

**HelpAge
International**

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HIV and AIDS peer education manual for older people



HIV and AIDS peer education manual for older people

This manual was developed by Epicentre AIDS Risk Management PTY Ltd
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How to use this manual

The purpose of this manual is to provide guidance and information on how to facilitate peer education sessions for older people. The manual also provides a variety of exercises and information that can be used during peer education training sessions.

Exercises in the manual are intended for individual, pair or group work. They are marked by symbols in the margin to help quickly identify how best to complete the activity.

The following key will guide you:



When you see a single face – the activity is to be done by participants on their own.



When you see two faces – participants should work with a partner.



When you see three faces – participants should work in small groups.



When you see all four faces – participants will discuss the issue together.



These are 'At home' tasks. When you see this symbol – ask participants to complete these exercises at home.



When you see lines like the ones below, it means that you should ask participants to record their responses in writing.

Glossary of terms

- **Age-disparate relationships:** Generally refers to relationships in which the age gap between sexual partners is five years or more. The terms 'inter-generational relationships' and 'cross-generation relationships' generally refer to those with a 10 year or greater age disparity between sexual partners.
- **Antibody:** A specific protein produced by the body's white blood cells to kill a specific foreign body; for example, antibodies are produced against the different kinds of colds, flu and HIV.
- **Antiretroviral therapy:** A triple or more antiretroviral drug combination.
- **Asymptomatic:** Showing no symptoms of disease.
- **Behaviour change:** Adoption and maintenance of healthy behaviours.
- **Bisexual:** Bi means two and is the term used for people that have attractions to members of the same and opposite sex.
- **Body fluids:** Includes all fluids coming from the body. Body fluids that contain sufficient HIV concentrations for HIV transmission are blood, semen, vaginal fluids or secretions, breast milk, amniotic fluid and pre-ejaculation fluid.
- **CD4 cells:** White blood cells which initiate the body's response to infections.
- **Concurrent partnerships:** Where a person has two or more sexual partners at one time for which first sex was reported six months or longer ago and the most recent sex is reported as less than or equal to six months ago.
- **Eligible for treatment:** People living with HIV for whom antiretroviral therapy is indicated, based upon a range of clinical and immunological parameters.
- **Epidemiology:** The study of a health-event, health-characteristic, or health-determinant patterns in a population.
- **Epidemic:** An unusual increase in the number of new cases of a disease in a human population. The population may be all the inhabitants of a given geographic area, the population of a school or similar institution, or everyone of a certain age or sex, such as the children or women of a region. Deciding whether an increase in the number of cases constitutes an epidemic is somewhat subjective, depending in part on what the usual or expected number of cases would be in the observed population. An epidemic may be restricted to one locale (an outbreak), be more general (an epidemic) or be global (a pandemic).
- **False negative:** A blood test for HIV that does not reveal the presence of HIV in a person with HIV. This may happen if the test is done before the person with HIV has developed detectable antibodies.
- **False positive:** A blood test for HIV that shows the presence of HIV in a person who does not have HIV. This happens when the test detects antibodies to another organism.
- **Generalised epidemic:** An epidemic that is self-sustaining through heterosexual transmission. In a generalised epidemic, HIV prevalence usually exceeds one per cent among pregnant women attending antenatal clinics.
- **Heterosexual:** Somebody who sexually desires members of the opposite sex.
- **HIV-positive:** Having tested positive for HIV infection.
- **HIV test:** A blood test to determine whether a person has HIV. Usually two or three tests are performed to confirm whether a person has HIV. Many different tests are available.
- **Immune deficiency:** A condition where the body's defence system is compromised.
- **Immune system:** The body's defence against infections. The parts of the immune system that produce antibodies include the skin, mucous membranes, glands, hairs, blood and cells.
- **Incidence:** The number of new cases of a disease or infection in a population over a certain period.
- **Men who have sex with men (MSM):** Males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity
- **Monogamy:** Practice of having a single partner during a period of time.

- **Non-communicable disease (NCD):** A medical condition or disease which is non-infectious. NCD's are diseases of long duration and generally slow progression. They include heart disease, stroke, cancer, asthma, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease and cataracts.
- **Older people:** The United Nations defines people over 60 years of age the "old population". For the purpose of this manual because the HIV response is generally focused on people aged 15–49, people aged 50 and above are included in the definition of older people.
- **Opportunistic infections:** Infections which occur in people with HIV. Usually uncommon in persons without HIV. Includes TB, pneumonia and meningitis.
- **Palliative care:** An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psycho-social and spiritual.
- **Prevalence:** The level of a disease in a population.
- **Surveillance screening:** Analysing the blood of a population or groups within a population to establish disease prevalence. Surveillance screening is usually unlinked and anonymous.
- **Re-infection of HIV:** Refers to getting infected with HIV a second or even more times.
- **Unprotected sex:** Also called unsafe sex. Sexual intercourse where an exchange of body fluids takes place with no barrier such as a condom can transmit an STI or HIV between partners.
- **Virus:** A tiny organism or germ that can cause disease in humans, animals and plants. Viruses that cause diseases in humans include HIV, polio, measles, common colds and flu.
- **Viral load:** the amount of active HIV in a person's blood.
- **Window period:** The time period between initial infection with HIV and the production of antibodies which is usually between 2 to 12 weeks. An HIV antibody test will be negative in this period although the person has HIV.

Acronyms

- **AIDS:** Acquired immunodeficiency syndrome.
- **ARV:** Antiretroviral, medication used in the treatment of HIV.
- **CMV:** Cytomegalovirus retinitis is a viral inflammation of the retina of the eye.
- **ED:** Erectile dysfunction, also known as impotence.
- **HAART:** Highly Active Antiretroviral Therapy or HAART, when several drugs, typically three or four, are taken in combination.
- **HBM:** Health Belief Model. This model aims to explain how behaviour changes.
- **HIV:** Human immunodeficiency virus.
- **HIV-1:** Strain of HIV.
- **HIV-2:** Strain of HIV.
- **HCT:** HIV counselling and testing.
- **IDDM:** Insulin dependent diabetes mellitus, also known as type 1 diabetes.
- **IEC:** Information, education and communication materials.
- **KAPB:** Knowledge, attitudes, practices and behaviour survey.
- **MSM:** Men who have sex with men.
- **NCD:** Non-communicable disease.
- **OVC:** Orphans and vulnerable children.
- **PE:** Peer educator.
- **PEP:** Post-exposure prophylactic.
- **PCP:** Pneumocystis pneumonia.
- **PMTCT:** Prevention of mother-to-child transmission.
- **STI:** Sexually transmitted infection.
- **TB:** Tuberculosis.
- **TOT:** Training of trainers.
- **VCT:** Voluntary counselling and testing for HIV.
- **WHO:** World Health Organization.

Background

HelpAge International (HelpAge) is a global network of not-for-profit organisations with a mission to work with and for disadvantaged older people worldwide to achieve a lasting improvement in the quality of their lives. HelpAge has a vision of a world in which all older people fulfil their potential to lead dignified, healthy and secure lives. HelpAge strives for the rights of disadvantaged older people to economic and physical security; healthcare and social services; and support in their caring role across the generations. In Africa, HelpAge has a network of more than 20 partner organisations.

HelpAge works with older peer educators to raise awareness of how HIV affects older people and their families. The role of the peer educators is to educate older people about HIV so they can protect themselves and help control the spread of HIV. Peer educators attend community meetings and social events, visit older people, including older carers of orphaned and vulnerable children and people living with HIV, to highlight key facts about HIV in older people and to help reduce isolation and stigma in their villages and communities.

This manual was borne out of the recognised need for a ‘standardised’ curriculum on HIV, AIDS and older people-related health issues to help ensure that “older people are able to more effectively protect themselves and their families from HIV and its effects”. It was developed to train volunteer older members of the community to educate other older people about HIV.

The manual is for trainers of peer educators. It provides guidelines on how to conduct sessions during training aimed at increasing knowledge, positively influencing attitudes and imparting useful skills with regards to HIV, sexually transmitted infections (STIs) and other subjects on health and older people.

HelpAge would like to thank the older people, trainers and government officials who participated in the pilots in Ethiopia and Tanzania and the trainers for their information and ideas to refine and finalise this manual.

We hope this manual helps raise awareness of how older people can protect themselves and others from HIV, and wish you every success in your valuable work.

Introduction to peer education for older people

Session outcomes:

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

- provide an overview of the purpose of this training course
- define who a peer educator is
- discuss peer education and group learning
- discuss the qualities of an effective peer educator
- understand ethical behaviour
- understand the roles and responsibilities of a peer educator

Introduction

HIV is a major challenge for older people in Africa. It affects older people in two main ways:

- They are at risk of and living with HIV. With increased access to ART people are surviving longer and living into their older age with HIV. The combination of this and new infections in older people is leading to an increased number of older people living with HIV.
- They become the major carers to their adult children who are living with HIV and take over the care of their orphaned grandchildren. HIV has altered family structures: when older people's adult children die, they once again become the head of household, providing care for orphaned grandchildren. They also care for those living with HIV in their households. The majority of older carers are women and many experience financial, physical and emotional stress due to their care-giving responsibilities.

Aims of this training programme

Older people are a population that has been neglected in HIV programmes in Africa yet research shows they are impacted by HIV as much as any other demographic. The aim of the training programme is to provide peer educators with information on HIV and AIDS to promote knowledge and understanding of HIV transmission, prevention, care and treatment in older people and their family members.

Objectives of training programme

To ensure that participants:

- understand the importance of peer education as a model for community education and develop an understanding of HIV transmission, prevention, care and treatment in older people
- develop skills in appropriately conveying information and messages on STIs, HIV and AIDS to older people
- understand how to support older people who care for people living with HIV and orphaned grandchildren
- provide older people with coping strategies in the face of the impact of the HIV epidemic

Who is a peer?

A peer is someone you share some common characteristics with. You could be the same sex, in the same age group, share the same beliefs, work in the same organisation or share other characteristics.

What is peer education?

Peer education is a process whereby well-trained and motivated people undertake informal or formal educational activities with their peers. It is aimed at developing peers' knowledge, understanding and skills to try and influence responsible behaviour and informed choices to mitigate the impacts of HIV and AIDS. Peer education can take place in small groups or through one-to-one discussions in a variety of settings where people gather to discuss issues affecting their lives, such as in the workplace, in shelters or homes.

- A **peer educator** is a person who gives information to educate, NOT advice, to a group of people and sometimes in a one-to-one situation. Peer educators volunteer to hold their positions and are not paid for their work.

