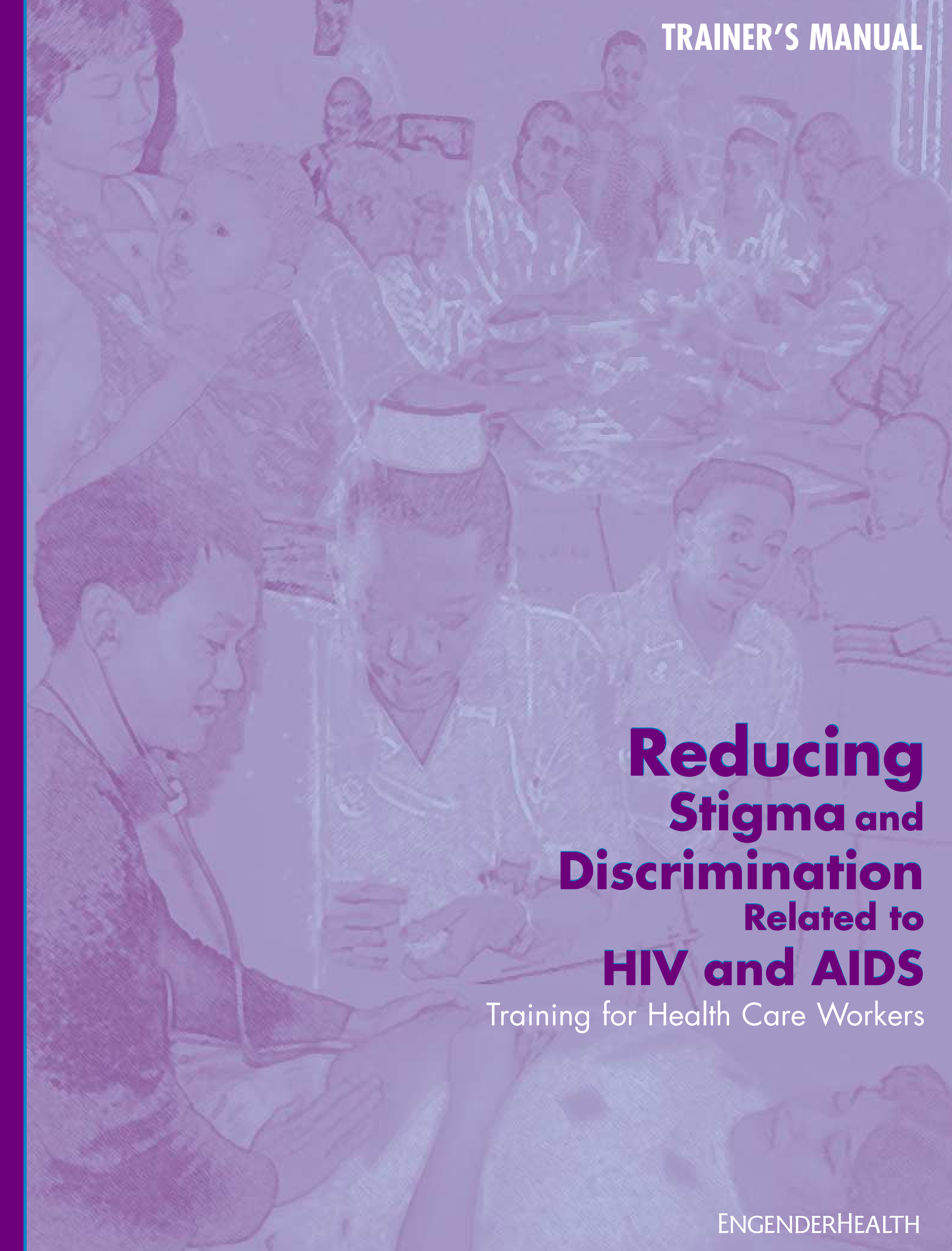

TRAINER'S MANUAL

Reducing Stigma and Discrimination Related to HIV and AIDS

Training for Health Care Workers

EngenderHealth

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Training for Health Care Workers

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This publication was made possible, in part, through support provided by the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement HRN-A-00-98-00042-00 and The William and Flora Hewlett Foundation. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID or the Hewlett Foundation.

Design and typesetting: Virginia Taddoni
Cover design: Virginia Taddoni
Cover photo credits: Cathryn Wilcox/CCP, J. Fortin, CGP (Photos courtesy of Photoshare, a service of The INFO Project.), Asiwa Obishai, Peter Twyman
Illustrations: Petra Röhr-Rouendaal
Printing: Printech Business Systems

ISBN 1-885063-42-3

Printed in the United States of America. Printed on recycled paper.

Library of Congress Cataloging-in-Publication data are available from the publisher.

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Acknowledgments

EngenderHealth would like to thank the following staff and consultants for their contribution to the development, field testing and publication of this manual: Betty Farrell, Isaiah Ndong, Peter Twyman, Julie Becker, Amy Shire, Fabio Saini, Damien Wohlfahrt, Jill Tabbutt-Henry, Levent Catagay, B.P. Singh, Joseph Ruminjo, Jean Ahlborg, Asiwa Obishai, Mofoluke Shobowale, Karen Landovitz, Anna Kurica, Maaza Seyoum, Tewodros Gebremichael, Antigoni Koumpounis, Wuleta Betemariam, Paul Perchal, Elan Shultz, Georgia Holt, Benjamin Weil, and Mark Barone.

Introduction

Background

Stigma and discrimination related to HIV and AIDS are a persistent problem in many health care facilities around the world, particularly in those countries hardest hit by the epidemic. Stigma and discrimination result in poor quality of care for those who are infected or ill (or suspected of being infected), frighten away potential clients in need of HIV-related and other services from seeking care, and undermine prevention efforts by limiting access and service utilization. There is a growing body of evidence suggesting that stigma and discrimination in health care settings have contributed to the limited uptake of HIV services such as voluntary counseling and testing (VCT) and programs for the prevention of mother-to-child HIV transmission. As HIV treatment programs become increasingly available in resource-poor countries, access to these life-saving services will depend on the degree to which health facilities welcome and respect the rights of HIV-positive clients.

Stigma and discrimination in health facilities have numerous causes, including lack of knowledge among staff about the modes and risk of HIV transmission, and judgmental attitudes and assumptions about the sexual lives of people living with HIV. Another significant cause of stigma and discrimination is health workers' fears of becoming infected during the course of their work. In the absence of assurance that they will be protected from the virus, and without access to drugs for post-exposure prophylaxis, health workers may engage in behavior that can prevent HIV-positive and other vulnerable individuals from receiving lifesaving care and support.

Some examples of stigmatizing attitudes, behaviors and actions documented in health care settings are as follows:

- Health workers who blame those who are infected with HIV.
- Health workers who poorly treat patients that belong to stigmatized populations or patients they believe to be infected.
- Health workers who breach client confidentiality by sharing test results with relatives and other staff, publicly marking a client's status.
- Health workers who discriminate against or do not cooperate with colleagues known to be infected with HIV.
- Health workers who demand routine, mandatory HIV testing, or insist on testing as a condition for providing services.
- Health workers who segregate or isolate HIV and AIDS patients in special beds or wards when there is no clinical need to do so.
- Health workers who discharge HIV-positive patients, regardless of overall health status, immediately or soon after test results become available.
- Health workers who withhold treatment from HIV and AIDS patients by treating them less aggressively than other seriously ill patients who are not HIV-positive, or provide substandard care.

Health workers' fears are not unfounded; they are based on real risks due to their lack of access to supplies and training in infection prevention and standard precautions. There is mounting evidence that medical transmission is an important, yet largely neglected route of HIV transmission in resource-poor settings. While sexual transmission undoubtedly accounts for the vast majority of cases, it is becoming clear that HIV programs have paid insufficient attention to transmission in health care settings. The number of cases of HIV infection through medical transmission is certainly not trivial; transmission of hepatitis B and C is also a serious risk.

Health workers' negative attitudes and behaviors are also driven by beliefs and myths about HIV and AIDS, lack of knowledge and skills in HIV and AIDS clinical management and counseling, lack of drugs and supplies, limited knowledge of the modes and risks of HIV transmission in health care settings, and an overestimation of the risk of HIV infection following occupational exposure. In addition, health care workers are members of the communities in which they work; their attitudes often reflect the prevalent stigma found in communities, especially toward marginalized populations such as sex workers. The following quote from a heath care provider in Kenya illustrates the challenge:

"Health workers are expected to know, feel and act certain ways. But what has prepared them for this [HIV and AIDS]? Many health workers have the same information the man in the street has. . . The disease is fatal! Who is not afraid of death? . . . Knowledge and skills, yes, that they have. It is part of many training programmes. But what about preparing them to come to terms with their fears and anxieties about their own sexuality and mortality, their prejudices?"[1]

The needs and obligations of HIV-positive health workers are also not being adequately addressed. Hospitals lack policies that protect the rights of infected staff to confidentiality, employment in a discrimination-free environment, insurance and sickness benefits, counseling, and medical care. Due to fear of stigmatization and unemployment, health workers avoid being tested to learn of their own HIV status, depriving themselves of the opportunity to receive timely emotional support and clinical care. By denying their own possible infection, health workers potentially expose their patients to infection.

Training Approach and Content

To reduce stigma and discrimination in health care settings, we need to address health care workers' fears about getting infected on the job, and their need to protect themselves through standard precautions. This manual uses participatory training methodologies to modify health care workers' attitudes while giving them practical knowledge and tools to both assure client rights and meet their own needs for a safe work environment. The training covers the following:

- Values clarification about HIV and AIDS
- Stigma and discrimination towards people believed or known to be HIV-positive
- Clients' rights to dignity, comfort, privacy, confidentiality, and safety
- Clients' right to receive services free from discrimination
- Basic information about HIV transmission
- Health care staff's need for safety from injury and infection on the job
- Standard precaution practices for infection prevention
- Detailed guidance for preventing occupational injury and exposure to HIV
- Post-exposure care, including post-exposure prophylaxis
- HIV testing issues in the health care setting
- A process for participants to develop personal and facility-wide action plans to address client rights, standard precautions, and post-exposure care.

[1] Healthcare provider, Kenya. List-serve discussion cited in: Lisanne Brown, Lea Trujillo, Kate Macintyre. "Interventions to Reduce HIV/AIDS Stigma: What Have We Learned?" Horizons Program, Tulane University, September 2001.

This manual contains current information and protocols for preventing and managing occupational exposure to HIV. Please note that the term *standard precautions* is used throughout this document. *Standard precautions* help protect both clients and health care staff from exposure not only to blood, but also to other body fluids that can transmit infection. This term encompasses the commonly used term *universal precautions*, which refers to practices performed to protect health care staff from exposure to bloodborne microorganisms.

How to Use This Manual

This training is best conducted as an on-site training with all staff of the health care facility, including laboratory staff, cleaners, guards, gardeners, receptionists, nurses, midwives, physicians, and other health workers. This approach ensures that all staff members benefit from the course and contribute to fostering change in their facility. Creating a welcoming environment for people living with HIV must involve all staff. If an on-site training is not possible, the trainers should develop a plan for ensuring that the knowledge and process is diffused from the training participants to other staff at the facility where they work.

While this training includes basic information about infection prevention, and a specific focus on standard precautions and prevention of needlestick and sharp injuries, it does not thoroughly cover infection prevention in health facilities. For more in-depth training materials on infection prevention, please refer to EngenderHealth's *Infection Prevention Curriculum: A Training Course for Health Care Providers and Other Staff of Hospitals and Clinics* (1999). To order a copy of this manual, go to EngenderHealth 's website at www.engenderhealth.org.

How Long Is the Training?

The entire content of this supplement is estimated to take at least two days, depending on the group. If the trainer would like to combine this training with a more intensive training on infection prevention practices, six days are needed.

Consideration for Low-literate or Non-literate Audiences

This training will be most effective if all staff in a health facility participate. In many settings, this means that the facilitator will need to accommodate participants with various levels of literacy. Low-literate/non-literate participants can work with the facilitator or other course participants, either individually or in small groups to complete the various activities. The facilitator or participant providing assistance can present the questions orally and write down the participant 's responses. Representational symbols that are understood by the low-literate/non-literate participants can replace word labels in some of the exercises.

Sample Training Schedules

The following suggested two-day training schedule includes the minimum information needed to reach the objectives of the training. Depending on the group, more time may be needed to focus on particular topics, or to engage in a more thorough site assessment and action plan process. In this case, three days are desirable.

▼▲ DAY 1 ▼▲	▼▲ DAY 2 ▼▲
Session 1: Welcome, introductions, pre-test (45 min.)	**Checking In:** Participants' insights from previous day's sessions (15 min.)
Session 2: Setting the stage (30 min.; time permitting)	**Session 10:** HIV-transmission overview: understanding personal and professional risk (60 min.)
Session 3: Impact of HIV and AIDS on our personal and professional lives (30 min.)	**Session 11:** Standard precautions in the health care setting and in home care (45 min.)
Session 4: Exploring our thoughts, beliefs, and attitudes about HIV and AIDS (30 min.)	**Session 12:** Prevention of needlestick and sharp instrument injuries (45 min.)
Session 5: Overview of clients' rights and providers' needs (45 min.)	
Lunch	**Lunch**
Session 6: HIV and AIDS stigma and discrimination in the health care setting (1 hour 30 min.)	**Session 13:** Post-exposure care and post-exposure prophylaxis (60 min.)
Session 7: Moving beyond "us" and "them" (45 min.)	**Session 14:** HIV testing and client rights (60 min.)
Session 8: Recognizing our own stigmatizing language and actions (45 min.)	**Session 15:** Action plan development (60 min.)
Session 9: Testimonials: people living with HIV or AIDS (45 min.)	**Session 16:** Post-test and closing (45 min.)

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session 1:

Introduction to the Training

Objectives

1. To articulate the participants' expectations of the training.
2. To review the objectives of the training.
3. To review the agenda for the training.