The main goal of most peer education activities is to educate so as to influence change in attitudes and behaviours that may be hindering people's own wellbeing and that of others. Peer education has been used in many areas of public health, including nutrition, education, family planning, substance abuse, violence prevention and HIV programmes.

Why peer educators?

Peer Educators are important because:

- They give an HIV programme greater relevance to older people in the community.
- 'Same age' role models help encourage people to accept information and to talk about matters that they might be uncomfortable talking about with younger people.
- They can help to break down the stereotypical view of older people as not being at risk of contracting HIV or in need of prevention activities.
- They can help to give a programme greater credibility and sustainability in the community.

Benefits to you of becoming a peer educator

- Helps increase knowledge of HIV and AIDS.
- Increases knowledge of other health risks affecting older people.
- Helps increase range of skills as a community educator.
- Enables people to contribute to the wellbeing of the community.



In pairs, discuss:

Many older people are uncomfortable talking about sexual matters. Ask participants to discuss in pairs how you [the facilitator] can talk about sexual relationships in a way that is acceptable. Can you talk plainly about sex? If not, how should you discuss sexual matters? They should appoint a leader to share their ideas with the whole group.

Why are peer educators effective in educating their peers?

Research has shown that peer education is a very effective method in getting people of all ages to change their behaviour. Many older people do not think they are at risk of HIV. We need to change this perspective and get older people to protect themselves.



Small group exercise

Ask participants to discuss why older peer educators will be effective in getting older people to effect positive change in their behaviour. Ask them what the benefit to an older person in becoming a peer educator is and why older people make good peer educators. They should appoint a leader to feedback to the group.

Peer education is effective in getting people to change behaviour because they have access to their peers, they can act as role models, they are good at communicating with their peers and they can identify with their peers and the problems they face.

Older people make good peer educators as they have the respect of the community. They are role models that others, both young and old, look up to, and they can potentially influence many people. Although it can be stressful to older people who become peer educators to be in the “limelight”, they can use their influence to great advantage in the community. Older people can relate more easily to other older people and are better equipped to educate their peers than a younger person.

Taking part in peer education provides the opportunity to develop:¹

- skills in facilitation, communication, negotiation and conflict-resolution
- accept and respect differences between people in the community
- increased self-esteem and purpose in life to help others
- increased knowledge and awareness of health-related issues in older people
- tolerance of other people
- a more outward looking attitude

The roles and responsibilities of a peer educator

HelpAge peer educators are expected to do home visits to share their knowledge about HIV and AIDS in older people and how to care for people living with HIV and orphaned children. The goal is for each peer educator to visit a ‘targeted’ number of homes at least once a month. Peer educators may also hold more structured activities such as education sessions in a church or community hall.

The roles and responsibilities of a HelpAge peer educator also include:

- attending community meetings and social events.
- helping reduce isolation and stigma in their villages and communities.
- referring their peers to services such as HIV counselling and testing (HCT) or treatment centres. Sometimes, older people require support and encouragement and will appreciate the peer educator going with them to the referred service centre.
- providing correct information and distribution of condoms where needed.

- filling out reporting forms after every visit or activity conducted.
- acting as a role model to others in positive behaviour on HIV and AIDS issues.

The position of a peer educator is voluntary, that is, unpaid. Peer educators agree to educate their older peers in health-seeking behaviour because they are committed to reducing illness in the community and raising awareness of how older people can protect themselves against HIV.

Peer educators are supported by a supervisor. They are expected to attend coaching sessions to provide feedback on the informal and formal sessions they have held and receive additional training, support and guidance. They should keep a diary of all contact sessions they have had including the content of the topics covered, the number of males and females and where the sessions were held.



Small group exercise

Ask participants to discuss why they decided to volunteer to be trained as older peer educators. Ask them to discuss the responsibilities of a HelpAge peer educator and how they will be able to fulfil the role. They should appoint a leader to feedback to the group.

The qualities of an effective older peer educator



Small group exercise

In the left-hand column below, you will find the top 10 qualities of a good older peer educator. Read these to the participants and ask them to match these qualities with their correct definitions from the right-hand column.

Qualities		Definitions
1 Open-minded	a)	Able to be trusted, won't let others down.
2 Knowledgeable	b)	Willing to change in new situations.
3 Exemplary	c)	Model the changes in behaviour required.
4 Trustworthy	d)	Able to imagine oneself in the position of someone else and so understand that person's feelings.
5 Caring	e)	Able to provide useful facts and ideas.
6 Committed	f)	Real and sincere: being oneself without hiding behind a job, title or role.
7 Flexible	g)	Sensible, trustworthy and able to make good practical and moral decisions.
8 Understanding	h)	Giving encouragement and help to someone in a difficult position.
9 Genuine	i)	Does not judge someone in order to find fault with them.
10 Non-judgmental	j)	Giving one's loyalty and total support.



Small group exercise

Ask participants to discuss which of the qualities listed above are most important in an older peer educator and what other qualities should be added to this list. They should appoint a leader to feedback to the group.

Read the thought bubbles below to the participants and ask them to discuss how these qualities will help them to help others.

Non-judgmental:

- Respect for others
- Does not judge others in order to find fault with them
- Allows each person to be themselves

Role models:

- Dress in a culturally and religiously appropriate way

Genuine:

- Being oneself without hiding behind a title, role or job
- Being sincere

Understanding:

- The ability to see things from another person's perspective
- Able to imagine themselves in 'someone else's shoes' in order to understand their fears, feelings or point of view



Ethical behaviour



Small group discussion

Ask participants to discuss what ethical behaviour older peer educators should have and what behaviour they should practice. They should appoint a leader to feedback to the group.

Ethics are principles that govern right and wrong practices and moral conduct. It is important that older peer educators have an ethical standard because it helps them manage their relationship with their peers. It guides them with regards to professionalism, integrity, privacy, confidentiality, community service and employment commitments.



Class discussion

Read the proposed ethical standard for older peer educators below to the participants and ask them if they agree with this standard. Are they happy to be held accountable to this standard?

I value and know who I am as an older person. I am an individual, friend and educator, an activist, a role model and a team member. I am an older peer educator.

I value and know my role as an older peer educator.

In order to best fulfil that role I will:

- grant individuals respect and dignity
- honour and strive to understand differences in people in all its forms
- recognise that Older People have a valuable contribution to make

I value and know my roles as a friend.

In order to best fulfil that role, I will:

- offer opportunities for older people and my family to explore their thoughts and feelings
- offer myself as a link between older people and the professional support services
- not manipulate any situation or another person's vulnerability for my own benefit
- maintain confidentiality, except when, to my best judgment, the person is in physical or mental danger which could result in self-harm or harm to others, has a problem beyond my ability to assist, or discloses information which I must report according to law

I value and know my roles as an older educator.

In order to best fulfil that role, I will:

- learn as much as possible about the issues that affect my older peers
- only offer information that I am qualified to offer and with the greatest accuracy possible
- accept feedback and support from my supervisor or other professional staff

I value and know my role as an older activist.

In order to best fulfil that role, I will:

- *refuse to be a bystander*
- *confront unhealthy attitudes and behaviours*
- *work to change my home and community environment to promote healthy choices for older people and my family*

I value and know my role as an older role model.

In order to best fulfil that role, I will:

- *make decisions in my own life that are positive and healthy*
- *challenge myself to continue my own physical, mental, spiritual and emotional growth*
- *accept guidance and confrontation from others who care about me*

I value and know my role as an older team member.

In order to best fulfil that role, I will:

- *accept supervision and support from my adviser*
- *commit to actively participate in the peer education group*
- *support and encourage my fellow older peer educators*

I value and know my role as an individual.

In order to best fulfil that role, I will:

- *understand that my primary responsibility is to myself*
- *not allow my peer education duties to interfere with my own goals and aspirations*
- *not allow my peer educator duties to put my emotional or physical wellbeing at risk*

Source: Adapted from - The BACCHUS Network Peer Educator Code of Ethics



Small group exercise

Ask participants to use this ethical code to develop a song or poem for peer educators and then share it with the group.

Factors that influence the effectiveness of older peer educators



Small group exercise

For an older peer educator to be effective, they have to share information and influence their peers to adopt health-seeking behaviour. Ask participants to discuss what factors influence how effective an older peer educator can be. They should appoint a leader to feedback to the group.

Internal	External
Their personal motivation and commitment.	Peer pressure in the community.
Personal beliefs.	Time that the older Peer Educator has to educate.
How much job satisfaction they receive.	Resources available to the older peer educator.
The training that they have received and knowledge acquired.	Possibility to get groups of older people together.
The physical health of the peer educator.	

Peer education skills for older people

Session outcomes:

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

- understand how to share information with groups of older people
- demonstrate the facilitation methodologies and techniques to train groups of older people
- demonstrate effective communication skills to promote understanding
- apply the management skills to implement the peer education programme
- demonstrate teamwork and leadership skills

Designing a peer education “Education Session”

There are two main ways that you will be educating your peers:

- through home visits and small groups
- through formal lessons in larger groups

Irrespective of where you educate your peers, it is important to plan your message and use techniques to engage your audience and maximise the learning that occurs. All education sessions should be structured, taking into account how older people learn.

What is learning?

Learning is defined as acquiring new or modifying existing knowledge, behaviour, skills, values or preferences.

When does learning occur?

1. Learning occurs when “something catches a person’s attention”, which makes them interested in the information.
2. Learning is processed together with prior knowledge until they arrive at conclusions and understanding.
3. The learning is then applied and tested for confirmation.

How to improve group learning

As a peer educator conducting a lesson for a small group, you need to design your lesson to gain *attention*, ensure that the *information is processed* and that the group arrive at the *correct conclusions*.

1. **Attention:** First you have to grab the group’s attention. The opening statement or icebreaker will either hook the group in or lose them. This hook should help the group to understand why the training is important to them and why they should listen, and thus start the learning process.
2. **Learning styles:** No matter what age, people learn in different ways. Some learn from seeing pictures or reading words, others learn from doing an activity or writing something down and some learn from what they hear. To meet all learning styles, the session must be presented in variety of ways. Include written words, pictures, sound, live action and practical exercises within every session.
3. **Process with prior experience:** All groups will compare new information with their previous knowledge and experience, especially older groups, who have more life experience and are used

to doing things a certain way. A peer educator needs to give peers the chance to reflect, question and compare. Use small group discussions to give older learners the chance to draw from their past and link it to today's information. It aids learning if the group is allowed to discuss their thoughts in an open and supportive way.