Time

45 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Prepare flipcharts with the training objectives and schedule
- Pens and paper for participants
- One copy of the blank pre-test for each participant (see *Trainer's Resource 1.1*)

Steps

1. Welcome participants and introduce facilitators.
2. Have participants introduce themselves and express at least one expectation that they have for the training. Write down all the expectations on flipchart paper as they are mentioned.
3. Review the objectives (see *Participant's Handbook Session 1: Introduction to the Training*), being sure to highlight which objectives address participants' expectations.[2]

By the end of this training, participants will be able to:

- Identify their own biases and fears related to HIV and AIDS, and explain how these attitudes can negatively influence interactions with HIV-positive clients or those perceived to be positive;
- Describe HIV prevalence statistics in their country and community;

[2] Note: The participants may have some expectations that will not be met by the training. It may be possible and appropriate to modify the training to meet those expectations (e.g., include some additional material). If some of the participants' expectations cannot be met, because they are impractical or outside the scope of the training, explain to the participants why this is the case.

- Explain the link between stigma and discrimination in the health care setting against HIV-positive persons or those thought to be infected;
- List clients' rights and health care staff's needs;
- Explain how HIV is transmitted in the health care or home care setting;
- Describe standard precautions for prevention of HIV transmission in the health care or home care setting;
- Describe post-exposure care procedures in the event of needlestick or sharp instrument injuries;
- Identify client rights issues related to HIV testing in the health care setting; and
- Develop individual and facility-specific work plans to implement or improve standard precaution and post-exposure care protocols, and to ensure clients' rights.

4. Pass out the pre-test and give participants 15-20 minutes to complete it (see Trainer's Resource 16.3 for the answers to the pre/post-test).

5. Review the training agenda.

Trainer's Resource 1.1
Pre-test

Instructions: Read each statement and write in the number for the answer that best reflects your attitudes, values, and comfort level related to HIV and AIDS and working with people who are living with HIV or AIDS.

Scale: 1 = strongly agree 2 = agree 3 = disagree 4 = strongly disagree

I believe…

_____I believe that people who are infected with HIV should not be treated in the same areas as other patients in order to protect the larger population from infection.

_____I believe that people infected with HIV are responsible for getting infected.

_____I believe that HIV-positive patients are the biggest threat to my safety at my place of work.

_____I believe most HIV-positive health care workers get infected at work.

I feel…

_____I feel that providing health services to people infected with HIV is a waste of resources since they are going to die soon anyway.

_____I feel that I am at high risk of becoming infected with HIV working in the health facility.

_____I feel that clients who have sexual relations with people of the same sex have a right to access the highest quality of health services in my facility.

_____I feel that clients who are sex workers have a right to access the highest quality of health services in my facility.

I am comfortable…

_____I am comfortable providing health services to clients who are HIV-positive.

_____I am comfortable performing surgical or invasive procedure on clients whose HIV status is unknown.

_____I am comfortable sharing the bathroom with a colleague who is infected with HIV.

_____I am comfortable assisting or being assisted by a colleague who is infected with HIV.

I avoid…

_____I avoid touching clients for fear of becoming infected with HIV.

_____I avoid touching clients' clothing and belongings for fear of becoming infected with HIV.

_____I avoid performing ANY task at work without wearing latex gloves.

Instructions: Decide whether each of the following statements is true or false. Write your response for each statement in the space provided, putting **T** for true and **F** for false.

True/False

1. _____ Withholding health services from a client believed or known to be HIV-positive is a violation of the client's human rights.

2. _____ When there are shortages of needles and syringes, it is acceptable to rinse the syringes in disinfectant solution and to reuse them as long as new needles are used.

3. _____ The risk of HIV transmission following needlestick or sharps injuries is very small, approximately 1 in 300.

4. _____ The risk of HIV transmission following a splash of blood or body fluids to non-intact skin or mucus membranes is very small, approximately 1 in 1,000.

5. _____ Standard precautions are designed to protect only health care workers from clients who may be infected with HIV or hepatitis.

6. _____ Standard precautions are also applicable when providing home-based care.

7. _____ Needlestick and sharps injuries can be prevented.

8. _____ It is appropriate to test clients who look like they are HIV-positive or clients preparing for surgery, to ensure that staff take precautions during surgery to prevent HIV transmission.

9. _____ A pregnant staff member who is accidentally injured by a needlestick or a sharp instrument cannot receive post-exposure prophylaxis due to the risk of damage to the fetus by antiretroviral drugs.

10. ____ A health worker who knows that he/she is HIV-positive can continue to work safely in service delivery as long as they avoid activities that present a risk of transmission to clients.

11. ____ To prevent transmission of HIV and other bloodborne infections in the health care setting, the staff should wear latex gloves for every client contact, including taking vital signs.

12. ____ To prevent stigma and discrimination in the health care setting, staff must treat all clients with respect and in a welcoming manner, provide privacy and confidentiality, and avoid creating segregated areas for clients who are known or believed to be HIV-positive.

13. ____ If a health care worker has a recent cut on her/his hand, the risk of HIV transmission following contact with a client's blood is higher than if the skin of the hand is intact.

14. ____ Exposure risk procedures are invasive procedures where there is a risk of injury to the health care worker that may result in the exposure of the client's open tissue to the blood of the worker.

15. ____ The risk of domestic violence related to HIV testing or disclosure of test results should be explored during pre- and post-HIV test counseling.

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session 2:

Setting the Stage

Objective

To set the tone for participants to explore the impact of attitudes toward people who are infected or believed to be infected with HIV and toward people living with AIDS.

Time

30-45 minutes (time permitting; adapt as needed and as time allows)

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Paper and pens
- Using pieces of paper (1/4 or 1/2 the size of a regular piece of paper), create cutout figures of a range of people in a community or family. These do not have to be elaborate. If you do not have the time to create the cutout figures, you can use the pieces of paper and simply write the sex and age on the paper. For example, "older woman, more than 50 years old," "adolescent male," "pregnant woman, in her 20s," etc. Do not write what their role in the community or family is or would be. For example, you should not write "pregnant woman, single, poor, mother of two, 24 years old." Only write out what you would be able to tell about a person from looking at them. Examples of characters can be found at the end of this exercise.
- Create about five characters for each small group of participants. At least one of those characters should have some identifying mark on the back of the paper that will signify that they are HIV-positive. This mark can be an "X", a dot, a check mark, a letter, etc. It should not be obvious, however, since participants should not know from the start whether any character is HIV-positive or not.
- Note: Each group should have a mix of characters, including one that is HIV-positive.
- Write the questions under Steps 2 and 3 below on flipchart paper.

Steps

1. Divide the participants into small groups of four or five people, depending on the number of participants.
2. After the groups have formed, hand them their characters. Ask them to take ten minutes to establish a story line for all their characters. They should all be part of the same household, although it is not

necessary that they be part of the same nuclear family. Ask the participants to answer the following questions for each character (display the questions on flipchart paper):

- What is his or her name?
- What is his or her age?
- What is his or her marital status?
- What is his or her relationship to the other characters (mother, grandmother, husband, aunt, cousin, etc.)?
- Does he or she have any children? How many? How old?
- Does he or she work? Where? Doing what? If he or she does not work, how does he or she spend his or her time?
- What is his or her socio-economic status?
- What are some of his or her interests?

3. Next, ask participants to turn over all their characters to find out which one is HIV-positive. Ask the participants to take another 15 minutes to create a second storyline, building on the first one, but now knowing which character is HIV-positive. Explain to them that they should choose one note-taker for the group, and one reporter who will give a five-minute presentation to the entire group on the storyline. This time, the small group participants should answer the following questions for each character (display the questions on flipchart paper):
   - For the characters who are not HIV-positive:
     - Does he or she know that that character is HIV-positive? If so, how does he or she feel about it? How did he or she find out?
     - What has changed in his or her everyday life as a result of that character being HIV-positive?
     - What are some of the bigger changes in his or her life as a result of that character being HIV-positive?
   - For the character who is HIV-positive:
     - How did he or she become infected?
     - How did he or she find out his or her HIV status?
     - How does he or she feel about being HIV-positive? (e.g.: positive outlook, death sentence, confused, angry, ashamed, indifferent, etc.)
     - Is he or she showing any symptoms of what could be AIDS?
     - What has changed in his or her everyday life as a result of being HIV-positive?
     - What are some of the bigger changes in his or her life as a result of being HIV-positive?
     - How has his or her relationship with the other characters in the household changed, if at all, as a result of being HIV-positive?
4. Ask the participants to stay in their groups and have each group report on their household's storyline.
5. After all the groups have presented their storyline, facilitate a large-group discussion about the process of creating the second storyline and how they feel about their story. For example, you can ask:
   - Did everyone in your small group agree on the group's story? If not, why?
   - Where did the ideas about the characters come from for the second storyline? Was it from situations you have witnessed or stories that you have heard or read about?
   - How did you feel while you were creating the second storyline?

- Do you think this is representative of what happens to a household in this region once someone becomes HIV-positive?
- Did examples of HIV and AIDS-related stigma and discrimination come out in the stories? In what way?

6. Conclude the exercise by commenting on how these stories shed light on the challenges people living with HIV and their families face on a day-to-day basis. Point out how stigma and discrimination may have negatively influenced some of the character's lives and ask the participants to think about these characters throughout the course of the training.

Examples of Characters

- Young woman in her 20s
- Young man in his 20s
- Woman in her 30s
- Man in his 30s
- Woman in her 40s
- Man in his 40s
- Woman in her 50s or older
- Man in his 60s or older
- Pregnant woman in her teens, 20s, 30s, 40s
- Adolescent male
- Adolescent female
- Newborn child
- Young boy, under 15 years old
- Young girl, under 15 years old

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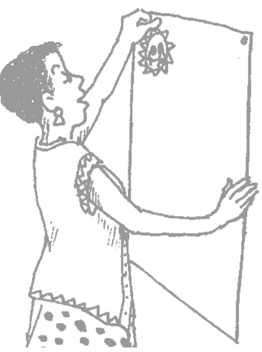

session 3:

Impact of HIV and AIDS on Our Personal and Professional Lives

Objectives

1. To allow participants an opportunity to explore their feelings and attitudes about how HIV and AIDS has affected them personally and professionally.
2. To encourage participants to consider different types of responses to HIV and AIDS within their community and country.
3. To foster empathy among participants for those living with HIV and AIDS, by enabling participants to imagine how they would feel if they were infected.
4. To demonstrate how fears and worries about HIV and AIDS can affect quality of care for clients.

Time

30–45 minutes (depending on the number of questions selected)

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Select questions to read from *Trainer's Resource 3.1*, or develop a handout with the selected questions
- Write summary points from *Essential Ideas to Consider* on a piece of flipchart paper
- Paper and pens or pencils for participants

Steps

1. Select questions to read from the *Trainer's Resource 3.1*. Be sure to use all three questions from the third category, *Professional Experiences with HIV and AIDS*.
2. Explain to participants that you will read a series of statements about their personal and professional experiences with HIV and AIDS. Ask them to reflect on each question for a minute or two. Tell them that they will not be required to share their thoughts unless they feel comfortable doing so.
   Alternative: If all participants are literate, distribute a handout with the selected questions to each participant (or write the questions on flipchart paper that is posted on the wall, show the questions on an overhead, or write them on a blackboard). Make sure participants have pens or pencils and writing paper to write down their answers. (They will not be required to share what they have written unless they feel comfortable doing so.)

3. Read the questions out loud, repeating several times. Pause between each question for about two minutes so participants can reflect on their experiences.
4. Ask for volunteers to share their thoughts on the first set of questions (*Personal Experiences with HIV and AIDS*). If the group is hesitant to begin, facilitators should share their own experiences to get them started.
5. After several volunteers share their experiences based on the first set of questions, ask for volunteers to discuss the other questions, grouped by topic.
6. Keep track of the main points participants bring up by writing them on flipchart paper and posting them on the wall. This will help guide the large-group discussion.
7. Lead a large-group discussion based on the following questions:

   Key Discussion Questions

   Note: Tailor these discussion questions based on the topics and specific issues raised by the participants.

   - How did you feel answering these questions?
   - How can thinking about these topics help us become better in our jobs?
   - How can our own attitudes about and personal experiences with HIV and AIDS affect our work?
   - Which questions were the most difficult to answer and why?
   - How has the existence of HIV and AIDS changed our priorities in life, both personally and professionally?
   - How can we confront and overcome our fears and concerns about working with clients who are HIV-positive?

   Possible responses include:

   - *Talk about our fears (with friends, co-workers, religious or spiritual leaders).*
   - *Learn more about HIV and AIDS and resources available to people living with HIV and AIDS in our communities.*
   - *Get to know or talk to someone living with HIV.*
   - *Ensure standard precautions/infection prevention procedures are in place and observed in the health care facility in which we work.*
8. **Summarize** the session by reviewing with participants the key points elicited from the discussion exercise and close by presenting the *Essential Ideas to Consider*.

Training Tips

- Instead of a large group, participants can share their ideas in pairs or small groups (with or without first writing responses to the questions on their own).
- Suggested questions are provided on three topics (see *Trainer's Resource #3.1*). Facilitators are encouraged to select questions they feel are most relevant to the needs of the participants, but should be sure to ask the questions related to *Professional Experiences with HIV and AIDS.*
  Note: It may be interesting to ask participants these questions again at the end of the training, drawing attention to changes or absence of change. If you plan to do this, take note of participants' responses during this session (record on newsprint) and save so you can compare them to their responses at the end of the training.

- Please note that some of these questions—especially those in the category *What If You Had HIV or AIDS?*—can be very personal and emotional for some participants, particularly people who may be infected with HIV. You should be aware of this possibility and prepare to address emotional issues as they arise.

Essential Ideas to Consider

- HIV and AIDS is an emotionally charged issue that is frequently associated with fear, stigma, and prejudice. Myths, misunderstandings, and mistreatment of clients can result from the sense of panic that surrounds HIV and AIDS. In addition, talking to clients about a life-threatening illness can be stressful and disturbing for health care staff.
- Fears and worries about HIV and AIDS in the workplace can increase health care staff's stress level, diminish job satisfaction, and decrease quality of services if they are not addressed adequately.
- As health care staff, it is important for us to be aware of our feelings, thoughts, and attitudes about HIV and AIDS. If we do not address our personal reactions and emotions, we may unintentionally treat HIV-positive clients, and those we suspect are infected or at-risk, differently than we normally treat clients, thereby diminishing the quality of care that we provide.
- It is our professional duty to ensure that our personal feelings, thoughts, and attitudes do not spill over to the work place. If they do, it is also our responsibility to determine what action to take to ensure that our clients' right to quality care is not compromised. (For example, to debrief with a supervisor about inappropriate feelings, thoughts and attitudes; to refer clients to other health providers if personal issues are interfering with quality of care; etc.)