- 4. Conclusions and understanding:** It is the group's job to draw conclusions about how the training will be used in their lives. The peer educator's job is to provide the group with information and give them time to practice new skills and draw their own conclusions in a non-judgmental way.
- 5. Application and testing:** After the training is over, the group will experiment, test and ultimately accept or reject the health-seeking message. During the follow-up phase, the peer educator should check on how the group has applied the learning to their own lives.
- 6. Feelings:** Training can stir deep feelings. When dealing with learning, especially with older people, it is important to address the feelings of the group. These feelings could include guilt, anger, fear and denial. It is important to encourage the group to verbalise their feelings and plan how to deal with them in the training or one-to-one discussions.
- 7. Atmosphere:** Finally, remember that people do not learn in an atmosphere of fear or mistrust. The peer educator is responsible for the atmosphere and level of trust within the group.

Structuring lessons

All lessons should have an attention-grabbing beginning, middle and end.

Icebreakers

Below are two examples of icebreakers for group training sessions:

- **Getting to know each other** – In pairs, ask people to find out each other's names, hobbies, family members, home places, their work, favourite colour, food and music. Once the time is over, the participants must choose three words to describe their assigned partner.
- **Trust** – Bring blindfolds to the training. In pairs, one person is blindfolded and led round the room or outside by their partner without any verbal communication. Switch roles. This game teaches people about their level of trust with their partner.

Below are two examples of icebreakers for small group home visit sessions:

- High impact statistics could be used to generate interest. An example would be: "Do you know that two-thirds of people who have HIV live in sub-Saharan Africa?" Another could be: "There are three million older people living with HIV in sub-Saharan Africa."
- A picture or poster could be shown first to get the group's attention.

Once the icebreaker is over, introduce the topic and explain the content of the education session. For example "How are you?"... "Today I would like to discuss 'What is HIV and AIDS and how it affects older people?' This will take about 30 minutes. Please feel free to ask any questions."

The middle

Now that the topic has been introduced, you should explain the session content in detail. Use a mixture of facilitation methods such as pictures, writing, role plays and group discussion to share the content and keep the attention of your peers.

The end

Summarise the key points of the education session and answer any questions. Discuss and agree when the next education session will take place.

Communication skills

Eye contact

Eye contact is an important communication tool. A quick glance sends a different message to a cold stare but both are forms of making eye contact. To maintain respect when speaking with elders, use sporadic or brief eye contact to signal such messages as “This is important – listen carefully”.

Also be observant and watch the reaction of the older peers to your message. Do they understand? Do they look puzzled? Are they enjoying the session? Are they tired? Are they bored? Would it be a good idea to speed up or slow down the session? Do they want to ask a question?



Voice

Make sure your voice is able to reach everybody who is part of your education group, even when there is noise in the background. Some older people may be hard of hearing and you need to make sure that they can hear you clearly.

Use your voice to engage and keep your peers’ attention. If you are feeling tired and let it show in your voice, or if you are not sure of your facts and sound unconfident, then your peers will quickly lose interest or perhaps even doubt what you are saying. If you talk in a monotonous voice, you will put your audience to sleep.

You can ‘energise’ your group and increase the pace of a session by raising the volume of your voice slightly. To gain attention, use your voice to emphasise important points.

You can ‘energise’ your group and increase the pace of a lesson by raising the volume of your voice slightly. To gain attention, use your voice to emphasise important points.



At home

Ask participants to experiment with their voice at home. They should read through the sentences below and then practice saying them aloud in as many different ways as possible. For example, they should emphasise certain words, pause at different places, speak softly or more loudly, project their voice to reach a bigger group, lower their voice as if they were speaking to someone one-to-one.

“I became a peer educator because I believe that each and every one of us has a duty to improve the health of my community and respond to HIV. I am one of you: an older member of my community. Like you, I want to keep the people I love and care for safe. I believe that knowledge is power. When you know the facts you can make decisions. My job is to inform you – to give you the facts about the virus and how it affects older people. I will be visiting you regularly to give you new information. Each time, I will cover a different topic in my education session, but you can come to me at any time and ask me questions.”

Listening skills

Listening is a vitally important skill to develop. All too often, people don’t listen; rather, they wait to talk or interrupt others so that they can speak.



On their own

Ask participants to rate their listening skills using the following scale.

Very good	Good	Average	Weak	Very weak
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Older people often need time to think in between what they are saying and if they are interrupted they will not be able to say what is important to them.

Peer educators need to become comfortable with silence. You need to become ‘active’ listeners. You need to listen to people with your ears, your eyes and your hearts. Peer educators give their peers facts – you are not qualified to give your peers advice or tell them what to do. This means that you must develop reflective listening. You must be able to listen and be attentive and reflect like a mirror what your peer is saying and help them find their own solutions.



Small group exercise

Ask participants to discuss what listening is and how it is different from communication in general? They should appoint a leader to feedback to the group.

Only seven per cent of listening involves words. The rest is made up of facial expressions and body language. Listening is different from hearing. Listening means understanding the meaning behind the words you are hearing.

How to listen using reflective listening

Reflective listening shows the other person that you are paying attention to them and understand what they are saying.

- **Do not interrupt** – Let the person finish what they are saying.
- **Paraphrase** – This means repeating back or restating what the person said to check for understanding. Say things like: “So do you mean...?” “Does that mean you think...?” or “What you are saying is...”
- **Perception checking** – This is an effort to understand the feelings behind the words. For example, say, “It sounds like that made you really angry”.
- **Ask questions** – Ask open-ended questions. This is a question that cannot be answered with just a ‘yes’ or ‘no’ response. It requires the person to give more details. Begin questions with who, why, where, when, what and how. Ask for additional details, examples and impressions. For example, “Why do you think...?”.
- **Approval** – Express approval or give praise to encourage further communication. This does not mean agreeing with what the person is saying. It means valuing the fact they have shared how they feel.

Reflective listening requires the use of verbal minimal responses to show the speaker that they have your full attention. This stops someone from dominating (“taking over”) the conversation.

Examples of verbal minimal responses include:



“OK”

“Right”

“I hear what you say”

“Uh-hm”

“A-ha”

“Go on...”

You need to be careful when you use these expressions. Sometimes, especially if you use too many of them, they can sound insincere and will prevent effective communication from taking place.

You can also use non-verbal minimal responses like nodding your head or using gestures to show that you are really listening and following what the speaker has to say.

These minimal responses help the speaker feel that the peer educator cares about what they are saying and that it is safe for them to say what they feel. Remember, your tone of voice, your body language and your facial expressions all help the speaker to “open up” because they believe you are truly interested in what they have to say.



In pairs

Ask one participant to tell the other about something important to them (for example, the trouble they are having at their church or with their grandchildren and so on). Their partner must practice reflective listening. Swap roles after three minutes.

Facilitation skills

Different people learn in different ways



On their own

Ask participants to spend a couple of minutes thinking about their learning experiences and how they learn best. Read out the following learning styles and ask them which they prefer.

I learn quickly when:

- I am **told** new information
- I **read** new information
- I **see** pictures of new information
- I **listen** and write down new information.
- I **do/practice** the new information

Knowing that people learn in different ways means that peer educators need to use different methods of teaching to accommodate people’s learning styles to keep their attention and to involve them in their own learning. There are many teaching methods or strategies to promote learning.

Group work

This method is useful if group members feel comfortable with one another and individuals are not hesitant to speak. If peer educators are doing a home visit and there are people of the same age that trust and respect each other, group work might be an appropriate method of facilitation. If there is not sufficient trust and a difference in age, for example, between a father-in-law and daughter-in-law, this might not be appropriate.

Research shows that people learn best when they are actively engaged in their own learning rather than behaving as passive observers. Evidence shows that reinforced learning leading to behavioural change is best accomplished through the active participation of the learners.

Role play and simulation

People often find it beneficial to practice new learning by acting in, or observing, a role play or simulated exercise. They are then more able and confident to transfer this learning to the “real world”. For example, the peer educator uses role play to discuss having an HIV test with their peers, where they take the role of the healthcare worker providing the test. Role plays should not be more than 15 minutes.

Participation in drama

Dramatic events can also be a powerful way of expressing important information. Not only do the participants of the drama learn from this method but the audience can also be brought into the drama. For example, the peer educator asks a group of older volunteers to put on a drama for the local church to teach people about caring for their grandchildren orphaned by HIV.



Storytelling and sharing one's experiences or case studies

People like to hear about the experiences of others and often find that they can relate to these experiences better than trying to grasp facts that seem to have little relevance to their own lives. Stories are also helpful in sharing important messages. Although the story might be about a fictional character, the message is one that the listener can easily relate to and understand. For example, tell your own story about living with HIV and the impact it has had on your life.

Experiential learning

Experiential learning is the process of taking meaning from direct experience. An example of experiential learning might be a trip to a hospice. Experiential learning requires no teacher and relates solely to the individual's direct experience.

Visual aids

Posters, photographs, pictures, slide presentations, videos and works of art can all be powerful educational tools. Discussions can follow the use of such visual aids. For example, ask your peers what the visual aid meant to them, what they liked or disliked about it, what was unclear, disturbing or helpful.

Learning aids

Flipcharts, factsheets, flash cards, wall charts, drawings done by the group or others, diagrams, tables and graphs provide clear and easy access to information. These learning aids can also be used to promote group discussion. For example, questions such as "What does this graph tell you?", "What is missing from this information?", "How could you go about getting this information?", "What does this drawing tell you?", "How would you have drawn this picture differently?", and "Why is that so?" all promote discussion. Models of anatomy can be used to help the learners understand how HIV and other sexually transmitted infections (STIs) are passed from one person to another. Models are also suitable for practising correct condom usage and many basic nursing care procedures.