Trainer's Resource 3.1
Suggested Questions about the Personal and Professional Impact of HIV and AIDS

Select several questions from each of the following categories:

Personal Experiences with HIV and AIDS

- When was the first time you heard about HIV and AIDS?
- What was your reaction and how did you feel about it?
- Do you know anyone who has HIV or AIDS or has died from AIDS? If you do, how did you react to that person when you first found out they had HIV?
- Have your reactions or feelings changed over time? If yes, in what way?
- Has your life changed because of HIV and AIDS? How? If it has not changed, why not?

What If You Had HIV or AIDS?

- If you were infected with HIV, would you want to know?
- What would motivate you to want to know your HIV status?
- How would you feel if someone conducted an HIV test without your knowledge or without your permission?
- If you were told that you had HIV, in what ways would it change your life?
- If you were told that you had HIV, whom would you want to share that information with? How would you want to share that information with them?
- If you were told that you had HIV, whom would you want to keep that information secret from? Why would you want to keep the information secret from them?
- How would you feel if other people spread the information that you were infected with HIV without your knowledge or permission?
- What would happen to your job if your boss or co-workers found out that you were infected?
- If you were infected with HIV, how would you want to be treated by others?
- If you had HIV, how would you want to be treated at a health care facility?

Professional Experiences with HIV and AIDS (use all three of these questions)

- If you work directly with clients, recall the first time you interacted with a client who you knew was HIV-positive. How did you feel providing health services for that person? Did you treat him or her differently than other clients? Why or why not? Thinking back, what things would you do differently now than what you did then?
- Do you think HIV-positive clients should be treated differently from clients who are not infected? Why or why not?
- What are your fears or concerns about providing health services for clients who are or might be infected with HIV?

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session 4:

Exploring Our Thoughts, Beliefs, and Attitudes about HIV and AIDS

Objectives

1. To explore participants' attitudes and values about a range of potentially sensitive issues related to HIV and AIDS.
2. To develop an understanding of and respect for the diversity of opinions within the group.
3. To recognize and become aware of our own values and attitudes regarding HIV and AIDS and how these might impact our work.
4. To explore how to remain neutral while working with clients despite our own values and attitudes.

Time

30-60 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Prepare two pieces of flipchart paper by writing "Agree" on one of them and "Disagree" on the other. Post the "Agree" and "Disagree" signs on opposite sides of the room, or on one large wall, a few body lengths apart.
- Select a list of value statements (see samples in the *Trainer's Resource 4.1*) and/or create new statements, depending on the needs and particular interests of your training group.
- Arrange the training room so that there is adequate open space for participants to assemble near the "Agree" and "Disagree" signs as well as in between the signs.
- Write summary points from *Essential Ideas to Consider* on a piece of flipchart paper.

Steps

1. Explain that this exercise will help us understand viewpoints that are different from our own, and to consider how these attitudes and beliefs about HIV and AIDS might affect the way we treat clients. State that there are no "right" or "wrong" answers and that we are all entitled to our own opinions.
2. Ask participants to gather in the center of the open area. Direct their attention to the "Agree" and "Disagree" signs.
3. Explain that you will be reading a series of value statements. After you read a statement aloud, the

participants will decide whether they agree or disagree with the statement, or if they are unsure of their response. Those who agree will move and stand by the "Agree" sign. Those who disagree will move and stand by the "Disagree" sign. Those who are unsure will remain in the middle of the room. Let participants know that if they hear something that causes them to change their opinion during the course of the activity, they may move from one area of the room to another.

4. Read a statement out loud. Ask participants to move to the appropriate area of the room, according to their opinion. Invite comments from one or two participants from each location ("Agree," "Disagree," and "Unsure"), to explain why they have chosen to stand where they are.
5. The facilitator remains neutral, by not offering interpretations for the statement that would influence participant responses. However, he or she can share factual information to clarify matters, as needed. After hearing a representative from each position, give participants the option of switching positions if they wish. When participants move, ask them what prompted their decision to change position.
6. Repeat this process until you have posed all the statements that you wish the group to consider.
7. Ask the participants to return to their seats for a group discussion. Facilitate a discussion to explore differences of opinions and values more deeply based on the following questions.
   Note: If time is limited, prioritize the questions you will use.

Key Discussion Questions

- How did you feel during this exercise? What was it like for you?
- Were there any opinions or values expressed that surprised you?
- Which statements were the most controversial and why?
- How can you explain the differences between individuals in this group?
- How did you feel when other people expressed values and beliefs that were different from yours?
- If you were an HIV-positive client at your facility, would you have a different opinion about these issues?
- Why is exploring these issues important?
- How might attitudes and beliefs affect the way you behave toward or treat clients?
- How do our fears about HIV and biases towards HIV-positive people or those thought to be infected or at risk influence our values, opinions, and actions?
- How can we keep our own values from influencing our work in a negative way?
- How might you address some of these difficult issues in your health care facility?

Training Tips

- During this exercise, it is important to emphasize that there are no "right" or "wrong" answers. We all respond to the statements based on our own beliefs and values, and the purpose of this activity is to help explore these differences where they exist.

- In addition, the facilitator should remain neutral throughout the exercise and maintain a balance among the different viewpoints expressed.
- In order to explore a range of issues, you may need to limit discussion of each statement to comments from one or two participants representing each position. Another option is to select a smaller number of questions that can facilitate discussion, helping participants to see how their attitudes and values influence their behavior in providing health services.
- If everyone moves to one side of the room (e.g. everyone "agrees" with the statement), you can ask the group how a person with the opposite opinion might defend their position. Alternatively, facilitators can step into that spot and speak out on that position, clarifying to the group that they are just stating the rationale for that position in a direct and straightforward manner.

8. **Summarize** the session by reviewing with participants the key points elicited from the discussion exercises and close by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- People get HIV because of what they or their partner(s) do, not because of who they are. Therefore, we should not make assumptions about who may or may not be infected.
- Testing of clients to determine their HIV status for the benefit of the provider may give the provider a false sense of security if the client is in the "window period." This is the interval shortly after infection when the level of antibodies is not high enough for the antibody test to detect infection.
- It is unethical to test a person without their knowledge or consent, to test a person and not give them the results, or to test a person without the appropriate pre-test and post-test counseling. (Session 14 addresses HIV testing issues.)
- Standard precautions are the best way to ensure prevention of transmission in a clinical setting and can help decrease provider and client fears about HIV transmission. (Session 11 covers standard precautions.)
- Health care workers have a professional obligation to remain objective and non-judgmental with clients and to avoid letting their personal beliefs and attitudes become barriers to providing compassionate and high quality care to clients.
- It is important to examine one's feelings, thoughts, and attitudes about AIDS, particularly in relation to our work as providers. This is a disease that is often associated with fear, stigma, prejudice, and highly charged emotions. There have been many myths and misunderstandings as a result of this. If we do not address our feelings and attitudes about HIV, we may consciously or subconsciously treat clients who are HIV-positive, or perceived to be infected or at risk, differently, thereby reducing the quality of care in our facility. Fears about HIV in the workplace can also lead to additional work-related stress and decreased job satisfaction and performance for some providers.

Trainer's Resource 4.1
Belief Statements

DO NOT DISTRIBUTE TO PARTICIPANTS

Select belief statements from the following list of options:

- It is okay to isolate HIV-positive patients in a separate ward.

- Patients who are HIV-positive should be treated the same as other patients.

- Since there is little we can do for a patient with AIDS, it is better to spend time and limited resources on patients with treatable illnesses.

- Clients who are thought to be at high risk for HIV should be treated the same as other clients.

- It is okay to reveal the HIV status of a patient to their spouse or close relatives.

- A provider should be much more careful of needlestick injuries or other potential exposure with a client who is a sex worker than with a monogamous married woman.

- Health care staff should routinely be tested for HIV as a means to prevent staff from infecting clients.

- Health care staff should have the right to refuse to provide services if materials they need to apply standard precautions are not available.

- An HIV-positive woman should not have a baby.

- People who get HIV through sex deserve it because of their behavior.

- People who get HIV through injecting illegal drugs deserve it because of their behavior.

- If a provider is afraid of getting HIV from a patient, he or she should have the option not to see that patient.

- If HIV testing is available, providers have a right to test their clients for HIV so they know the HIV status of the clients they treat.

- A surgeon has the right to test a patient for HIV without their consent prior to surgery.
- An HIV-positive health care provider should not be allowed to treat patients.
- Clients have a right to know if a health provider is infected with HIV.
- Providers who work at facilities where sex workers receive care are at higher risk for getting exposed to HIV on the job, than those providers who work at facilities that do not see sex workers.
- It is best to treat HIV patients at a separate facility, rather than in the same facility as other patients.
- Pregnant women thought to be at risk for HIV should be tested for HIV whether or not they agree to it.
- Women with HIV who get pregnant should be encouraged to terminate their pregnancy.

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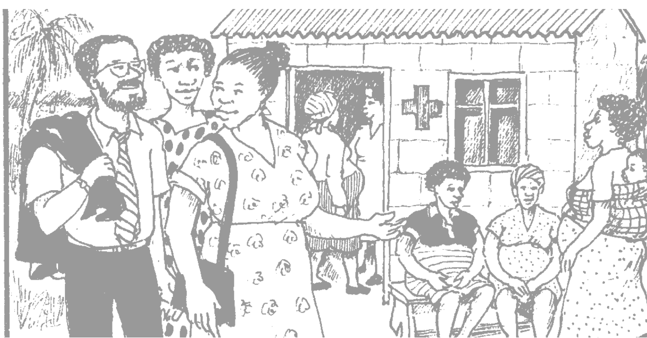

session 5:

Overview of Clients' Rights and Health Care Staff's Needs

Objectives

1. To review the basic rights of health care clients.
2. To review health care workers needs, particularly in relation to safety.

Time

45-60 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Review *Participant's Handbook Session 5: Overview of Clients' Rights and Health Care Staff's Needs*
- Write summary points from *Essential Ideas to Consider* on flipchart paper

Steps

1. Introduce the exercise by reviewing the objectives.
2. Begin by facilitating a large-group discussion using the following questions:
   - What rights do all health care clients have?
   - In your country, are these rights respected? Which ones are not? Please explain.
   - What do health care staff need in order to be effective and provide quality services to clients?
   - In your country, do health care staff get their needs met? Please explain.
3. Direct participants to the *Overview of Clients' Rights and Health Care Staff's Needs* in their *Participant's Handbook* (page 13) and review it with them. Be sure to refer back to the lists created by the participants to highlight similarities and differences. Answer any questions participants may have about the handout.
4. Next, divide participants into four or five groups, depending on how large the group is (each group should have no more the six people). Assign the groups the following questions to discuss and present back to the large group

(give two groups the same questions if you have more than four groups):

Group 1:

- Why is it important to come to a common understanding of clients' rights and health care staff's needs?
- Why is respecting the rights of all clients important and how does it improve the health of the community/country?

Group 2:

- In your facility, are health care staff's needs met? Why or why not?
- How have HIV and AIDS impacted the needs of health care staff?

Group 3:

- In your facility, are clients' rights respected? Why or why not?
- Are the rights of HIV-positive clients ever violated? How?

Group 4:

- What systems need to be in place to assure clients' rights and health care staff's needs?
- What are the challenges to putting these systems in place?

5. Have each small group quickly report back the responses to their discussion questions.
6. Conclude the session by reviewing the *Essential Ideas to Consider*.

Essential Ideas to Consider

- To ensure quality services, the rights of clients must be respected. For HIV-positive clients who often face discrimination in health care facilities, assuring their rights to dignity, privacy and confidentiality is essential to make them feel welcome and comfortable accessing services.
- With the advent of the HIV and AIDS epidemic, fear of HIV infection on the job has often increased health care workers' anxiety. Training, supervision, and supplies related to the prevention of infections in the health care facility must be in place to ensure a safe work environment and to reduce these fears.

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session 6:

Stigma and Discrimination Related to HIV and AIDS in Health Care Settings

Objectives

1. To define stigma and discrimination.
2. To explore how and why stigma is associated with people living with HIV and AIDS.
3. To examine how stigma related to HIV and AIDS impacts health care services for people with HIV and those perceived to be HIV-positive or at high risk for HIV infection.

Time

90+ minutes, depending on the time available.

Materials and Advance Preparation

- Flipchart paper
- Markers or chalk (different colors, enough for participants to use)
- Tape
- *Trainer's Resource 6.1: Sample Case Scenarios on HIV and AIDS Stigma and Discrimination*
- Review *Participant's Handbook Session 6: HIV and AIDS Discrimination in the Health Care Setting*
- Write the definitions of stigma and discrimination on flipchart paper (see Step 2 below)
- Attach two pieces of flipchart paper together and draw a tree trunk with the words "AIDS Stigma" written in the center of the trunk
- Prepare 20-25 individual leaf-shaped pieces of paper (cut to about the size of a hand)
- Prepare 20-25 individual root-shaped pieces of paper (cut to forearm length and the width of two fingers)
- Cut small slips of paper, the same number as there are participants. On half of the slips write "leaves" and on the other half of the slips write "roots." Fold papers and place them in a container or bag for participants to select.
- Write summary points from *Essential Ideas to Consider* on a piece of flipchart paper
- Costumes or props for the role-plays, if available (e.g. white coats, clip boards, etc.)

Steps

1. Introduce the session by presenting the objectives.
2. Begin the exercise by asking the participants to brainstorm the definitions of *stigma and discrimination*. Write the responses on the flipchart. Summarize the brainstorm by presenting the following definitions:

3. Next, explain that we will be exploring HIV and AIDS-related stigma using the image of a tree to represent the problem. The base, or trunk, of this tree will represent the problem: stigma related to HIV and AIDS. The roots of the tree will represent the causes of stigma related to HIV and AIDS in their community (cultural, economic, social) and the leaves and branches will represent the consequences.
4. Divide participants into two groups by asking each to pick one piece of paper from the bag or container (prepared in advance). All participants selecting a piece of paper with "leaves" written on it form one group; give them the leaf-shaped pieces of paper prepared in advance. All participants selecting a piece of paper with "roots" written on it form the second group; give them the root-shaped pieces of paper prepared in advance.
5. Give each group markers and flipchart paper and instruct them to choose a recorder and a reporter.

■ **Stigma** is defined as an undesirable or discrediting attribute that a person or group possesses that results in the reduction of that person's or group's status in the eyes of society. Stigma can result from a physical characteristic, such as the visible symptoms of a disease, or from negative attitudes toward the behavior of a group, such as homosexuals or prostitutes.

■ **Discrimination**, which can be expressed as both negative attitudes or particular behavior or actions, is often described as a distinction that is made about a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. For example, stigma can lead to prejudice and active discrimination directed toward persons who are actually, or are simply perceived to be, infected with HIV, and the social groups and persons with whom they are associated.

6. Instruct the "leaves" group to brainstorm a list of consequences of HIV stigma and the "roots" group to brainstorm a list of causes of HIV stigma. Each item from their respective list should then be written on a leaf (leaves group) or on a root (roots group). Give the small groups 30 minutes to brainstorm their list and prepare their presentation.
7. Encourage the "roots" group to dig as deeply as they can to explore the underlying causes. For example, one root of HIV stigma may be its association with "sex work," the causes of which might be "poverty," "lack of resources to support one's family," or "men seeing women as sex objects." Going deeper, the roots of "poverty" might be "restrictive government policies," "scarcity of community resources," "colonialism," "legal restrictions of women's right to own property," or "unequal resources worldwide."
8. Encourage the leaves group to think of consequences on different levels. For example, some of the leaves may be "health facilities turn HIV-positive people away," "people are losing their jobs," "women are getting kicked out of their homes," "women are being blamed by the community," or

"women are getting beaten by their husbands." Follow each branch leading out of the consequences and write additional ones. For example, "clients die," "children are orphaned," "children have no means of support, education, or occupational training, resulting in poverty," etc.

9. Have each group present their work by explaining and taping each root and each leaf to the trunk of the tree.
10. Facilitate the group discussion by exploring more deeply and discussing some important causes or consequences that may not have been presented.
11. Once the tree is complete, ask the following questions, using the tree as reference:
    - How does stigma lead to discrimination?
    - Why is stigma associated with HIV and AIDS?
    - Is there stigma related to HIV and AIDS in your community? If yes, how is it expressed?
    - Are certain groups of people in your community stigmatized because they are thought to be more likely to have HIV or AIDS?
    - Does HIV discrimination exist in your facility? If yes, what are some examples?
    - How does discrimination affect quality of care for clients coming to your facility?
12. Following the discussion, point out to participants that additional information on stigma and discrimination can be found in the *Overview of Stigma & Discrimination Related to HIV and AIDS* on pages 19-22 of their handbook.

[Note: Because of the length of this session, you may want to give the group a short break before continuing on to the next step]

13. Next, tell participants that we will be examining stigma and discrimination from the perspective of someone who is HIV-positive or presumed to be. In a large-group brainstorm, ask the following questions, writing participants' responses on flipchart paper:
    - What are some of the concerns that an HIV-positive person in your community might have?
    - What concerns might an HIV-positive person have about coming to a health care facility in your community?

    Possible responses may include:
    - *Fear of telling partner and family*
    - *Fear, anger, sadness, and other emotions related to death*
    - *Concern about pregnancy and mother-to-child HIV transmission*
    - *Concern about transmitting HIV to others*
    - *Fear of stigma in the community*
    - *Fear of violence or abandonment by partner and family*
    - *Fear of revealing their HIV status to their health care provider*
    - *Concerns about confidentiality if they tell people about their HIV status*
    - *Fear of losing one's job if others find out they are infected*
    - *Concern about maintaining health and questions about expected life span*
    - *Questions about possible treatments for self and prevention of mother-to-child HIV transmission*
    - *Confusion or misinformation about how s/he became infected*

- *Hopelessness or suicidal thoughts*
- *Concern about the future for her/his partner and children*
- *Lack of economic or social support*

14. After the brainstorming session, divide participants into small groups of four or five people and explain that they will be developing skits to demonstrate HIV and AIDS discrimination in health care settings.

15. Using *Trainer's Resource 6.1: Sample Case Scenarios on HIV and AIDS Stigma and Discrimination*, assign each group one case scenario, selecting those that most closely reflect the reality of the participants' health facilities. Instruct the groups to create a skit based on the scenario assigned to them (they can refer to page 18 of their handbook for the scenario descriptions). Each skit should portray the scenario described and how the situation could be addressed to reduce stigma and discrimination in the health care facility. As many group members as possible should assume a role in the skit ("client," "colleague," "staff," or "family member"). If there are not enough roles for each group member to have a part in the scenario, participants can choose whether they want to be "actors" or "directors" (group members who are not acting in the role play, but will provide suggestions and ideas to those who are). If you have props or costumes available, encourage the groups to use them. Give groups 15 minutes to prepare.
16. After 15 minutes, call the groups back together into the larger group and invite each group to present its skit. Ask the audience to observe the skit carefully, thinking about the questions from page 18 of the *Participant's Handbook* (*Case Scenario Questions Related to HIV and AIDS Stigma and Discrimination*).
17. After all the skits have been completed, lead a group discussion using the *Case Scenario Questions*.

Case Scenario Questions

- Do you think these are realistic scenarios?
- What ethical and rights dilemmas did these scenarios explore?
- What did you observe in the behavior of the health care staff that did not reflect discrimination against the client/colleague known or presumed to be infected with HIV?

- What did you observe in the behavior of the health care staff that reflected discrimination against the client/colleague known or presumed to be infected with HIV?
- What would you do differently to ensure that people with HIV, or those presumed to be HIV-positive, are not discriminated against?

Summarize the session by reviewing with participants the key points from the discussion related to:

- Causes and consequences of HIV stigma;
- Behaviors or practices in the health care setting that are discriminatory;
- The ways health care staff and communities can ensure that people with HIV, or who are thought to have HIV, are not discriminated against. For example, in the community, health education activities can help to raise awareness about HIV; providers and stakeholders can advocate for legislation that outlaws discrimination; health care policy-makers can ensure that policies and monitoring systems are in place to protect clients' and providers' safety and their rights to confidentiality and privacy; and HIV-positive persons' speaker bureaus can be created to raise awareness and "put a face" on the epidemic.

Close the session by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- HIV-positive clients, those presumed to be infected, and those perceived to be at risk for infection, often face stigma, threats of violence, and ostracism in the communities in which they live. It is critical to make the clinic a warm, welcoming, and non-judgmental environment that is open to and respectful of all clients, regardless of their HIV status.
- Make sure that your clinic provides an environment where clients can seek services and information about HIV and AIDS without fearing discrimination from service providers, or that community members will learn about their situation. This means establishing systems that ensure client privacy and confidentiality.
- Sometimes health care workers fear getting infected while working with HIV-positive clients. This fear may lead to discrimination against those clients. Standard precautions to prevent HIV transmission greatly reduce the risk of infections on the job and allay such fears. (Session 11 covers standard precautions in detail.) However, health care workers must protect themselves from sexual transmission of HIV as well.

Trainer's Resource 6.1
Sample Case Scenarios on HIV and AIDS Stigma and Discrimination

Each of the following is a different scenario for the development of a skit. If there are not enough characters for a group, participants can choose to add characters to the scenario or to be "directors" (group members who are not acting in the role play, but will provide suggestions and ideas to those who are).

1. A man with AIDS is being treated by a physician who does not want to touch him.

2. A few nurses and clinic assistants are gossiping about an HIV-positive client in front of other clients.

3. A very sick HIV-positive woman is in the clinic's waiting room with her three children. Her husband and in-laws threw her out of the house and she has nowhere else to go.

4. One of the clinic assistant's female relatives comes to the clinic with her child who is sick. She confides in a provider that her husband is HIV-positive and that she is afraid and confused. After the session, the provider immediately tells another provider. They gossip about the clinic assistant and her "dirty" and "immoral" relatives and begin to snub her.

5. When an HIV-positive woman who is known to be a sex worker leaves the clinic after a family planning appointment, other women in the waiting room loudly complain that they do not appreciate being treated in an environment where "sick" and "dirty" women are seen. They don't want the same doctors, nurses, or equipment touching them.

6. A surgeon who is HIV-positive is dressing in the doctors' changing room when she overhears staff talking negatively about people with AIDS.

7. You observe two providers who use gloves to perform every task, clinical and non-clinical, because a client in the room "looks like she is a sex worker and must have AIDS."

8. A midwife working in a clinic hears that one of the other midwives in the clinic is infected with HIV. She gossips about this to you, a staff person in the clinic.

9. The director of a district hospital learns that an orderly who has worked in the operating theater for many years is infected with HIV. Without giving any explanation, he instructs the orderly's immediate supervisor to transfer the orderly to another section of the hospital right away.

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session 7:

*Moving Beyond "Us" and "Them:"
Understanding the Perspective of Clients
Living with HIV and AIDS*

Objectives

1. To better articulate the perspective of clients living with HIV and AIDS.
2. To describe the impact of health care workers' behaviors on HIV-positive clients' health and well-being.

Time

45-60 minutes

Materials and Advance Preparation

- Sheets of paper or large cards (two per participant)
- A pen or pencil for each participant
- Flipchart paper
- Markers
- Tape
- Write the questions under Step 2 on one flipchart paper and those under Step 4 on another

Steps

1. Introduce the exercise by reviewing the objectives and explaining that in this session we will be attempting to see the world from the perspective of a person living with HIV.
2. Distribute two sheets of paper or cards to each participant. Explain that they are to write one response on each card, and that they should not write their names on the cards. Instruct them to write responses to the following (read and also post the flipchart with the questions on the wall):
   - Briefly describe a situation you have witnessed, either at your own facility or elsewhere, where an HIV-positive client was treated poorly because of their HIV status.
   - Briefly describe a situation you have witnessed where an HIV-positive patient was treated well.

   NOTE: Read the example below and tell participants that if they have not personally witnessed such situations, they can either recount stories they have heard, or make them up.

EXAMPLE CARD
A woman came to the hospital in labor. At a certain point in her care, the doctor found out that she was HIV-positive and refused to assist the delivery. He didn't say anything to her, he just left the hospital. She was forced to seek care elsewhere.

EXAMPLE CARD

A man came to the health post because he had a troublesome cough that would not go away. He worried all the way there about telling the nurse that he is HIV-positive. He thought they might ask him to go away. In the end he told her and she praised him for doing so, as it was important to know. She treated him just like she would any patient, with dignity and respect, in a caring manner.

3. Give them 10 minutes to complete their responses, then collect the cards in two piles: positive experiences and negative experiences. Redistribute one positive and one negative card to each participant.
4. Next, ask the participants to imagine that they are the clients described in the two cards they received. Starting with the "negative experience" card and then moving on to the "positive experience" card, ask them to reflect on and write short responses to the following questions (read the questions and also refer participants to page 23 of their handbook). Give them 10-15 minutes.
   - How would you feel if you were in this situation?
   - What would your reaction be?
   - Would you return to that hospital or clinic? Why or why not?
   - If not, what would you do for care?
5. Next, divide the group into pairs and instruct participants to share their reflections with their partner (15 minutes).
6. Reconvene the large group and lead a short wrap-up discussion using the following questions as a guide:
   - How did it feel to imagine that you were the HIV-positive clients on your cards?
   - What client rights issues came up?
   - How did this exercise help us understand the impact of health care staff's behaviors?
   - What can we do in our facilities to make sure that "positive experiences" are the norm for HIV-positive clients?
7. Collect the cards and post them on the wall for the remainder of the workshop.
8. Conclude by highlighting some of the key points made during the discussion and by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- It is important for us to understand the perspective of clients living with HIV so that we can provide appropriate and compassionate care and support.
- We should strive to create an environment in our health care facilities where HIV-positive clients are treated the way we would want to be treated if we were in their situation.

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session 8:

Recognizing Our Own Stigmatizing Language and Discriminatory Actions

Objectives

1. To identify language and practices used in health care facilities that contribute to the stigmatization of and discrimination against people living with HIV and AIDS.
2. To identify non-stigmatizing language to use when talking about HIV and people living with HIV and AIDS.
3. To identify ways to treat HIV-positive clients in a non-stigmatizing or non-discriminatory way.

Time

45-60 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Prepare two letter-sized sheets of paper, marking one "STIGMATIZING/ DISCRIMINATORY" and the other "NON-STIGMATIZING/ NON-DISCRIMINATORY"
- Clear a wall space so there is room to post all of the cards
- Arrange the room so all participants will be able to stand by the wall where the cards are posted for discussion
- Review *Trainer's Resource 8.1*

Steps

1. Introduce the exercise by reviewing the objectives.
2. Split participants into four small groups. Each group will brainstorm one of the following:
   - Group 1: Stigmatizing words/phrases/language related to HIV or people living with HIV
   - Group 2: Actions or practices you might see in the health care setting that stigmatize or discriminate against HIV-positive patients
   - Group 3: Non-stigmatizing words/phrases/language related to HIV or people living with HIV
   - Group 4: Actions or practices you might see in the health care setting that are non-stigmatizing/non-discriminatory to HIV-positive patients

3. Explain that each group should come up with as many points as they can, but at least five, and write each one on a separate card or sheet of paper. Give examples of stigmatizing and non-stigmatizing language and discriminatory and non-discriminatory actions to get the groups started (see *Trainer's Resource 8.1*). Allow 20 minutes for this activity.
4. Using a large clear wall, post the sheets marked "STIGMATIZING/ DISCRIMINATORY" and "NON-STIGMATIZING/ NON-DISCRIMINATORY," and have groups put their response cards under the appropriate heading.
5. Keep the groups at the wall and have them review all the cards written by other groups.
6. Once all participants have had the time to review the cards, lead a group discussion (with participants still standing by the wall) using the following questions:
   - Do you agree with the placement of all the cards under the "stigmatizing/ discriminatory" column?
   - Do you agree with the placement of all the cards under the "non-stigmatizing/ non-discriminatory" column?
   - What are the origins of some of the terms in the stigmatizing column?
   - Why are the stigmatizing words perpetuated?
   - What are the most respectful and appropriate terms to use to refer to HIV-positive persons?
   - What are the origins of some of the discriminatory practices?
   - Why is discriminatory behavior perpetuated?
   - What are examples of respectful and appropriate ways to treat HIV-positive persons?
   - What would your facility need to do to eliminate stigmatizing language and discriminatory practices?
7. During the discussion, add terms and actions from *Trainer's Resource 8.1* if the groups do not come up with them on their own.
8. Highlight some of the following:
   - The use of HIV/AIDS versus HIV and/or AIDS: Point out how the former makes no distinction between being HIV-positive and having AIDS. Stress that in order to make people aware that HIV-positive people can live healthy and productive lives, without illness, we should not combine the two acronyms.
   - AIDS victim, sufferer, etc: Similarly these terms do not recognize that HIV-positive people can live healthy, productive lives, and that they are not necessarily in need of other's pity.
   - High-risk group: This phrase has contributed to the stigmatization of certain groups in society, such as commercial sex workers and truck drivers, as the source of the HIV epidemic. It has also contributed to people's reluctance to get tested or disclose their HIV status because they do not want to be associated with these groups. Finally, it has contributed to denial about the risk behaviors of those who do not identify with any of the so-called "high-risk groups."