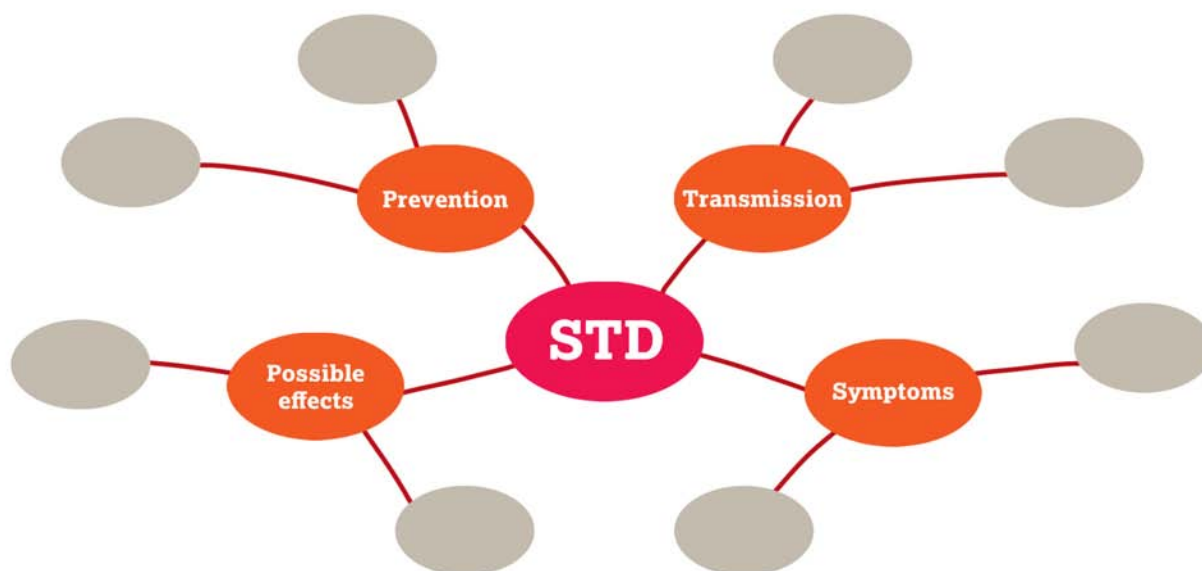
Debates

Using debate as a facilitation tool increases learner involvement and participation. Set a topic and get your peer to debate with you. Then swap and get them to debate the opposite point of view.

Brainstorming

Brainstorming is a creative technique to get the group or just one person to solve a problem. This is how to brainstorm:

1. Define the issue. In this example, the issue is "sexually transmitted infections".
2. List the effects and solutions.
3. Set a time limit.
4. Try to identify as many ideas as possible once the brainstorming starts. Write them down using lines from the central idea. There must be absolutely no criticising of ideas. No matter how daft, how impossible or how silly an idea is, it must be written down.
5. Choose the best ideas.



Small group exercise

Ask participants to develop a session for a home visit. They should assume that there are one or two people in the home and their job is to deliver an education session. They should use at least four of the techniques explained above to perform this task. As a group, they will have three minutes to deliver their lesson. The topic they need to cover is “How to build a food garden”.

Peer education and group learning

Groups can be defined as two or more people connected by a social relationship.² They can be formal or informal and last for just one training session or have a much longer lifespan.

Group processes

Group behaviour influences how individuals learn because people of all ages, in a group, interact and influence each other. This can be negative or positive. Groups have patterns of behaviour that are distinct to them including:

- patterns of communication and coordination
- patterns of influence
- roles and relationships between members
- patterns of dominance (for example, who leads, who defers)
- balance of task focus versus social focus
- level of group effectiveness
- how conflict is handled



Class discussion

Ask participants to discuss how the group's patterns of behaviour impact on their peer education training.

Peer educators have to understand and utilise the patterns to assist the group to learn and adopt health-seeking behaviour. For example, if the leader of the group supports a difficult issue like promoting condom use in older people, having an HIV test or talking about sexual issues, then the rest of the group will follow. The peer educator will have to be careful about how they get the support of the leaders to influence the group positively and prevent negative behaviour.

Scientists have found that young people learn faster but older people use the information better!

(Anitei 2006)

Changing behaviour in older people

Session outcomes:

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

- explain the promotion of wellbeing
- explain human motivation and behavioural change
- use accepted strategies and techniques to facilitate behavioural change

Seventy five per cent of poor health is caused by behaviour. As people age, the lifestyle decisions they made when they were young will affect their personal health. As a peer educator, it is important to understand what lifestyle choices have a negative impact on your peers' health and also how to encourage people to change their behaviour.

Why do older people do things that put their health at risk?



Class exercise

Ask participants to tell stories or give examples of how older people put their health at risk through their behaviour.

People take risks for a number of reasons.

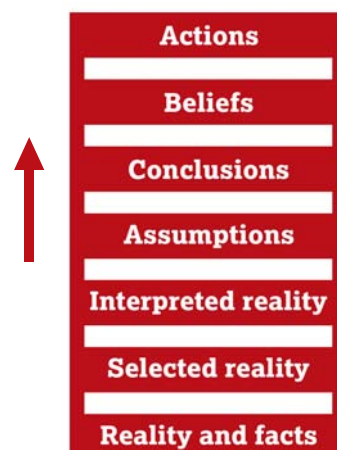
- 1. Ignorance:** older people might be unaware of the potential consequences of the risks they are taking. For example, many years ago people were not aware of how damaging tobacco was to their health and took up smoking without having all the health risk facts.
- 2. It will not happen to me:** another reason why people take risks is that they don't believe that the risk can happen to them. For example, no smoker will admit that they might get cancer from their habit. All of them think: "It will not happen to me".
- 3. Have not thought through the consequence:** very few people think through the consequences of their actions. Rather, they jump at the chance to feel good and don't consider the cost they might have to pay later.

How do people make decisions?

The ladder of inference³ describes the thinking process that people go through, usually without realising it, to get from a fact to a decision or action.

Starting at the bottom of the ladder:

1. You experience the reality and fact.
2. You interpret these facts selectively based on your beliefs and prior experience.
3. You decide what they mean (you are not always right).
4. You apply your existing assumptions, sometimes without considering them.
5. You draw conclusions based on the interpreted facts and your assumptions.
6. You develop beliefs based on these conclusions.
7. You take actions that seem "right" because they are based on what you believe.



Older people have set ideas and beliefs that they have acquired over their lives. Changing these beliefs, even if they are wrong, is hard. These beliefs have a huge influence on their reality and can lead them to ignore or miss the true facts and skip steps in the reasoning process.

The ladder of inference can be used to inform your peers how to get back to the facts and use their beliefs and experiences to positive effect.

Use the following steps to challenge thinking using the Ladder of Inference:

1. Stop! Consider your reasoning.
2. Identify where on the ladder you are.
3. Select your data or check your reality.
4. Interpret what it means.
5. Make or test assumptions.
6. Form or test conclusions.
7. Decide what to do and why.

Following this step-by-step reasoning can lead to better results, based on reality, therefore avoiding unnecessary mistakes and conflict.

Self-awareness is defined as knowing yourself and this includes having a clear picture of your personality, including strengths, weaknesses, thoughts, beliefs, motivation and emotions. Self-awareness allows you to understand other people, how they see you, your attitude and your responses to them.

As you develop self-awareness you are able to make changes in your thoughts and assumptions. Having better self-awareness allows you to question honestly your reality and make better decisions; to see where your thoughts and emotions are taking you; and to understand the control you have of your emotions, behaviour and personality, so that you can make the changes you want. Until you are aware of the controls to your thoughts, emotions, words and behaviour, you will have difficulty making changes in the direction of your life.

A way of viewing and helping us develop our self-awareness is through Johari's Window.⁴



Class exercise

Show participants the illustration below and explain how the 'window' works.

	Things I know	Things I don't know
Things they know	The Open Area	The Blind Spot
Things they don't know	The Hidden Area	The Unknown Area

There are four areas to Johari's Window. Imagine a window divided into four squares, with each square representing information about you.

- **The open area (arena)** contains things that both you and the group know about you – it is out in the open.
- **The blind spot** has things that the group knows about you but you don't know about yourself.
- **The hidden area (facade)** has things that you know but they don't.
- **The unknown area** contains things that neither you nor the group are aware of.

Johari's Window can help you realise your degree of self-awareness and give you direction to explore how you might increase this awareness. For example, if you ask for feedback from your group, the blind spot might decrease as the open area increases. If you disclose something about yourself, the hidden area will decrease and feed into the open area. The idea is that over time, the open area becomes the biggest while the others decrease. Of course, there are things that will

always remain in the hidden area for both yourself and the people you mix with.

As a peer educator and senior member in your family and community, you are to be agents of change, so it is important that you get to know yourselves (your strengths and weaknesses) and that you get to know others. Open communication can help you do this. Communication creates a healthy learning environment.

As a peer educator you should “personalise” examples. For example, “I was scared of going for HCT but I decided that...” Your openness will encourage your peers to communicate openly and honestly too.



Small group exercise

Ask the participants to use the ‘window’ above to fill in examples in the ‘open area’, that is, things they know about themselves which others in the group know. For example, they are impatient or they have a kiosk.

Now ask them to hand their ‘window’ to at least two people in their group and ask them to fill in some examples about them in the ‘blind spot’. For example, they cough when they are nervous; they have a great smile and so on. Tell them to be honest.

When they get their ‘window’ back, they should examine what was written in the ‘blind spot’. Ask them if they are surprised at what was written? Shocked? How do they feel?

In private, ask participants to fill in some examples in the ‘hidden area’. For example, they dislike their job or they are having trouble with their partner. Would they be comfortable sharing these things with their group? Ask them why not?

Components of healthy living

Peer education with older people aims to reduce health risks through education and behaviour change programmes. The act of changing behaviour is complex and for it to be sustainable the programme must address all aspects of older people’s health, including physical, mental and social health.

The World Health Organization (WHO) defined health in its broader sense in 1946 as “a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity”.

As an older peer educator, you will need to educate your peers on all aspects of health. This includes a combination of physical health, mental health and social wellbeing, together sometimes referred to as the “health triangle”.

- **Physical health:** includes everything from physical fitness to overall wellness. A person is in good physical health if every part of their body is functioning properly.
- **Emotional health:** a person that is mentally healthy can enjoy life and has a balance between life activities, for example, work - home - life balance. A person who is mentally healthy is resilient and can cope with life’s demands and stresses.
- **Socio-cultural health:** is determined by the conditions in which people are born, grow, live, work and age and influences their health.
- **Spiritual health:** is linked to someone’s purpose for living. It is their central core or soul that allows them to gain strength and hope.