9. Conclude by highlighting some of the key points made during the discussion and by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- Most health care personnel are committed to providing high quality services to all, including people living with HIV and AIDS. However, we sometimes use stigmatizing language or act in discriminatory ways without realizing we are doing so. Raising awareness about the language we use and our practices in the health care setting is a first step in creating change and providing appropriate and compassionate care and support.
- There are many ways to make our health care facility "non-stigmatizing" and "non-discriminatory." By doing so we can create an environment in which people living with HIV or AIDS feel welcome and where everyone can access the prevention, care, and support services they need.

Trainer's Resource 8.1
Recognizing Our Own Stigmatizing Language and Discriminatory Actions

Examples of stigmatizing and non-stigmatizing language and discriminatory and non-discriminatory actions:

Stigmatizing Language

- AIDS victim
- Slim disease
- Bad blood
- AIDS sufferer
- AIDS carrier
- AIDS is a death sentence
- High-risk groups
- HIV/AIDS
- AIDS orphan

Non-stigmatizing Language

- HIV-positive person
- Person living with HIV
- People living with HIV or AIDS
- HIV and AIDS
- HIV-positive patient
- Positive living

Discriminatory Actions and Practices in the Health Care Setting

- Coding of HIV-positive patients' charts
- Double-gloving when taking pulse of HIV-positive patient
- Change of facial expression when finding out you are treating an HIV-positive patient
- Denial of full, unconditional, high quality care and treatment
- Isolating HIV-positive patients in a corner or special ward
- Refusing to touch an HIV-positive patient
- Expressing a fatal prognosis—that there are "no options" or that "there is nothing we can do."

Non-discriminatory Actions and Practices in the Health Care Setting

- Warm greetings, showing care and compassion
- Not labeling or coding client's files
- Touching an HIV-positive patient
- Respect, privacy, dignity, right to opinion
- Listening
- Emotional support
- Ensuring confidentiality
- Not wearing gloves when examining patients or giving medication
- Positive non-verbal communication (nodding, smiling, eye contact)

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session 9:

Testimonials:
People Living with
HIV or AIDS

Objectives

To enable participants to better understand some of the hopes, concerns, and issues that people living with HIV or AIDS face.

Time

45 minutes

Materials and Advance Preparation

- An adequately equipped facility: enough chairs, a table for a panel discussion, a microphone if the room is large, etc.
- Sample discussion points
- Invite a group of people living with HIV or AIDS to the training. If this is not feasible in your setting, instead of a panel this exercise can be carried out in the form of an individual presentation followed by a question and answer session. If no person living with HIV or AIDS can come to the training, an alternate exercise is for participants to create testimonials, individually or in small groups, and present to the larger group as if they were HIV-positive or have AIDS.
- Set up enough chairs and a table in front of the room if it is a panel, or arrange the chairs in a circle if it is just one person presenting, before the discussion begins.
- To help the panel members or individual presenter prepare, provide them with the following sample questions in advance. This will provide them with the opportunity to think about their answers in advance. Tell the invited guests that the information shared in the training will be kept confidential by the participants. (If participants are creating their own stories, ask them to make sure they incorporate into their story answers to the following questions.)
  - How did you get infected?
  - How long have you been infected?
  - How did you find out you were infected?
  - How old were you when you found out?
  - How did you feel when you found out?
  - How did you tell others you were infected?
  - Have any of your relationships changed as a result of others knowing or suspecting that you are HIV-positive?
  - What do you enjoy doing in your spare time? What are some of your interests? Have they changed at all because you are HIV-positive? If so, how?

- What are some of your major concerns regarding your HIV status?
- What are some examples of stigma and discrimination you have faced? How did that make you feel?
- What are some of your hopes and dreams regarding your future? Have they changed at all because you are HIV-positive? If so, in what way?
- What advice would you give to health care workers on what to do and say and what not to do and say with their HIV-positive patients?

Steps

1. Explain to workshop participants that the goal of this exercise is to hear from people living with HIV or AIDS, and to discuss with them some of their hopes and concerns.
2. Describe the process of the panel or individual presentation and discussion. First, each panelist will introduce him or herself, and then each one will spend five to ten minutes discussing their situation. After all the panelists have spoken, participants will be able to ask them questions and engage in a dialogue. The trainer(s) should moderate and facilitate the discussion.
3. IMPORTANT: Before the invited guests arrive, tell participants that all information shared by the guest speaker(s) should be kept confidential and should not be repeated outside the room. Ask participants if they can agree to these terms.
4. If the participants tend to address most of the questions to one panelist, ask the other panelists if they would like to answer the question as well.
5. When there are about ten minutes left, inform the group that there is time for two more questions.
6. When the time is up, thank the panelists with a round of applause.
7. After the panelists leave, facilitate a discussion by asking the following questions:
   - Were you surprised by the answers that the panelist provided?
   - Do you think the panelists are representative of HIV-positive members of this community? Why or why not?
   - What was the most useful information you heard from the panelists?
   - How do you think you will use this information?
8. Conclude the activity by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- The topics and issues the panelists discussed are personal, but are likely to also be concerns and issues other people living with HIV or AIDS are facing. This information is useful because we were able to hear firsthand the concerns, hopes, and issues some people living with HIV or AIDS have.
- As service providers, the participants should talk and listen to their clients who are living with HIV or AIDS. This way, the participants can become more aware of the complexity of issues and the reality some of the clients they are serving have to face.

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session 10:

HIV Transmission Overview: Understanding Personal and Professional Risk

Objectives

1. To clarify levels of risk of transmission of HIV for various practices and the factors that influence risk.
2. To dispel myths about HIV transmission.
3. To explore the most common risk factors for HIV transmission in health care facilities.

Time

60-75 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Review *Participant's Handbook Session 10: HIV Transmission Overview: Understanding Personal and Professional Risk*
- Flipchart paper
- Markers
- Tape
- Prepare five cards using letter-sized colored cards or paper, with the following titles:

High Risk | *Medium Risk* | *Low Risk* | *No Risk* | *Unknown Risk*

- Post the five title cards high on a wall, with plenty of space below and between each for participants to post behavior cards. Place the cards in the order suggested above to create a continuum from "high risk" to "unknown risk."
- Prepare behavior and myth cards (see *Trainer's Resource 10.1: Sample Behavior or Myth Cards*) using letter-sized paper or cards, with one behavior or myth per card or piece of paper. Include local myths, if available.
- Make sure that the space in front of the wall is cleared so that the participants have enough room to mingle as they post their cards.

- Pieces of tape (prepare many pieces in advance for participants to stick cards or pieces of paper to the wall rapidly).
- Prepare flipchart with summary points from *Essential Ideas to Consider*.
- Prepare flipchart with summary of modes of HIV transmission (see box on page 47).
- Review *Trainer's Resource 10.2*.

Steps

1. Distribute all of the cards with behaviors and myths to the participants, trying to ensure that each participant has the same number of cards. Provide the participants with an adequate number of pieces of tape to post their behavior or myth cards on the wall.
2. Instruct the participants to read their cards and to determine on their own what level of HIV risk every card poses. Then ask the participants to go to the wall all at once and place each of their cards along the continuum according to their assessment of the risk of HIV transmission posed by the activity on each of their cards ("High Risk," "Medium Risk," "Low Risk," "No Risk," or "Unknown Risk").
3. Once all the cards are placed, facilitate a discussion based on the questions below. Be sure to allow participants to answer their peers' questions and to share their knowledge of the relative risks of various behaviors. Affirm accurate responses and correct any misconceptions that do not get resolved in discussion among participants.

   Key Discussion Questions

   - Do you disagree with the placement of any cards? Where should they go instead and why?
   - Are you confused by the placement of any cards? Why is a particular card placed where it is along the continuum?
   - Which cards did you find most difficult to place along the continuum?
   - Which cards can be categorized as myths? Are there other myths about HIV transmission that you have heard about in your community? Where do these myths come from and how can we dispel them?
4. To conclude and summarize the discussion, refer the participants to the hand-out *HIV Risk Continuum* on page 40 of the *Participant's Handbook* and review with the group.
5. Using a prepared flipchart, present an overview of HIV transmission as indicated below. Refer participants to page 33 of their handbook (*HIV Transmission*).

Overview of HIV Transmission

HIV is spread through three main modes. These modes of transmission are linked to exposure to the body fluids (blood, semen, vaginal fluids, and breast milk) of infected individuals. Specifically, HIV can be transmitted through:

Sexual contact:

- Vaginal sex
- Anal sex
- Oral sex

Blood contact:

- Injections/needles (sharing needles, intravenous drugs, drug paraphernalia, or injury from contaminated needles or other sharp objects)
- Cutting tools (using contaminated skin-piercing instruments, such as scalpels, needles, razor blades, tattoo needles, circumcision instruments)
- Transfusions (receiving infected blood or blood products) or transplant of an infected organ
- Contact with broken skin (exposure to blood through cuts or lesions)

Mother-to-child HIV transmission:

- Pregnancy
- Delivery
- Breastfeeding

6. Next, conduct a large-group discussion of the following questions:
   - What are the ways HIV can be transmitted in the health care setting from client to health care worker?
   - What are the ways HIV can be transmitted in the health care setting from client to client?
   - What are the ways HIV can be transmitted in the health care setting from health care worker to client?
   - How can HIV be transmitted outside the facility through health care worker practices?
7. Refer participants to page 37 of their handbook (*HIV Transmission in the Health Care Setting and in Home Care*) and review the content with participants.

Training Tips

- Instead of providing pre-written behavior or myth cards, as a first step in the activity, the group can brainstorm a list of sexual behaviors that are practiced in their culture and of all the ways someone can get HIV. Once the list is established, the different behaviors and factors are written on separate cards, and the exercise is conducted as described above.
- This exercise can be long and involved, or conducted quickly, depending on how long the group takes to analyze the risk continuum and to dispel the myths. For example, when discussing the placement of the cards, the facilitator can either provide an overall summary of the risk continuum when working with a more advanced training group, or discuss the placement of each card, one by one, for a less knowledgeable group. Also, the facilitator can provide fewer cards by, for example,

concentrating on actual HIV risks exclusively rather than incorporating myths as well.

- It is recommended that the facilitator add cards with local myths to tailor this exercise to the needs of each group.
- Sometimes participants place behaviors that they find offensive in the "high risk" category, even if they present little risk of infection. If this happens in your group, recall how attitudes and judgments can influence a counselor's assessment of risk.

Summarize the session by reviewing with participants the key points elicited from the discussion points related to:

- The confirmed ways that HIV is transmitted with emphasis on transmission in the health care setting—provider to client, client to provider, and client to client; and
- The common misconceptions of how HIV can be transmitted.

Close the session by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- As health care workers, whether we counsel clients or not, it is important for us to understand the behaviors and situations that can lead to HIV infection. This information will not only help us better serve our clients, but can help us better understand the risk for HIV infection in the health care setting and in our own lives.
- Variations in sexual behavior, relationships, and social factors can influence HIV risk. Risk of transmission depends on the context in which a particular behavior occurs, as well as other factors such as age (younger women may be more susceptible due to less mature vaginal tissue; a woman who is significantly younger than her partner may have difficulty negotiating safer sex practices), gender (women may have difficulty negotiating safer sex practices with their partner), whether or not a partner is infected, whether or not a person is a "giver" or "receiver" of body fluids during sexual activity, and the difficulty of knowing a partner's sexual history and infection status.
- Often HIV myths and misconceptions are focused on specific groups that are marginalized in a community (commercial sex workers, for example). It is important for health care workers to recognize how these myths contribute to discrimination against these groups so that we can help prevent stigma and ensure that our services are welcoming and accessible to all groups.
- By understanding the various risks for HIV transmission in health care settings, we can better protect ourselves from infection. Standard precautions against HIV infection should be in place to reduce the risk. (Session 11 covers standard precautions.)
- Unprotected sexual intercourse and unsafe sexual practices carry a significantly higher risk of HIV transmission than accidental exposure to blood and body fluids in the health care setting.
- Identifying groups of people as "high-risk" leads to unjust stigma and discrimination. Shifting the language from "risk groups" to "risk behaviors" is a very important distinction that has a positive effect on attitudes toward people infected with HIV.

Trainer's Resource 10.1
Sample Behavior or Myth Cards

Note: Select at least 20 practices from this list for the exercise.

Abstinence
Masturbation
Sexual stimulation of another's genitals using hands
Sex with a monogamous, uninfected partner
Oral sex on a man (fellatio) with a condom
Oral sex on a man (fellatio) without a condom
Oral sex on a woman (cunnilingus)
Vaginal sex with a condom
Vaginal sex without a condom
Vaginal sex with multiple partners always using a condom
Anal sex with a condom
Anal sex without a condom
Massage
Having unprotected sex with your partner or spouse
Hugging a person with HIV
Vaginal sex with withdrawal prior to ejaculation
Re-using sharp instruments to cut the skin
Re-using injection needles or syringes between clients
Sitting on a public toilet seat
Getting bitten by a mosquito
Breastfeeding from an HIV-positive mother
Receiving a blood transfusion
Helping someone with a nosebleed
Sharing eating utensils with an HIV-positive person
Donating blood
Getting pierced
Shaking hands with an HIV-positive person
Labor and delivery (risk to child, mother is HIV-positive)
Sharing needles to inject drugs
Going to the dentist
Performing a pelvic exam during delivery without gloves
Performing a delivery without gloves
Recapping a used needle
Cleaning up a blood spill wearing latex gloves

Cleaning up a blood spill without wearing latex gloves
Performing a cesarean section delivery wearing latex gloves
Traditional circumcision (male)
Female genital cutting (female circumcision)
Getting a client's blood on your hands
Getting a client's blood on your hand (which has a recent cut on it)
Getting a client's blood on your hand (which has a rash on it)
Getting a client's blood on your hand which has a torn cuticle
Getting blood from a client splashed in your eye
Getting blood from a client splashed into your mouth
Sticking yourself with a used needle in the lab
Taking a blood pressure without gloves
Taking temperature without gloves
Performing an abdominal exam without gloves
Performing an antenatal abdominal exam without gloves

Trainer's Resource 10.2
HIV Risk Continuum

Practice	Risk	Notes
Abstinence	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Masturbation	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Unprotected sex with a monogamous, uninfected partner	No risk	Having unprotected sex in a monogamous relationship carries no risk as long as both partners are uninfected. However, it is often difficult to know if a partner is truly monogamous and uninfected.
Sharing eating utensils with an HIV-positive person	No risk	Studies have found that saliva does not contain enough virus to allow for HIV transmission.
Shaking hands with an HIV-positive person	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Sitting on a public toilet seat	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Getting bitten by a mosquito	No risk	Studies have found that mosquitoes do not transmit HIV between people.
Massage	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Hugging an HIV-positive person	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Helping someone with a nosebleed	No risk	If the skin on your hands is intact, then there is no risk for transmission.
Taking a blood pressure without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Taking a temperature without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Performing an abdominal exam without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Performing an antenatal abdominal exam without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Getting a client's blood on your hands	No risk	If the skin on your hands is intact, then there is no risk for transmission.
Cleaning up a blood spill wearing latex gloves	No risk	The gloves offer protection from the possible exchange of body fluids.
Performing a cesarean section delivery with gloves	Low risk/ No risk	In the absence of sharps injury, the risk of HIV transmission is very low.
Sexual stimulation of another's genitals using hands	Low Risk/ No risk	Risk is very low if there are no cuts or broken skin on hands, especially if there is no contact with secretions, semen, or menstrual blood.

Practice	Risk	Notes
Oral sex on a man (fellatio) with a condom	Low Risk/ No risk	Risk is very low if the condom is used correctly. However, some STIs (e.g. herpes) can be transmitted though contact with skin not covered by the condom.
Vaginal sex with a condom	Low risk	As long as the condom is used correctly, the risk of transmission is low. Some sexually transmitted infections (e.g. herpes) can still be transmitted though contact with skin not covered by the condom.
Vaginal sex with multiple partners; condom use every time	Low risk	Multiple partners increase risk, however correct and consistent condom use lowers risk. A new condom must be used with every partner and for every sexual act.
Cleaning up a blood spill without wearing latex gloves	Low risk	Risk is higher if hands have cuts or rashes.
Getting blood from a client splashed in your eye	Low risk	The risk of transmission is approximately 1 in 1,000.
Getting blood from a client splashed into your mouth	Low risk	The risk of transmission is approximately 1 in 1,000.
Performing a delivery without wearing latex gloves	Low risk	The risk of transmission is low as long as the skin of the hands is intact.
Performing a pelvic exam during labor without wearing gloves	Low risk	The risk of transmission is low as long as the skin is intact. However, meticulous handwashing is required to minimize infection transmission.
Getting a client's blood on your hand that has a recent cut on it	Low risk	Depending on the size and depth of the cut, the amount of blood, and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Getting a client's blood on your hand which has a rash	Low risk	Depending on the severity of the rash, the amount of blood and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Getting a client's blood on your hand with a torn cuticle	Low risk	Depending on the size and depth of the tear, the amount of blood and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Recapping a used needle	Low risk	Although the risk of injury is high, the actual risk of infection is low (approximately 1 in 300).
Sticking yourself with a used needle in the lab	Low risk/ possibly medium risk	The approximate risk of transmission is 1 in 300. Risk may vary depending on depth of injury and source patient's stage of illness.
Anal sex with a condom	Low/ possibly medium risk	Risk of condom breakage is greater than for vaginal sex. Some STIs (e.g. herpes) can be transmitted though contact with skin not covered by the condom.

Practice	Risk	Notes
Oral sex on a man (fellatio) without a condom	Low/ possibly medium risk	HIV can be transmitted through oral sex, though the risk is very low unless there are cuts or sores in the mouth. The risk of transmission is lower if no semen enters the mouth.
Oral sex on a woman (cunnilingus)	Low/ possibly medium risk	HIV can be transmitted through oral sex, though the risk is very low unless there are cuts or sores in the mouth.
Unprotected vaginal sex with withdrawal prior to ejaculation	High risk	HIV can be present in pre-ejaculate, and therefore, risk of transmission is high, however withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other sexually transmitted infections.
Vaginal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk.
Anal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk.
Re-using sharp instruments to cut skin (e.g. instruments used for scarification, FGM, tattoos)	High risk	If these instruments have been used on others and are not properly processed, HIV and hepatitis could be transmitted
Re-using injection needles or syringes between clients	High risk	Injection needles must be disposed of in a puncture-resistant container (disposable) or processed for reuse to prevent transmission of bloodborne organisms from one client to another. To process correctly, use high-level disinfection or sterilization.
Breastfeeding from an HIV-positive mother	High risk	Although the risk is relatively high, if no other good source of nutrition is available, it is still recommended that an HIV-positive woman breastfeed.
Labor and delivery, risk to child when mother is HIV-positive	High risk	Risk can be significantly reduced with certain antiretroviral drug regimens and safe obstetric practices.
Sharing needles, syringes, drugs or other drug paraphernalia	High risk	HIV and hepatitis can readily be transmitted from an infected person through sharing of injection needles and syringes.
Traditional circumcision	Unknown risk	If the razor blade or cutting instrument is re-used and not properly sterilized, risk could be high.
Going to the dentist	Unknown risk	Depends on the dentist's infection prevention practices.
Having unprotected sex with your spouse	Unknown risk	It may be difficult to know whether your spouse engages in activities that put you at risk.
Receiving a blood transfusion	Unknown risk	In many countries, the blood supply is adequately screened for HIV.
Donating blood	Unknown risk	In the presence of correct infection prevention practices, there is no risk.

From *Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. Trainer's Manual.*
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session 11:

Standard Precautions in the Health Care Setting and in Home Care

Objectives

1. To provide participants with guidance regarding the principles and practices of standard precautions to prevent HIV transmission in health care and home care settings.
2. To support participants' critical thinking in implementing standard precautions in resource-constrained settings.

Time

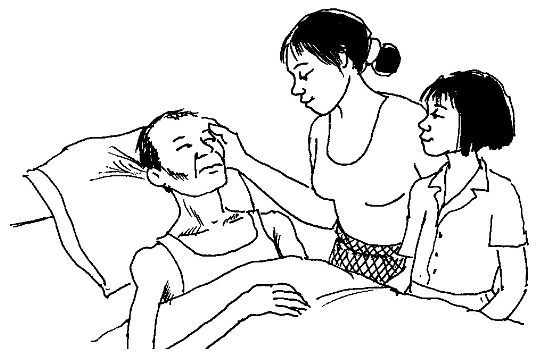
45 -120 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Prepare a flipchart with the definition of standard precautions (see page 43 of the *Participant's Handbook*).
- On flipchart paper write the following list:
  - Handwashing
  - Gloves
  - Eye protection
  - Protective clothing
  - Instrument processing
  - Handling sharps
  - Environmental cleanliness and waste disposal
  - Handling and processing of linen.
- Prepare a second flipchart with the following questions:
  - How does it protect against HIV infection?
  - What is the proper standard precaution procedure?
  - What are the challenges to implementing proper procedures and how can we overcome them?
- Review *Participant's Handbook Session 11: Standard Precautions in the Health Care Setting and in Home Care* and *Participant's Handbook Appendix B: Infection Prevention: A Reference Booklet for Health Care Providers*.
- Pre-select three or four case studies and review answers from *Trainer's Resource 11.1* for small-group discussions.

Steps

1. Introduce this session by asking the group to define *standard precautions*. Summarize the various definitions offered by the group by presenting the definition from page 43 of the *Participant's Handbook*. Be sure to make the distinction between *standard precautions* and *universal precautions*, emphasizing that standard precautions are design to protect everyone---providers, clients, and the community being served.
2. Tell the participants that they will be reviewing essential standard precaution practices by focusing on specific issues or areas within the health care setting and in home care.
3. Explain that home care can include health care workers going to clients' homes, family members providing care to their loved ones, or traditional health care providers such as birth attendants working in the home. Display the prepared flipchart paper and review the list of categories:
   - Handwashing
   - Gloves
   - Eye protection
   - Protective clothing
   - Instrument processing
   - Handling sharps
   - Environmental cleanliness and waste disposal
   - Handling and processing of linens



4. Divide participants into four small groups.
5. Assign groups 1 and 2 **standard precautions in the health care setting,** assigning group 1 the first four items on the list and group 2 the remaining four items.
6. Assign groups 3 and 4 **standard precautions in the home care setting,** assigning group 3 the first four items on the list and group 4 the remaining four items.
7. Instruct the groups to brainstorm all the standard precaution issues that need to be taken into consideration related to the items on the list for their setting. For each item on the list, the groups should answer the following questions (display the questions on a flipchart):
   - How does it protect against HIV infection?
   - What is the proper standard precaution procedure?
   - What are the challenges to implementing proper procedures and how can we overcome them?
8. Instruct each group that they have 15-30 minutes (depending on the time you have for this session) for their brainstorm and that they should select a person to record responses and report back to the large group.
9. Once they have completed their brainstorms, reassemble the group and have each small group present their work.
10. Guide the discussion by validating correct content, correcting inaccurate content, and expanding where content is missing. Use the Participant's Handbook *Session 11: Standard Precautions in the Health Care Setting and in Home Care* and *Participant's Handbook Appendix B* as references.
11. Link principles and practices of standard precautions to their application in resource-constrained settings.
12. Next, explain that we will now apply the information we just reviewed to real life health care situations by analyzing case studies.

13. Time permitting, divide participants into three or four small groups. Assign each group one of the case studies from the *Participant's Handbook*, *Session 11 (p.47)*. Be sure to review the answer key (*Trainer's Resource 11.1*) prior to the exercise.
14. Instruct the groups to read their case study and the case study questions. Give the groups 15 to 20 minutes to brainstorm responses to case study questions and to prepare a brief presentation. Each group should select a recorder and reporter.
15. After 15 to 20 minutes, have each group present the results of their case study analysis. Allow time for discussion after each presentation. Use the answer key to validate and/or correct the groups' responses.
16. Direct participants to the relevant pages in the handbook at the end of the discussion.

Summarize the session by reviewing with participants the *Essential Ideas to Consider*.

Essential Ideas to Consider

- Standard precautions prevent infection in both providers and clients and should be used with all clients, regardless of known or presumed infection status.
- Consistent handwashing, use of glove and other protective attire, avoiding recapping used needles, and safe disposal of contaminated waste are all vital standard precaution procedures that should be followed in both the health and home care settings.
- Simple and practical recommendations exist for effectively implementing standard precautions, even in resource-constrained settings.

Trainer's Resource 11.1
Case Studies: Standard Precautions in Resource-Constrained Settings Answer Key

Case Study #1:

Mrs. Yaro is a mother of four who just delivered a baby at home. You are the community nurse making your home visits when you find the family preparing to bring Mrs. Yaro to the facility because she has been bleeding more heavily than she did after her other deliveries. You observe that her clothing is very bloody, indicating active bleeding. You don't have any more sterile gloves in your bag but you have disposable gloves.

In managing this situation to provide necessary treatment and protect yourself and the client from bloodborne microorganisms, what should you do?

Wash your hands before beginning to examine the client. Use disposable gloves to examine Mrs. Yaro to determine the source of bleeding. If you have the necessary supplies, repair any laceration(s) if indicated. When finished, place used gloves in a doubled, plastic bag (or ask the family to prepare a 0.5 percent bleach solution and soak gloves for 10 minutes) and discard at the home or health center. Administer IM medication using sterile technique, if indicated. Insert IV using sterile technique, if indicated, in preparation for transport to the facility. Place used needle, syringes, catheter-stylus in a puncture-proof container to carry back with you to the health center for disposal. Clean up or instruct family members to clean up spills of blood with 0.5 percent bleach solution. Instruct family members to soak the bloodied clothing separately in cold water with bleach, and then launder separately in detergent and water with bleach solution. Wash hands after completing client care. Question the family about how they handled the placenta; if necessary, inform them to handle the placenta with gloves or intact plastic bags over their hands.

Case Study #2:

Anita works in a woman's health clinic and is responsible for charting client's blood pressure, temperature, and weight, and for drawing a few drops of blood from clients' fingers to check their hematocrit. She does not usually wear gloves during any part of this process but does wash her hands before seeing the next client. In cases where the client looks thin and 'sickly' Anita wears gloves, as she is concerned that these clients might be infected with HIV.

Is this an appropriate infection prevention practice? Why?

Anita should not draw blood from a client without wearing gloves, regardless of the amount of blood being drawn. Anita should put gloves on after charting the weight and before drawing the blood. She should also wash her hands after removing the gloves and before picking up a pen to continue charting vitals. Wearing gloves when there is possible contact with blood or other body fluids is part of standard precautions. These precautions should be followed with every client regardless of whether or not you think the client might have an infection. It is safer to act as if every client is infected rather than to apply standard precautions to some clients and not others.