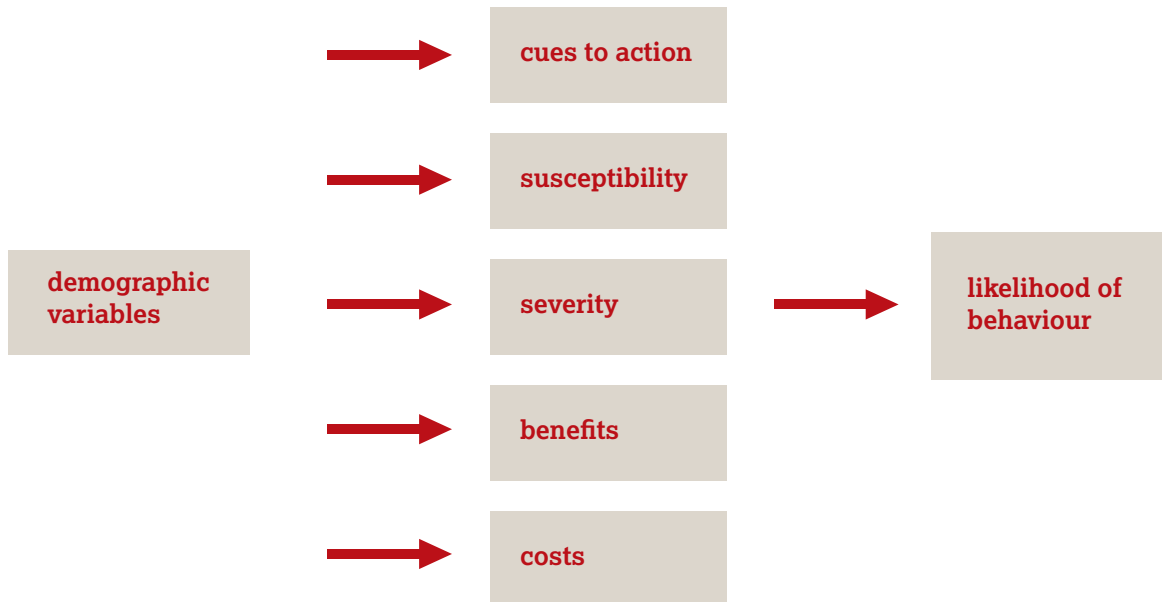
In pairs

Ask participants to work in pairs to develop their own poster to promote holistic health in older people, including physical health, emotional health, social health and spiritual health.

Behaviour change model

The Health Belief Model (HBM) (see diagram below) is a successful behaviour change methodology commonly used in peer education to try to influence behaviour. The HBM is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals.

Health Belief Model⁵



On their own

Read through the table below and ask participants to decide how they see change – as a crisis or as an opportunity. As people age, they become less able to handle change as they become less flexible in their thinking. Participants should discuss the table with the group to see how they manage change.

	I see change as a crisis	I see change as an opportunity
Is change negative?	You will probably approach change expecting negative results. This is what you will get.	You will probably be motivated and feel as if you have been given an opportunity for growth in yourself, your relationships and your community.
Is change a contest?	You might think of change as a competition in which there are winners and losers, in which someone is right and someone is wrong.	You are likely to look for a way where each person wins and each person's views and feelings are respected.
Is there one right solution?	You tend to dig in and resist change by refusing to consider other possibilities.	If you approach change wanting to explore all the options available, it is possible that you will find solutions to satisfy all involved.

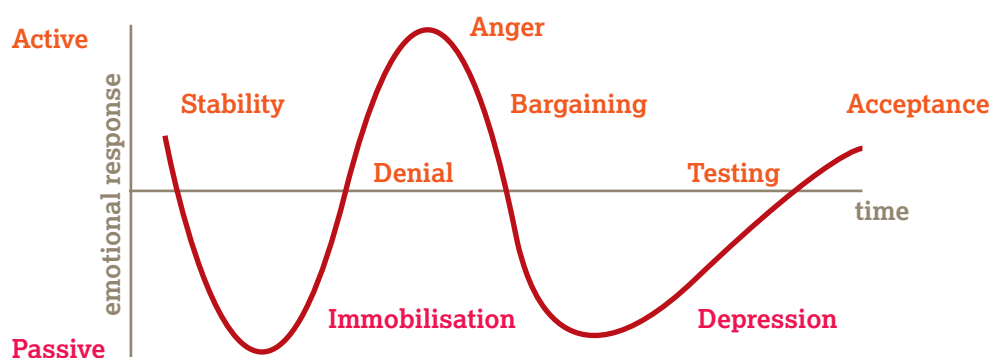
Change is an on-going process that takes time

Everyone experiences a variety of changes in their lives. Sometimes they may not even be aware of these changes but the really significant changes may affect them deeply, and in many cases, affect the course of their life. Change can often be a painful experience.



On their own

Ask participants to think of any major change they are facing in their life right now that is causing them stress. This change could be at home, at work, in their community, within their family or as a citizen of their country. Describe to them the diagram below and then ask them where they are in the cycle of change with regards to this particular change.



Source: The Kübler-Ross grief cycle⁶

The phases of change people go through are not clear-cut or clearly separated. They may feel a mixture of emotions as they progress through the cycle of change. Just because they are depressed one day does not mean that they are going to remain that way. In time, their feelings will change and they will move on along the change cycle and feel a range of other emotions.

Some phases of the change process are easier to deal with than others. Some people take longer to work through a phase than others – because people are different. For example, a man who has tested HIV-positive could stay in a deep depression for months. His friend, who tested positive at the same time, could move from depression to “taking action” within a couple of weeks.

Everyone’s reaction to stress is different. The important thing is that they move on along the change cycle. Change calls for adaptation. If they do not adapt, their personal development stops and you will become stuck in a deeply depressed rut.

As people go through a cycle of change, their feelings, thoughts and behaviours shift and alter.



Small group exercise

Ask the participants to read through the story below. It gives extracts from the diary of Vincent. The diary is written over a period of months. They should use the column on the left-hand side to fill in what stage of change Vincent is going through. They should underline sentences that show typical feelings, thoughts and behaviours in these stages. Note: the names in this story have been changed to protect the identity of the characters.

Stage	Vincent's diary
	<p>My minister has become an older Peer Educator. He talked to us about HIV today. He says if we don't practice safe sex or have protected sex we can die of AIDS. Is he telling the truth? Surely HIV does not affect old people like me? I don't want to die. I slept with Sandra last night. We didn't use a condom. My wife is away and has been working in the city for many years. I get lonely and I deserve to be happy. Sandra makes me feel like a real man, but who has she slept with before me? I am sure a lot of people. Am I at risk of getting HIV? Should someone like me, an old man, get tested? I've got to think about this. Maybe I shouldn't sleep with Sandra again. Maybe I should get tested. But I don't want to be told I'm going to die and what will I say to my wife? Maybe it's better not to know. But what if the Peer Educator is right?</p>
	<p>I saw Sandra last night. We had sex and she stayed the night. I thought about what the minister said and what my wife would do if she found out I had another woman. But I don't think I am at risk at this old age. Some people say that only weak men get AIDS. Even though I am old, I am strong and Sandra does not look sick. I don't want to hear what the Peer Educator has to say.</p>
	<p>Every time I urinate I get a burning feeling and I've got pains in my stomach. What if Sandra has given me a disease? What if I've got an STI? What will my wife say if she finds out? The minister-peer educator says STI's help spread HIV and if you have an STI there is a greater chance of getting HIV. Well, if I've got it, I've got it. Nothing I can do about it now.</p>
Danger zone	
	<p>I have had a test and now I know for sure that I am HIV-Positive. I'm going to die eventually, but how I live my life up until then is up to me. I have been told that there are things I can do to prolong my life. If I do everything they tell me to, I will be able to continue living for a long time. I can still have sex. Just protected sex. Some of those condoms they showed us are quite cool! I know it won't be easy to change but I'm going to try. Still don't know how I will tell my wife.</p>
	<p>I think I will just forget the whole thing. How am I going to tell my wife? It is better to just pretend I never tested and continue life as it was before. I spoke to my wife on the phone and all is well. Why tell her and make my life difficult. Sandra came to visit again. We used a condom. It was strange at first but she never asked why I wanted the condom. I bet she knew she was Positive and did not tell me.</p>
	<p>I am putting on weight again. I am eating properly, too. I told my wife when she came home – I could not infect her by keeping quiet. She was very cross but it is now two months later and she has forgiven me. She wanted to be tested and I went with her to the clinic. A young boy asked us why grandparents wanted to be tested and I told them to mind their own business. I feel so much better now. Sandra is HIV-Positive, I hear. I saw her outside the clinic yesterday. She was crying. I'll visit her tomorrow and see how she is doing. She looks as if she needs a friend right now. I have promised my wife I will be faithful and I mean to live up to that promise.</p>

The Danger Zone

Look back at the diagram of the cycles of change. The danger zone is clearly marked. The danger zone is what it sounds like – a dangerous stage in the change cycle.

In the danger zone people can choose to ignore a situation and carry on as they did before without

making any changes denying that there is a need to change. They can remain stuck in this danger zone for a long time.

Danger zone example

Vincent could have chosen not to be tested for HIV or he could have been tested and decided to ignore all the warnings and carry on his life much the same as before. Either choice would have shortened his lifespan. He would have become sicker, faster. He could also have passed HIV on to his wife.

In the danger zone people can decide to make changes and then make the wrong choices or make the right choices but then decide it is too hard to sustain their behaviour.

Combining the ladder of inference and the stages of change

Now put the theories about the ladder of inference and the stages of change together.

Your job as a peer educator is to add more available data at the bottom of the ladder so that the older person who is stuck on the cycle of change can move into a healthier place in their life.

Changing behaviour is not easy



Small group exercise

Ask participants to work in groups of three. Ask them to name themselves A, B and C.

- A and B line up against one wall. A’s aim is to keep moving towards the other side of the room while B tries to push A in another direction.
- C stands behind A putting his/her hands on the back of A’s shoulders and gently but consistently pushing A forward so that A must start walking towards the other side of the room.
- As A starts walking, C must continue to increase the pressure. A will be able to feel how C is steering him/her while B continues to push A in another direction.
- When A starts going in a direction that he/she doesn’t want to go, spin to one side, in the same speed or rhythm as the pusher, rolling along that person’s arm, maintaining contact, so that A ends up in the back, pushing the person who was pushing them. Now it is A’s turn to steer.

Ask the participants to think about the exercise they have just completed. Their partner may have been pushing them in a direction they did not want to go in. Why did they allow this?

Ask the participants to think about their own life so far. Have they ever been driven to do something they really didn’t care about, or they did because they felt they had to go along with it? What kept them going in that direction?

Ask the participants when they felt powerful during this exercise. Why?

Ask participants what they learnt about change from this exercise.

Ask participants what is needed before change can take place.

This exercise demonstrates that as soon as people are willing to change, they find themselves in a powerful position of choice. Resistance to change, however, does not have to come from someone (or something) else: it can come from within yourself.



Small group exercise

John is 55 years old and smokes 20 cigarettes a day. John's wife does not work, his daughter has died as a result of AIDS and they are looking after her four children.

Ask participants to discuss how John knows that smoking is bad for his health.

Ask participants to discuss why if John knows that smoking is bad for his health, he doesn't give up.

Ask participants to discuss what they think it would take for John to give up smoking (that is, to change his behaviour)?



A change in values is necessary before any behavioural change **may** take place.