Case Study #3:

Dr. Asante is the director of the Suta Clinic, which is holding a community health fair. During the opening session, many more community members arrive than the space can accommodate, and they spill out into the bushy areas. As the opening speech is being given, a painful wail is heard from the back of the crowd: a man has stepped on a needle and syringe, which is now sticking out of his foot. Upon inspection of the area where the man has been standing, Dr. Asante finds a pile of fresh medical waste at the base of a tree. He becomes angry and confused—since the clinic has an incinerator, he does not understand why the medical waste was dumped there. He discusses the issue with the staff responsible for waste disposal and running the incinerator, who tell him that they often receive more waste than the incinerator can handle and sometimes have to dump waste in the trees.

What are the waste-disposal issues here and what can be done about this situation?

The inappropriate practices here are improper sharps disposal and the dumping of medical waste in areas that are accessible to the community.

After treating the injury and explaining the potential risk to the injured man, Dr. Asante should:

- **Hold a meeting with the staff members responsible for waste disposal, sharing the incident and describing the risk to the community from such accidents**
- **Immediately assess the overall waste-disposal practices among all levels of staff**
- **Institute a program to get staff to sort waste so that the only waste going to the incinerator is medical waste that can cause infection or injury if not properly disposed of**
- **Set up an in-service refresher course immediately for all staff to reinforce their roles in waste disposal for infection prevention, including the safe use and disposal of sharps**
- **Conduct periodic follow-up evaluations to assess the consistency of correct waste-disposal practices after the refresher course**

Case Study #4:

Your clinic has a special container for disposing of sharps. The container is located in the vaccination room, since that is where most injections are usually given. Occasionally, clients need to be given injections in the treatment room, which is down the hall from the vaccination room. When this occurs, the nurses recap the hypodermic needles, carry them down the hall to the vaccination room, and dispose of them in the sharps-disposal container.

What should be done differently to reduce the risk of infections at your clinic?

The number-one cause of occupational exposure to bloodborne pathogens is needlestick injuries, many of which occur while recapping needles.

To reduce the risk of infections to health care workers, needles should not routinely be recapped before disposal.

Puncture-resistant sharps-disposal containers should be placed in every room where sharps are used. The uncapped needle and attached syringe should be immediately disposed of in a puncture-resistant container.

Case Study #5:

You are the supervisor visiting a health post in a rural area. During your visit you observe that there are more mothers than usual bringing their infants for immunization. Though the session is almost over, there are at least 20 mothers with their children still waiting. The housekeeping person is boiling needles and syringes to keep up with the demand but you also notice that one of the older nurses is giving injections and only changing the needle, reusing the same syringe. When you point out to her that this practice is not the correct technique for giving injections, she replies that she does not want to keep the women waiting longer than they already have and that it is only the needle that pierces the skin that needs to be sterile.

In managing this situation to prevent unsafe injection practices, what should you do?

Inform the nurse that needles and syringes that are reusable should be sterilized by autoclave (steam under pressure) since they come in contact with blood. Only one sterile needle and syringe should be used for each client. Where sterilization is not possible, high-level disinfection by boiling would be appropriate and acceptable. Explain to the nurse that the practice of only changing the needle, though commonly done, is unsafe because the negative pressure or suction produced when the needle is removed draws up whatever is in the needle into the syringe. When the syringe is reused with another person, the material from the previous person contaminates the injection. Share with the nurse that there is increasing concern among the health leadership about the role of unsafe injection practices in HIV transmission. Ask her to look at ten of the infants waiting to be seen and visualize that unsafe injection practices could cause two to four of those infants to become infected with HIV.

Suggest to the nurse that if supplies start running low, that she should praise the mothers for coming and inform them that to prevent infections you are taking a little extra time to make the needles and syringes safe for use; the mothers will appreciate being informed, it will show that you care about their well-being and they will trust you, and it is the respectful thing to do.

Ensure that the supply of reusable and disposable needles and syringes is adequate for high-volume sessions. Develop a schedule for keeping the used needles, syringes, and instruments processed so that the staff does not wait until the supply is almost depleted to begin processing them.

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session 12:

Prevention of Needlestick and Sharp Instrument Injuries

Objectives

To increase participants' knowledge of strategies for preventing needlestick and sharp instrument injuries.

Time

45-60 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Small prizes (e.g., sweets, special pens, etc.)
- Review *Participant's Handbook Session 12: Prevention of Needlestick and Sharps Injuries*

Steps

1. Introduce the session by emphasizing that a focus on preventing needlestick and sharp instrument injuries is essential. Preventing these injuries eliminates the physical, psychological, and emotional stress associated with HIV testing, waiting for a test, and the side effects of using post-exposure prophylaxis drugs following an exposure. It is also far more cost-effective than instituting post-exposure care, including post-exposure prophylaxis.
2. Provide flipchart paper and as many markers as there are participants.
3. Divide the group into two teams and ask participants to choose a team leader.
4. Ask Team 1 to list as many actions as they can **to prevent injuries by sharp instruments.**
5. Ask Team 2 to list as many actions as they can **to prevent injuries by needles.**
6. Instruct the teams that they have five minutes to brainstorm their lists. Time the brainstorming segment. As many of the team members who can fit around the flipchart to write can do so.
7. When the teams have finished, review the lists with the large group.
8. Give a prize to the team that has the most correct responses/number of actions.
9. Ask participants if there are any other actions that they can think of to add to the lists. The facilitator should add actions that are not mentioned by participants.

10. Lead a discussion by asking participants the following questions:
    - What safety practices should be followed during surgical procedures (e.g., cesarean section, tubal sterilization, vasectomy, and other invasive procedures) that require more than one person to perform?
    - How can the surgical team prevent or minimize the risk of injuries from needles and sharp instruments?
11. List participant responses, validate or correct as needed, and add other actions that participants may not have included in their responses.
12. Emphasize that the most important actions that surgical team members can take to minimize injuries from sharp instruments are:
    - *Avoiding hand-to-hand transfer when passing sharp instruments between staff*
    - *Creating a safety zone where instruments can be placed by the user and safely picked up by the assistant*
    - *Avoiding placing sharp instruments in kidney basins from which it is difficult to pick them up*
    - *Announcing whenever sharps are transferred (e.g., the surgeon always says "needle back" or "sharp back" when he is passing these instruments back to the safety zone).*
13. Direct participants to their handbook: *Prevention of Needlestick and Sharps Injuries*.

Conclude the session by asking a volunteer to summarize the ways that staff can protect themselves and each other from needlestick and sharp instrument injuries. Refer to the content on pages 49-51 of the *Participant's Handbook*.

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session 13:

Post-exposure Care and Post-exposure Prophylaxis

Objectives

1. To examine health care staff's feelings about the risk of occupational exposure to HIV.
2. To review options for care following an exposure to blood in the health care setting.
3. To prepare health care staff to manage accidental exposure to blood according to WHO and UNAIDS recommendations.

Time

60-75 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Review *Participant's Handbook Session 13: Post-exposure Care and Post-exposure Prophylaxis*
- Prepare flipchart with post-exposure prophylaxis algorithm (see page 53 of the *Participant's Handbook*)
- Prepare flipchart with summary points

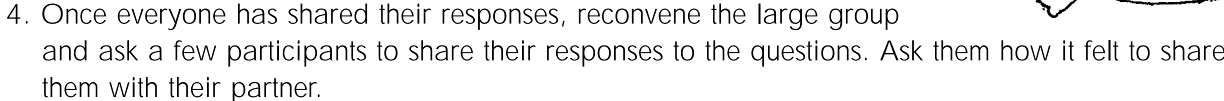
Steps

1. Introduce the session by emphasizing that the risk of HIV infection after occupational exposures to HIV—through needlesticks or cuts; splashes in the eyes, nose, or mouth; or skin exposure—is very low. Risk from all exposures is probably increased if the exposure involves a large volume of blood or if there is a high level of HIV in the blood. Most health care staff living with HIV were infected through sexual contact, and, to a lesser degree through intravenous drug use, blood transfusions, and invasive surgical procedures, including organ transplantation.[3] Acknowledge that in spite of best efforts to prevent exposure, accidents will happen occasionally and as health care workers we live with the possibility of injuries every day. Explain that before we talk specifically about what can be done to reduce the risk of infection following a potential exposure, we are going to explore our feelings about the possibility of exposure.

[3] "HIV and the Workplace and Universal Precautions," Fact 11, www.who.int/HIV_AIDS/Nursesmidwivesfs/fact-sheet-11/index.html.

2. Tell participants that you are going to ask a few questions related to the subject and you would like them to think about or write down their responses. Read the following question: If you were exposed to blood on the job (for example you were stuck by a needle or blood got in your eye),
   - What would you think?
   - How would you feel?
   - What would you do?
3. After participants have had sufficient time to reflect on the questions, split the group into pairs and instruct them to share their responses with their partner (for about 5-10 minutes).

   Note: This exercise might bring up strong emotions in those participants who have lived through this situation, some of whom may have been infected with HIV or another bloodborne illness as a result. Be sensitive to this and be sure to acknowledge it at the beginning of the exercise.



4. Once everyone has shared their responses, reconvene the large group and ask a few participants to share their responses to the questions. Ask them how it felt to share them with their partner.
5. Next, explain that we will review options for reducing the risk of infection following exposure to blood or body fluids. Present the content on post-exposure care and post-exposure prophylaxis from the *Participant's Handbook Section 13.* Display the post-exposure prophylaxis algorithm flipchart to support the presentation.

   Note: In many settings, post-exposure prophylaxis might not be available. The facilitator should use her/his discretion about the extent to which this material should be covered. However, health care workers should at a minimum be aware of post-exposure prophylaxis so that they can advocate for policy development and access to the drugs if they are not currently available.
6. Allow for participants' questions and clarify as necessary.
7. Direct participants to page 53 of their handbooks for more information on post-exposure care and post-exposure prophylaxis. Review any content that was not covered during the presentation and discussion.
8. Ask participants if they are aware of whether their facilities have established and/or posted post-exposure care protocols where all staff can see and use them.
9. If the participants do not know, have them find out (if the training is on site), or have them investigate upon returning to their sites.
10. Continue the discussion by asking participants the following questions:
    - What might be done in settings where no post-exposure care protocols exist?
    - What might be done where post-exposure care exists but post-exposure prophylaxis is not available (i.e. the drug(s) are not available)?
11. Close the session by presenting the *Essential Ideas to Consider*.

Essential Ideas to Consider

- Risk of HIV infection following occupational exposure is very low—most occupational exposures do not result in infection.
- Following exposure to infected blood, immediately clean the wound.
- Counsel the injured health care worker.
- Assess the risk and share findings during counseling of the injured health care worker.
- Offer HIV testing to the source client and provide counseling before and after HIV testing if the client consents to being tested.
- Provide counseling before and after HIV testing of the injured health care worker.
- Provide antiretroviral drug therapy, if indicated, available, and the health care worker consents.
- Provide follow-up monitoring and counseling, including voluntary counseling and testing periodically up to six months after exposure (e.g., at six weeks, 12 weeks, and six months).

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session 14:

HIV Testing and Client Rights

Objectives

1. To review the elements of HIV voluntary counseling and testing (VCT) and the meaning of positive and negative test results.
2. To explore the meaning of the "window period" as related to HIV antibody testing.
3. To review clients' right to informed and voluntary decision-making and informed consent before HIV testing.
4. To explore practical and ethical issues related to HIV testing that may arise in health care settings.

Time

60 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Review *Participant's Handbook Session 14: HIV Testing and Client Rights*

Steps

Introduce the exercise by communicating the following: health care staff's concerns about infections from bloodborne organisms including HIV, particularly staff who are involved in direct client care or in performing invasive procedures, have sometimes led staff to inappropriately order or request HIV testing of clients before performing procedures. They do this in the belief that knowledge of the client's HIV status will help them to better protect themselves from exposure. This thinking interferes with the staff consistently performing infection prevention practices that are designed to protect all health care staff, clients, and the communities they serve. It also violates the clients' rights to make informed and voluntary decisions about their healthcare.

1. Divide participants into four small groups. Assign each group a set of questions to discuss and answer. Groups should write their responses on flipchart paper and choose one person to present back to the large group.

   Group A:

   - What is voluntary and informed decision-making?
   - What is informed consent?
   - How do these concepts apply to HIV testing?

Group B:

- What is the purpose of voluntary counseling and testing?
- What motivates people to get tested?
- Why might someone choose not to get tested for HIV?

Group C:

- What do health care staff need to do to ensure that the rights of VCT clients are respected?
- Is there ever a justification for performing HIV antibody testing without the client's knowledge?
- What are the consequences of clients being tested without their knowledge and without counseling?

Group D:

- Do health care workers get tested periodically for HIV in your community and in your facility? Why or why not?
- Can HIV-positive health care staff continue to work? Why or why not?
- What can HIV-positive staff do to minimize the risk of transmitting HIV to clients?
- What challenges do HIV-positive health care workers face?
- What can health facilities do to protect the rights of HIV-positive health workers?

2. Present the content of the *Participant's Handbook Session 14: HIV Testing and Client Rights*.
3. Emphasize the *Essential Ideas to Consider* at the close of the discussion.

Essential Ideas to Consider

- Whether or not to test for HIV is a personal choice influenced by many factors, including knowledge about HIV, knowledge about the benefits and drawbacks of testing, the level of stigma in the community, the potential for being subjected to ostracism or violence if one tests positive, and personal ideas and feelings about risk, death and dying, among others.
- HIV antibody testing will not necessarily give accurate information about HIV status. If the client was recently infected, he/she may be in the "window period," when there are insufficient amounts of HIV antibodies for the screening test to detect.
- HIV antibody testing must not be used as a tool for discrimination. People must not be tested without their knowledge or against their will, and positive HIV test results must not be used to deny treatment to anyone or to segregate them from other patients (unless it is clinically warranted for their own health).
- VCT can help clients to adopt behaviors to prevent infection or repeated exposure to the virus and to make realistic plans for themselves and their family members. For those who test positive, VCT can provide linkages to treatment, care and support programs.
- Health care staff may not ethically refuse to treat a client who is HIV-positive, nor should they withhold indicated procedures for fear of the risk to themselves of acquiring the virus. They can protect themselves from exposure to blood-borne organisms and reduce their risk of occupational HIV infection by consistently performing standard precautions.
- Health care workers who know they are HIV-positive should not be involved in any activities or procedures that would present a risk of transmission to clients. Although the risk is low, health care staff can accidentally transmit HIV to clients. Therefore, health care workers should get tested for HIV and always protect clients while delivering services.
- Employment policies should be developed and instituted that protect the privacy and confidentiality of staff and that support staff living with HIV to be as productive as possible without social isolation.