In John's case, he currently values smoking and the pleasure he associates with smoking **more** than he values his health. His family and community have not put pressure on him to give up smoking. Only when he experiences something that affects his values such as a partner threatening to leave, a heart attack, losing a limb or a stroke will John weigh up the pleasure he takes in smoking against what could happen to him. Even then he will probably need ongoing help to enable and assist him to change his behaviour.

Resistance to change

The job of a peer educator is to be an agent of change. You need to be able to change people's attitudes and behaviour. Although your job will be rewarding, it will not be easy. Change is natural but so is resistance to change. You will almost certainly encounter some resistance in discussion and in your training sessions.

As change agents peer educators must:

- be aware of the different forms resistance can take
- understand the underlying causes of resistance
- be prepared to deal with it constructively

The different forms of resistance

Resistance can take many forms:

Outright refusal

This can range from walking out of a peer education session to not taking part in a discussion. At worst, this hostile resistance may indicate a challenge to your authority as a peer educator, lack of motivation or even a dislike of other people in the peer group. At best, this form of resistance might indicate that the person is feeling unwell, or is unwilling to take risks and appear foolish in the eyes of their peers, or it might mean that the person does not understand what is going on in the training session.

Do-it-to-me

Here, the resistor appears to distance themselves by “sitting back” and choosing to observe rather than to participate. For example, they might remain silent for long periods at a time or continuously refuse to take part. You have to decide whether the person is genuinely resisting, is possibly shy or is ‘lost’.

Sabotaging the education session

This is the varied type of resistance people will probably recognise from their own school days. It can include anything from deliberately arriving late for a session, continually asking instructions to be repeated or carrying on a whispered conversation with another peer. This is an effective method of sabotage and can be unnerving, particularly as this type of resistor often forms a group or cell.

Breaking ground rules

This is one of the more obvious forms of resistance and can raise anxieties within the group because it is a deliberate breaking of the rules to which the resistor has probably been a party to making. For example, if the agreed rule is that peers will not make personal comments about their peers’ sexual behaviour, then somebody deliberately does this, feelings will be hurt, tempers may rise and the quality of communication will break down. This will make it hard for learning to take place.

Not following instructions

If you have to explain, repeat or clarify the same instructions for the third time, this is a deliberate strategy of resistance.

Personal attack on the peer educator

This method is intended to send the peer educator off balance and on the defensive. Remarks such as “But how can we believe you when you are younger than us, or you have a whole lot of girlfriends you sleep with or you don’t even have a school certificate” might be made. Few people can resist the urge to defend or explain themselves, so if you are not on your guard or if you take these remarks personally, then a heated argument could follow. You need to understand why such remarks are made (see the next section ‘Underlying causes of resistance’) and to deal with the cause rather than the remarks themselves.

Denying the validity

This is a tactic used to undermine your professionalism and/or experience. It often begins with remarks such as “You don’t understand our situation”. For example, someone could say, “Yes, but you don’t understand. You have a wife. You can have sex any time you want. When I want sex I have to take anyone I can. There’s no time to think about condoms!”

Story capping

This technique is one often experienced in your personal life. For example, a neighbour who always seems to have a ‘bigger and better’ tale to tell than yours. In an education session it serves to focus a fair share of time and/or attention on the story-capper, to take away attention from the point of the lesson and to side-track learning.



On their own

Ask participants if they have used any of these strategies today. Ask them why?

A four-stage technique for dealing with resistance

There is a four-stage technique for dealing with resistance.

1. Identify what form resistance is taking

Be alert. Notice and be sensitive to what is going on around you – ‘see, listen and feel’. As a general guideline: the first time something happens (or is said or asked or refused) accept it at face value; the second time it happens, be aware of it but, again, respond in good faith; the third time it happens, determine its cause and take action.

2. Name the resistance

Point out, either to the individual concerned or the group, that you are aware of the resistance and provide an opportunity for it to be dealt with. This must be done in a neutral way. Do not judge, threaten or accuse – merely state your awareness.

3. Remain quiet and wait for a response

Having stated the resistance, remain quiet and wait. This is not as easy as it sounds. It allows the resistor three options. They may decide to:

- explain the problem
- work through the problem with you
- just drop the issue and let the session continue.
- Whatever their decision, the responsibility of resistance remains with the resistor.

4. Deal with the underlying problem and move on

Having obtained a response, you are now in a position to discuss and resolve the problem causing resistance. Whatever the reason for resistance, once it has been made public, you must deal with the problem before the session can continue.

HIV epidemiology in older people

Session outcomes:

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

- modify their existing knowledge about HIV and AIDS
- differentiate between HIV and AIDS
- discuss the basic workings of the immune system in older people

How much do you already know about HIV and AIDS?



On their own

Read the following questions to participants and ask them to tick (✓) those that they feel they know the answer to and put a cross (✗) by those that they feel they need more information about.

1. What is HIV?
2. What is AIDS?
3. What is the difference between HIV and AIDS?
4. If someone is HIV+, how do they ensure that they don't pass the virus on to anyone else?
5. How does someone get HIV?
6. Can an older person get HIV?
7. Why should older people get tested for HIV?
8. What is a 'window period'?
9. Will older people progress faster from HIV to AIDS?
10. What is an opportunistic infection?
11. If someone is living with HIV, how do they protect themselves from getting AIDS?



Small group exercise

Read the questions below to the participants and ask them to answer them as thoroughly as possible.

- Do you know what HIV and AIDS stand for?
- What is the difference between a virus and bacteria?
- How do we kill bacteria?
- We almost all get a cold or flu each winter. This is a virus. Can we kill it? How do we treat flu?
- What would happen if a person of any age with HIV lived in a plastic bubble?

What is HIV?

HIV stands for human immunodeficiency virus.

- H:** Human – the virus infects human beings.
- I:** Immunodeficiency – having a weak immune system with no strength to fight off infections.
- V:** Virus – a type of germ, something that cannot be cured. Only the symptoms can be treated.

HIV is a virus that weakens the body's immune system, ultimately leading to AIDS. If a person has the virus, that person is said to be HIV-positive or living with HIV. Anyone, at any age, can get HIV. HIV can only live, in infectious quantities, in the blood, breast milk, semen or vaginal fluids of a person who has HIV.

HIV is passed on from one person to another when blood, semen, vaginal fluid or breast milk from a person living with HIV enters the body of a HIV-negative person. It then begins to attack the body from the inside by destroying the body's immune system. An older person's immune system is already compromised due to the effects of ageing and the virus will progress faster than in a younger person.

How does our immune system work in older people?

The immune system is like your body's army – it defends you against germs and diseases. As you get older, this system is not as effective as it was when you were young.

Your body defends itself against germs in two ways:

- The first line of defence is your skin. Healthy, unbroken skin prevents germs from entering your bodies. Open cuts, sores and wounds provide entry points for germs and diseases. As you age, you are at increased risk for skin injury. Your skin is thinner, more fragile, and the protective subcutaneous fat layer is lost. In addition, your ability to sense touch, pressure, vibration, heat and cold may be reduced. Thus, your skin is at higher risk of injury.
- The second line of defence is the body's immune system. The immune system of a person of any age is a body-wide network of cells and organs that defends the body against attacks by 'foreign' invaders such as bacteria and viruses. These white blood cells are called CD4 cells which fight infection including any germ or virus that enters the body such as flu, measles, chickenpox and so on. Every day people breathe in germs and if their immune system is healthy then it has no trouble fighting off these germs. When a germ enters the body, the CD4 cells recognise it as an enemy and fight to destroy it. As you age, your immune system does not work as effectively and puts you at more risk of disease and infection.

Generally, it takes longer for older people to heal although even an older immune system will continue to fight off germs once they have entered the body and, in time, people will get better. However, later in life, the immune system becomes less tolerant of the body's own cells and sometimes an autoimmune disorder develops where normal tissue is mistaken for non-self-tissue and immune cells attack certain organs or tissues.

How is HIV able to get past and destroy the immune system?

The one virus that the CD4 fighter cells cannot beat is HIV because HIV attacks and destroys the body's immune system cells. There are different strains of HIV but they all belong to the same family of viruses called retroviruses. Retroviruses invade the body's white blood cells and once they have managed to invade the structure of the CD4 cells, they multiply by replicating themselves. They do this by 'disguising' themselves so that the CD4 cells do not recognise them as the 'enemy'. As it reproduces itself, it destroys the CD4 fighter cells.

When these CD4 cells get wiped out by HIV, the body's immune system becomes damaged. This means that the body starts to lose its power to defend itself against other germs and viruses that the immune system could easily have beaten. Without a strong immune system, common viruses and infections can easily kill a person.

What is AIDS?



Small group exercise

Ask the participants to discuss what AIDS stands for?

AIDS stands for acquired immune deficiency syndrome.

- A:** Acquired – obtained from outside sources.
- I:** Immune – your body's ability to fight illness.
- D:** Deficiency – not enough ability to fight off illness.
- S:** Syndrome – not just one kind of illness, a cluster of several illnesses.

HIV is the virus which causes AIDS. Some of the early signs of AIDS include sores on the skin and in the mouth, weight loss, diarrhoea and persistent coughs. Later, the person may get TB, pneumonia or brain and nerve diseases. These are called opportunistic infections. They take the opportunity to attack the body because the immune system is no longer able to fight them off. Once the person's CD4 cell count drops below a certain point (200) and a person is suffering from one or more opportunistic infections, the person is said to have AIDS.

Although AIDS is a 'disease', it is not a specific illness. It is a collection of many different conditions that show in the body (or specific parts of the body) because HIV has weakened the immune system. It is more accurate to define AIDS as a syndrome of opportunistic infections, diseases and certain cancers. All or any of which has the ability to kill the person in the final stages of AIDS.

From HIV to AIDS in older people

How long does it take for HIV to develop into AIDS in older people?



Small group exercise

Ask the participants to discuss how long it takes for HIV to develop into AIDS in an older person.

HIV progression to AIDS in older people

Since immune function declines with age, HIV can progress more rapidly in older people without treatment.

When receiving treatment, older people respond the same as younger people. Studies show that three months after older people start HIV drugs, called antiretroviral (ARV) therapies, their CD4 counts increase and their viral load (the amount of the virus in the body) drops much the same as they do in younger people. Some older patients do not restore their CD4 counts to as high a level as younger people and this may be due to the ageing process itself.

When an older person is living with HIV, the CD4 cell loss can be greater than in younger people. Studies have found that older people with HIV who are not taking ARVs are twice as likely to die as younger people with HIV. Therefore, older people are at greater risk than younger people if they delay treatment.

Clinical staging of HIV disease⁷

The flow chart below shows the progression of HIV to AIDS.

Clinical Stage 1:

Two weeks after infection, a person shows typical flu-like symptoms. These may include: swollen glands, fever, headaches, aching muscles, general tiredness and diarrhoea. This phase may last up to eight weeks. The person then enters the asymptomatic stage and may have no further symptoms except enlarged lymph nodes.

Clinical Stage 2:

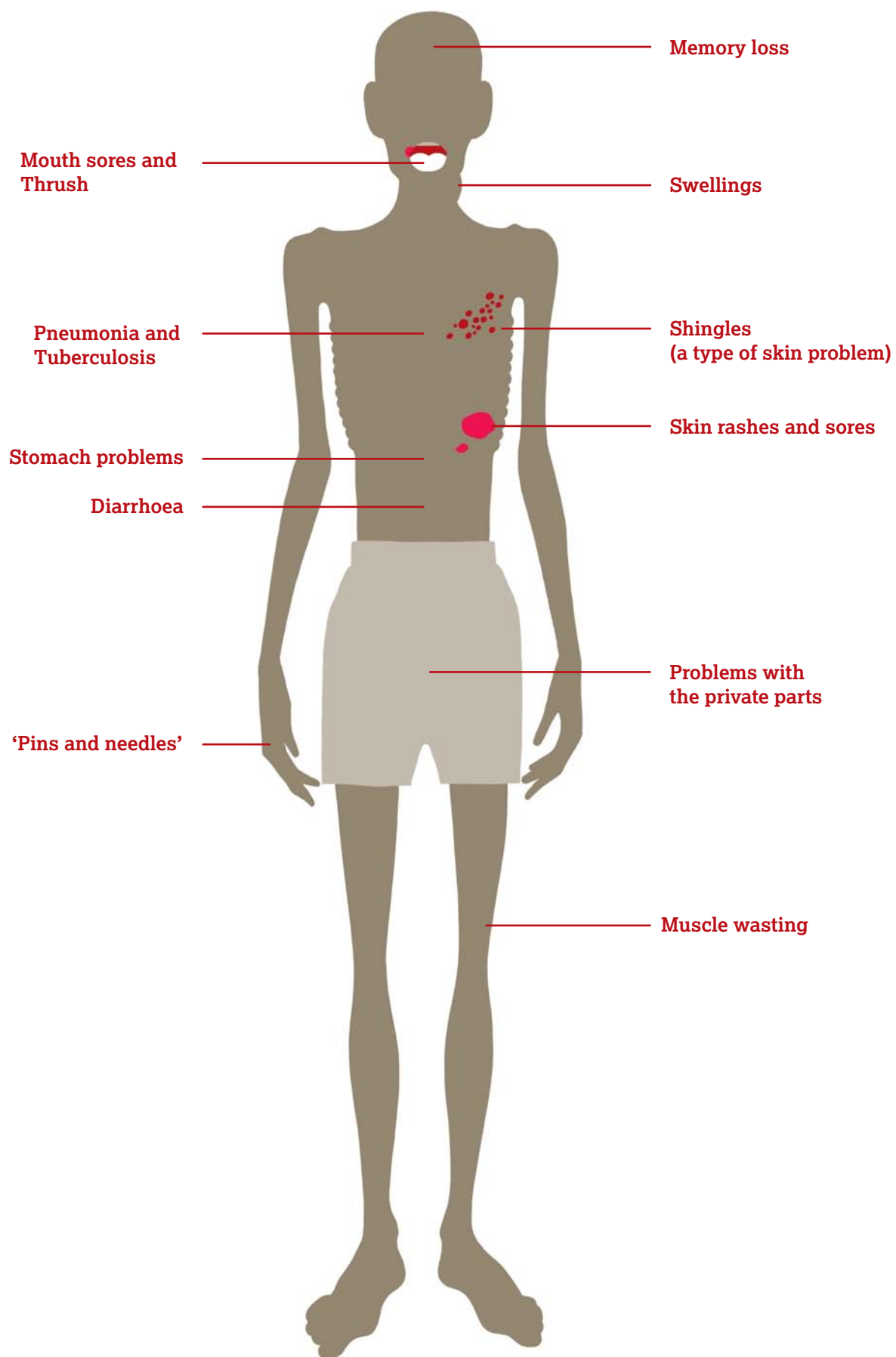
Symptoms include moderate unexplained weight loss, repeated chest infections, shingles, rashes, swollen glands, mouth ulcers, weight loss. Cuts take longer to heal. At this stage, factors such as nutrition and medical treatment play a vital role in slowing down the progression of HIV to AIDS.

Clinical Stage 3:

Signs and symptoms include excessive weight loss, chest infections such as TB and pneumonia; cancers; and diarrhea. Many people only discover their HIV status at this stage. The person may spend less than 50 per cent of the time in bed.

Clinical Stage 4:

The immune system is now totally deficient and collapses. Germs and opportunistic infections which would not pose a serious threat to a person with no HIV will cause death in a person living with HIV. Signs and symptoms are usually severe and include HIV wasting syndrome. The person gets tired extremely easily and may spend more than 50 per cent of the time in bed.



HIV-related illnesses involve many parts of the body, including breathing and skin, as well as the nervous system. A crucial issue regarding HIV in older people is to identify which health conditions are age-related and which are HIV-related, as age and HIV affect people in similar ways.

Early signs of AIDS in older people include:

- fevers and sweating at night
- sores on private parts that do not get better
- painful skin rashes for example, shingles
- thrush – a white rash inside the mouth
- sores on the lip that do not heal
- signs of TB – coughs, sweating and weight loss
- swellings under the arm and groin, behind the ear and on the neck

Later signs of AIDS include:

- tuberculosis (TB)
- pneumonia (or a bad cough and fever)
- ‘pins and needles’ and pains in the hands and feet
- diarrhea that does not go away and stomach problems
- loss of weight
- headaches, fits, blackouts, loss of memory and difficulty in concentrating
- dark blue marks on the skin
- difficulty in swallowing

Most people with AIDS will get one or more of the above sicknesses but will not get them all at the same time.

Note: A person can only tell whether he/she has HIV through an HIV test and must not rely on the presence of signs and symptoms.

HIV diagnosis in older people

Many older people with HIV are not diagnosed because doctors do not link the conditions to HIV but rather link them to old age. Bacterial infections, pneumonias, herpes virus infections (including herpes zoster) and other infections are all diseases that become more common in older age and are similar to HIV-related conditions.

Even though the manifestations of HIV resemble other diseases of ageing, it is important to understand that HIV may be responsible for such symptoms as fatigue, shortness of breath, chronic pain, weight loss and rashes.

Where did HIV come from? A brief history and prevalence of HIV in older people

Session outcomes:

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

- identify where HIV came from
- explain the difference between HIV-1 and HIV-2
- explain what is meant by prevalence and incidence
- explain why some groups of people are more susceptible to HIV than others
- demonstrate an understanding of HIV prevalence among older people

Previous epidemics in history



Class discussion

Ask participants to discuss what other epidemics have been responsible for killing many people?

Three other epidemics have had far-reaching effects on the world.

• The bubonic plague, also known as the Black Death

There were three major epidemics in the 6th, 14th and 17th centuries. The death toll was 137 million.

• Smallpox

From 1518 to 1605, this epidemic reduced the population of Mexico from 25.1 million people to 1.1 million.

• Influenza

An epidemic that occurred Europe in 1918 and 1919 after the First World War. The death toll was one million.

Where did HIV and AIDS come from

HIV has caused great fear and suspicion. This has led to many rumours and false beliefs or theories about where, how and why HIV originated.



Class discussion

Below is a list of theories or myths about the origins of HIV. A myth is a belief that is incorrect and cannot be proven. Read the list to the participants and ask them to discuss what other myths they have heard about that can be added to this list?

Myths about the origin of HIV

- The Russians created HIV.
- The Americans created HIV.
- The United States Central Intelligence Agency (CIA) created HIV for chemical warfare.
- It was present in a polio vaccine.
- It jumped from monkeys to man.
- It came from men who have sex with men.

A brief history of HIV

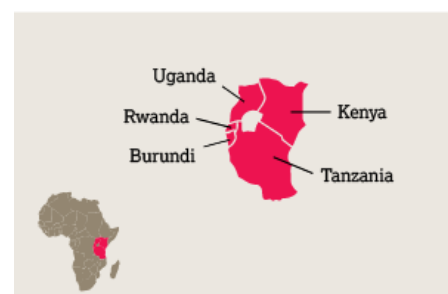


Class discussion

Ask participants to discuss the history of HIV and the role their country has played in the history of HIV.

The 1970s – The first HIV epidemic

The first HIV epidemic is believed to have occurred in Kinshasa in the Democratic Republic of the Congo (DRC), formerly Zaire, in the 1970s. It is speculated that HIV was brought to the city by a person living with HIV who travelled from Cameroon by river down into the Congo. On arrival in Kinshasa, the virus entered a wide urban sexual network and spread quickly. The world's first heterosexually spread HIV epidemic had begun and was signalled by a surge in opportunistic infections in the Congolese capital.



The 1980s – Spread and reaction

Although HIV was probably carried into East Africa (Uganda, Rwanda, Burundi, Tanzania and Kenya) in the 1970s from DRC, it only reached epidemic levels in the region in the early 1980s.⁸

It is thought that sex workers played a large part in the accelerated transmission rate in East Africa. In Nairobi, for example, 85 per cent of sex workers were living with HIV by 1986.¹⁰

Uganda was hit very hard by the HIV epidemic in the 1980s. By the end of the decade, HIV prevalence among pregnant women in Uganda's capital had peaked at over 30 per cent.¹³



The early 1980s also saw HIV spread further into West Africa, however, in the Western Equatorial countries of Gabon, Congo-Brazzaville and Cameroon, the virus did not cause large epidemics¹⁴ because the long distances between cities, the difficulty of travel, the violence and insecurity in the region meant that there were not the sexual networks that would allow the spread of HIV to epidemic proportions.

West Africa had generally high levels of infection of HIV although nowhere near the proportions of East Africa.

Truck drivers, alongside other migrants such as soldiers, traders and miners, have been identified as a group which facilitated the initial rapid spread of HIV as they engaged with sex workers and spread HIV outwards on the transport and trade routes. In the 1980s, 35 per cent of tested Ugandan truck drivers were living with HIV,¹⁸ as were 30 per cent of military personnel from General Amin's Ugandan army.¹⁹



In 1988, the second highest prevalence of HIV in all of Africa was found on the Tanzam road linking Tanzania and Zambia.²⁰

As the decade progressed so too did the epidemic, moving south through Malawi, Zambia, Mozambique, Zimbabwe and Botswana. Although the virus arrived comparatively late in this region, it spurred a devastating epidemic in the general population. By the end of the 1980s, the southern African countries of Malawi, Zambia, Zimbabwe and Botswana were on the verge of overtaking East Africa as the focus of the global HIV epidemic.