Note: You may wish to ask participants "How many of you have been tested for HIV? What was the experience like for you? How did you feel?" Be sure to tell participants that they do not have to share the results of the test during this discussion.

session 15:

Action Plan Development

Objectives

To give participants an opportunity to apply what they have learned during the training to their personal practices and their facilities.

Time

60-120 minutes

Materials and Advance Preparation

- Flipchart paper
- Markers
- Tape
- Pens/pencils
- Review *Participant's Handbook Session 15: Action Plan Development*
- Prepare pieces of flipchart paper with a blank action plan chart (*see Trainer's Resources 15.1*)
- *Participant's Handbook, Appendix A: HIV-related Stigma and Discrimination and Standard Precautions Assessment Tool*

Steps

1. Direct participants to *Session 15: Action Plan Development* on page 65 of their handbook.
2. OPTION A: Ask each participant to write their responses to the questions on the worksheet entitled, "At My Facility," on pages 65 to 66 of the Participant's Handbook. Remind them to answer the questions as honestly as possible. Ask participants to think about their responses to each question to see if responses reflect appropriate attention to reducing stigma and discrimination as well as good infection prevention practices, or if there are problems that need to be addressed. Ask participants to brainstorm and write down any problems they identify and select the three most urgent problems (allow 15 minutes). **Note:** If some participants are not literate split the group into pairs, assigning those who are not literate to a person who is.
3. Reconvene the large group and ask people to share their responses. If this is an on-site training, record the three most commonly cited problems on flipchart paper.
4. Display the flipchart with the blank action plan and explain that they will develop a facility-wide action plan.
   - If the training is on-site, the group can develop one common plan to address the three most urgent

problems identified in the previous activity. Ask for a volunteer from the group to record the work plan on the flipchart during the discussion.

- If there are participants from different facilities ask them each (or in small groups if there are several from one facility) to develop a plan.

5. OPTION B: This option takes more time (about 120 minutes). Split participants into 3-4 small groups. If the participants are from different health facilities, split into small groups by facility. (If there is only one participant from a facility, group them with another individual or small group.) Direct participants to the ***Participant's Handbook, Appendix A: HIV-related Stigma and Discrimination and Standard Precautions Assessment Tool***. Have each group spend about 30 minutes conducting the assessment of their facility using this assessment checklist.
6. Once the small groups have completed the Facility Assessment Tool, instruct them to develop a Facility Action Plan using the tool on page 67 of the *Participant's Handbook*. First, identify the three most urgent problems and write them in the problem column. Next, for each problem, list the steps that need to be taken to resolve the problem. Identify any resources needed to complete each action step and then identify the person or persons who will carry out the step and by when. The action plan should implement new knowledge, attitudes, and skills learned during this training.
7. Next, ask each participant to complete a Personal Action Plan using the table on page 68 of the *Participant's Handbook*. Their plan should include personal steps they will take to implement new knowledge, attitudes and skills learned during this workshop in their daily work, plus any assignments they have as part of the facility-wide action plan.
8. Allow 15 minutes for completion of the Personal Action Plans.
9. Reassure participants that they may choose to present and discuss their personal action plans privately with a facilitator.
10. Tell participants to share the Facility Action Plans with relevant supervisors to facilitate management-level support for the plan. If this is an on-site training it is recommended that the facility action plan be presented to supervisors before the close of the training, if possible.
11. Use both the Facility Action Plans and Personal Action Plans as tools for follow-up of the training to assess their implementation and assist the participants in problem solving.

Trainer's Resource 15.1
Facility Action Plan

Instructions
Given your resources in the previous activity, design an action plan to address the identified problems.

Problem	Action Step	Resources Needed	By Whom	By When
Problem #1	a.			
	b.			
	c.			
Problem #2	a.			
	b.			
	c.			
Problem #3	a.			
	b.			
	c.			

session 16:

Post-test and Closing

Purpose and Objectives

To assess participants' knowledge of the material covered during this training.

Time

45-60 minutes

Materials and Advance Preparation

- Pens/pencils
- One copy of the blank post-test for each participant (see Trainer's Resource 16.1)

Steps

1. Pass out blank copies of the post-test (Trainer's Resource 16.1).
2. Give participants 15-20 minutes to complete the post-test. If time permits you can also ask participants to complete the case study (Trainer's Resource 16.2).
3. Close by reviewing the post-test (Trainer's Resource 16.3 is the answer key) and highlighting the most important issues raised during the training. Refer to the original goals and objectives and participant expectations identified on the first day. Acknowledge the effort the participants made to share their ideas and actively participate.

   Review the case study if you have asked the participants to complete it (see Trainer's Resource 16.4).
4. Ask the participants if they would like to add anything.
5. Distribute certificates of completion or carry out some other formal closing.

Trainer's Resource 16.1
Post-test

Instructions: Read each statement and write in the number for the answer that best reflects your attitudes, values, and comfort level related to HIV and AIDS and working with people who are living with HIV or AIDS.

Scale: 1 = strongly agree 2 = agree 3 = disagree 4 = strongly disagree

I believe…

_____I believe that people who are infected with HIV should not be treated in the same areas as other patients in order to protect the larger population from infection.

_____I believe that people infected with HIV are responsible for getting infected.

_____I believe that HIV-positive patients are the biggest threat to my safety at my place of work.

_____I believe most HIV-positive health care workers get infected at work.

I feel…

_____I feel that providing health services to people infected with HIV is a waste of resources since they are going to die soon anyway.

_____I feel that I am at high risk of becoming infected with HIV working in the health facility.

_____I feel that clients who have sexual relations with people of the same sex have a right to access the highest quality of health services in my facility.

_____I feel that clients who are sex workers have a right to access the highest quality of health services in my facility.

I am comfortable…

_____I am comfortable providing health services to clients who are HIV-positive.

_____I am comfortable performing surgical or invasive procedure on clients whose HIV status is unknown.

_____I am comfortable sharing the bathroom with a colleague who is infected with HIV.

_____I am comfortable assisting or being assisted by a colleague who is infected with HIV.

I avoid…

_____I avoid touching clients for fear of becoming infected with HIV.

_____I avoid touching clients' clothing and belongings for fear of becoming infected with HIV.

_____I avoid performing ANY task at work without wearing latex gloves.

Trainer's Resource 16.1

Instructions: Decide whether each of the following statements is true or false. Write your response for each statement in the space provided, putting **T** for true and **F** for false.

True/False

1. _____ Withholding health services from a client believed or known to be HIV-positive is a violation of the client's human rights.

2. _____ When there are shortages of needles and syringes, it is acceptable to rinse the syringes in disinfectant solution and to reuse them as long as new needles are used.

3. _____ The risk of HIV transmission following needlestick or sharps injuries is very small, approximately 1 in 300.

4. _____ The risk of HIV transmission following a splash of blood or body fluids to non-intact skin or mucus membranes is very small, approximately 1 in 1,000.

5. _____ Standard precautions are designed to protect only health care workers from clients who may be infected with HIV or hepatitis.

6. _____ Standard precautions are also applicable when providing home-based care.

7. _____ Needlestick and sharps injuries can be prevented.

8. _____ It is appropriate to test clients who look like they are HIV-positive or clients preparing for surgery, to ensure that staff take precautions during surgery to prevent HIV transmission.

9. _____ A pregnant staff member who is accidentally injured by a needlestick or a sharp instrument cannot receive post-exposure prophylaxis due to the risk of damage to the fetus by antiretroviral drugs.

10. ____ A health worker who knows that he/she is HIV-positive can continue to work safely in service delivery as long as they avoid activities that present a risk of transmission to clients.

11. ____ To prevent transmission of HIV and other bloodborne infections in the health care setting, the staff should wear latex gloves for every client contact, including taking vital signs.

12. ____ To prevent stigma and discrimination in the health care setting, staff must treat all clients with respect and in a welcoming manner, provide privacy and confidentiality, and avoid creating segregated areas for clients who are known or believed to be HIV-positive.

13. ____ If a health care worker has a recent cut on her/his hand, the risk of HIV transmission following contact with a client's blood is higher than if the skin of the hand is intact.

14. ____ Exposure risk procedures are invasive procedures where there is a risk of injury to the health care worker that may result in the exposure of the client's open tissue to the blood of the worker.

15. ____ The risk of domestic violence related to HIV testing or disclosure of test results should be explored during pre- and post-HIV test counseling.

Trainer's Resource 16.2
Post-Test Case Study

Review the following case study and answer the questions below:

Case Study

In a community health center, the staff consists of two midwives, three nurses, and a clinical officer. The community and staff have attended several funerals for people believed to have had AIDS. The staff are worried about their risk of becoming infected with HIV at work. During a delivery at the health center, the midwife stuck herself with the suture needle while repairing a laceration. The nursing staff immediately informed the clinical officer who cleansed the wound with alcohol and reassured her that since it was not a deep wound, she would be fine. Besides, there is nothing that could be done for her anyway.

Questions

Is the clinical officer's management appropriate? Is his advice accurate?

How would you manage this situation?

Trainer's Resource 16.3
Pre/Post-test Answer Key

There are really no right or wrong answers for the first set of questions on the pre and post-test (those in the sections beginning "I believe…", "I feel…", etc). These questions are to gauge participant's attitudes and can be used to see if there were changes in attitudes as a result of the training.

1. **True** Withholding health services from a client believed or known to be HIV-positive is a violation of the client's human rights.

2. **False** When there are shortages of needles and syringes, it is acceptable to rinse the syringes in disinfectant solution and to reuse them as long as new needles are used.

3. **True** The risk of HIV transmission following needlestick or sharps injuries is very small, approximately 1 in 300.

4. **True** The risk of HIV transmission following a splash of blood or body fluids to non-intact skin or mucus membranes is very small, approximately 1 in 1,000.

5. **False** Standard precautions are designed to protect only health care workers from clients who may be infected with HIV or hepatitis.

6. **True** Standard precautions are also applicable when providing home-based care.

7. **True** Needlestick and sharps injuries can be prevented.

8. **False** It is appropriate to test clients who look like they are HIV-positive or clients preparing for surgery, to ensure that staff take precautions during surgery to prevent HIV transmission.

9. **False** A pregnant staff member who is accidentally injured by a needlestick or a sharp instrument cannot receive post-exposure prophylaxis due to the risk of damage to the fetus by antiretroviral drugs.

10. **True** A health worker who knows that he/she is HIV-positive can continue to work safely in service delivery as long as they avoid activities that present a risk of transmission to clients.

11. **False** To prevent transmission of HIV and other bloodborne infections in the health care setting, the staff should wear latex gloves for every client contact, including taking vital signs.

12. **True** To prevent stigma and discrimination in the health care setting, staff must treat all clients with respect and in a welcoming manner, provide privacy and confidentiality, and avoid creating segregated areas for clients who are known or believed to be HIV-positive.

13. **True** If a health care worker has a recent cut on her/his hand, the risk of HIV transmission following contact with a client's blood is higher than if the skin of the hand is intact.

14. **True** Exposure risk procedures are invasive procedures where there is a risk of injury to the health care worker that may result in the exposure of the client's open tissue to the blood of the worker.

15. **True** The risk of domestic violence related to HIV testing or disclosure of test results should be explored during pre- and post-HIV test counseling.

Trainer's Resource 16.4
Case Study Answer Key

Case Study

In a community health center, the staff consists of two midwives, three nurses, and a clinical officer. The community and staff have attended several funerals for people believed to have had AIDS. The staff are worried about their risk of becoming infected with HIV at work. During a delivery at the health center, the midwife stuck herself with the suture needle while repairing a laceration. The nursing staff immediately informed the clinical officer who cleansed the wound with alcohol and reassured her that since it was not a deep wound, she would be fine. Besides, there is nothing that could be done for her anyway.

Questions

Is the clinical officer's management appropriate? Is his advice accurate?

NO

How would you manage this situation?

The clinical officer should:

- Immediately flush the injured area with running water, wash the injured area with soap and water, and allow the site to bleed briefly.
- If feasible, assess the injured midwife's risk of infection following exposure and the need for prophylaxis, including voluntary counseling, HIV testing, treatment, and follow-up care. If possible, determine the client's HIV status through counseling and testing.
- The clinical officer should report the incident to the supervisor of the health center and facilitate the midwife being seen at the closest hospital that can provide HIV counseling, testing, and/or prophylaxis. If available, antibody testing should be done as soon as possible for a baseline and periodically for the next six months after exposure (e.g., at six weeks, 12 weeks, and six months).
- Counsel the injured midwife about the possible side effects associated with the use of prophylactic drugs (ZDV and 3TC), if one or both of these are available.
- Counsel the midwife about behaviors that will prevent HIV transmission to others, such as not donating blood and practicing safer sex. Counsel her to use latex condoms consistently and correctly to reduce the risk of HIV. Encourage her to bring her partner with her for counseling.
- If prophylactic drugs are used, assess toxicity by taking blood from the midwife for complete blood count, kidney, and liver function tests before starting treatment and repeat blood test two weeks after starting treatment.
- Instruct the midwife to report any sudden or severe flu-like illness that occurs during the follow-up period, especially if it involves fever, rash, muscle aches, tiredness, malaise, or swollen glands. These symptoms may suggest HIV infection, drug reaction, or other medical conditions. Instruct her to contact her provider if any questions or problems occur during the follow-up period.
- Use the incident to offer an in-service lesson to the rest of the staff for prevention of sharp injuries and for orienting staff to the management of sharp injuries. <u>Be careful to maintain the midwife's confidentiality</u>.
- Recognize and address the injured midwife's emotional reactions, fears, and concerns related to herself and to sharing the information with her partner/spouse and/or family.