In South Africa, blood specimens showed a 16 per cent infection rate among tested men who had sex with men in Johannesburg in 1983. The small-scale epidemic was then largely confined to white men who had sex with men but exploded into the heterosexual population of South Africa by the mid-1990s, now having the largest number of people living with HIV in the world.

Addressing the HIV epidemic

The most important thing to focus on is what can be done about HIV now. Take the story of the man who sees a green snake going into his house. Does he ask “What kind of snake is this? Where does it come from? Who put it here?” No – he kills the snake before it bites his family. We know HIV is here. We know people are dying and we need to prevent it spreading.

Strains of HIV

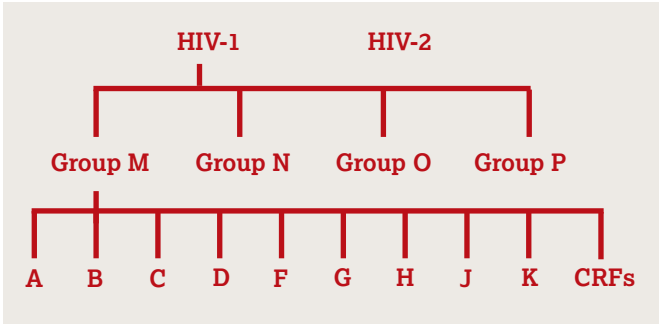


Small group exercise

Ask participants what the difference is between HIV-1 and HIV-2 and how many strains of HIV are there?

HIV-1 and HIV-2

There are two major strains of the virus, HIV-1 and HIV-2. HIV-2 has effects like those of HIV-1 but is usually only found in West Africa and rarely found elsewhere. There are a few differences between the two strains. HIV-2 is harder to spread and slower to progress from HIV to AIDS.



Subtype of HIV-1

The strains of HIV-1 can be classified into four groups: M, N, O and P but more than 90 per cent of HIV-1 infections belong to group M. Modern HIV tests detect more subtypes of HIV but it is possible that routine tests will not detect rare subtype O and HIV-2. Within group M, there are nine sub-groups, A to K. It is possible to have more than one subtype.

- Subtype A is mainly found in West and Central Africa
- Subtype B is most commonly found in Europe, the Americas, Japan and Australia and is the predominant subtype found among men who have sex with men
- Subtype C is mostly found in southern and East Africa, India and Nepal. It has caused the world’s worst HIV epidemics and is responsible for around 50 per cent of all infections
- Subtype D is generally only found in East and Central Africa
- Subtype F has been found in Central Africa, South America and Eastern Europe
- Subtype G has been found in West Africa, East Africa and Central Europe

- Subtype H has only been found in Central Africa
- Subtype J has only been found in Central America
- Subtype K has only been found in the Democratic Republic of Congo (DRC) and Cameroon.⁸
- Most antiretroviral (ARV) therapies have been developed to treat subtype B but there is no reason to believe that these medications will be less effective against other strains, though some subtypes may be more likely to develop resistance to certain drugs.⁹

Note: When a person is living with HIV they can still get other strains (types) of the virus

Difference between prevalence and incidence

Incidence = the number of NEW infections



Prevalence = the number of HIV-positive people

Incidence refers to new infections in a given time.

Prevalence refers to the number of people who are currently living with HIV.



Class discussion

Ask participants to discuss why it is important to study the incidence and prevalence of HIV within a given population. For example, among older people.

Studying the incidence of HIV in older people over time shows whether the rate of new infections is increasing or slowing down which demonstrates if the HIV programmes being carried out with older people are effective. Prevalence shows how many older people will need treatment, care and support for HIV.

HIV around the world

There are about 34 million people living with HIV (2010). Each year, around 2.6 million more people are infected and 1.8 million people die of AIDS related illnesses.¹⁰

The worst affected region is sub-Saharan Africa, which is home to 66 per cent of people living with HIV. Fast-growing epidemics include Eastern Europe and Central Asia.



Class discussion

Ask participants to discuss why Africa has greater HIV prevalence than other continents.

There is no conclusive answer to this question but there is consensus that many factors have played a role in increasing the transmission rate in Africa, including poverty, economic disparity, social instability, gender inequality, sexual violence, other sexually transmitted infections (which facilitate HIV transmission), lack of male circumcision, rapid urbanisation and modernisation, and ineffective leadership during critical periods in the epidemic’s spread.¹¹

Other scientific theories that have shown a measurable impact on transmission include:

- HIV subtypes found in Africa could be stronger and have increased transmission rates
- Genetic factors (there is a gene found in Africans that makes them more likely to contract HIV)¹²
- Parasitic worm infections (common in sub-Saharan Africa) may have also increased transmission rates in Africa¹³

Whether concurrent partnerships have influenced the high rates of infection in Africa is hotly debated. The Joint United Nations Programme on HIV/AIDS (UNAIDS) defines a concurrent sexual partnership as “overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner”. All researchers agree that the risk of contracting HIV is high in concurrent partnerships. What researchers cannot agree on is whether there is empirical evidence that concurrent relationships are more common in Africa than other parts of the world.

HIV in your country among older people



Class Discussion

Ask participants to discuss what the HIV prevalence is in their country among the general population and among older people and what percentage of orphaned children are being cared for by older people?

HIV prevalence among older people aged ≥ 50 years and people aged 15–49 years in sub-Saharan Africa, by country, 2007¹⁴

Country	Older adults who are HIV-positive		People aged 15–49 who are HIV-positive		People aged ≥ 15 who are HIV-positive		HIV+ older adults as a percentage of all HIV-positive people aged ≥ 15
	No	%	No	%	No	%	
Ethiopia	157 700	2.1	732 300	2.1	890 000		17.7
Kenya	1 690 100	5.6	1 430 900	7.8	16 000 000		10.6
Uganda	150 100	6.8	659 900	5.4	810 000		18.5
Tanzania	150 100	5.4	1 100 800	6.2	1 300 000		15.3
South Africa	679 700	10.2	4 720 300	18.1	5 400 000		12.6

In sub-Saharan Africa, 5.5 million people are now on antiretroviral (ARV) treatment, meaning that people living with HIV are living longer and sexual transmission of HIV among older people is occurring. It is estimated that about 3 million people aged 50 and over are living with HIV in sub-Saharan Africa. This represents about 14.3 per cent of all people infected in the region¹⁵.

Human rights of older people infected or affected by HIV

Session outcomes:

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

- understand that older people often miss out on vital information, testing and treatment
- explore how older people are affected by HIV, either directly or indirectly
- explain the stigma, discrimination and violence against older people who are infected with HIV
- discuss the vulnerability of older women to HIV infection and the impact

Older peer educators will have experienced how older people have been marginalised in the national response to HIV. Prevention programmes have not focused on older people and testing and treatment programmes have not targeted older people.

HIV and discrimination against older people



Small group exercise

Ask participants to discuss how they think older people experience discrimination and stigma as a result of living with HIV or being affected by HIV?

HIV-related stigma and discrimination in older people are major obstacles to receiving HIV prevention, treatment, care and support services. Older people living with HIV face stigma due to their age and status.

What are older people's rights?

Specific rights relevant to older people living with HIV

While older people enjoy the same universal rights as everyone else, some rights are particularly relevant to the experience of ageing:

- Right to freedom from discrimination
- Right to freedom from violence
- Right to social security
- Right to health
- Right to work
- Right to property and inheritance

The Universal Declaration of Human Rights states that “all human beings are born free and equal in dignity and rights”. This equality does not change with age or if they are living with HIV: older men and women who are living with HIV have the same rights as people younger who are living with HIV.

The rights of older people who are living with HIV are embedded in international human rights conventions on economic, social, civil and political rights, yet are not made specific.

Older people face very specific threats to their rights in relation to HIV discrimination and age discrimination, for example, in access to healthcare, in employment, in property and inheritance rights, in access to information and education, and in humanitarian responses. Older people also face particular forms of violence and abuse. They face particular threats to their rights in care settings and as carers themselves.

The right to health services for older people

Health, HIV and human rights are inextricably linked. According to the World Health Organization (WHO), every country in the world is now party to at least one human rights treaty that addresses health-related rights, yet many people still do not have access to essential HIV services that can prevent HIV infections and save lives. Antiretroviral treatment is still only available to one-third of people in need and this includes older and younger people. Even with the expansion of programmes to prevent mother-to-child transmission of HIV, in 2009 only 53 per cent of pregnant women living with HIV were able to access treatment to prevent passing the virus on to their infants. The impact of this on older people is that they will be left caring for orphaned children who are also living with HIV. This will increase the emotional and financial burden on them.

Social support services

Social security protection is regarded by the United Nations as a basic human right and should include access to health services, pension and unemployment protection, but the reality is that for the vast majority of sub-Saharan African countries, social protection and pensions are lacking.



Small group exercise

Ask participants to discuss what rights and access the people in their country have to the following:

- Social welfare, including old age pensions, unemployment insurance, ill health and childcare grants
- Health services, including HIV testing, prophylaxis, treatment for opportunistic infections and antiretroviral treatment

Legislation that discriminates against older people with HIV



Class discussion

Ask participants to discuss what the laws are in their country that help protect older people who are living with HIV and what the laws are that protect older people from becoming HIV-positive.

Ask the participants to list the legislation that has either protected or discriminated against older people with HIV.

Positive laws and policies create an environment in which HIV prevention, treatment, care and support services can be easily accessed. Examples of positive laws and practices include laws that protect people living with HIV from discrimination.

Criminalising of HIV transmission

Discriminatory laws and policies can prevent people from accessing HIV prevention, treatment and care services. This effectively criminalises the lives of people living with HIV.

Examples include laws that:

- criminalise unintentional transmission or exposure of HIV
- criminalise sex work among consenting adults
- criminalise same sex, sexual relations
- impose compulsory or cohesive drug treatment for people who use drugs, or prohibits the provision of harm reduction services for people who use drugs
- restrict or deny entry/stay/residence or require deportation of non-nationals living with HIV

There is an increasing trend in countries toward the application of criminal laws to HIV exposure and transmission.

Many African countries have introduced specific legislation criminalising HIV exposure and transmission using a set of model laws. The model law does not take into account that older women cannot choose to abstain from sex with their partner or insist on condom use, regardless of their HIV status. It ignores the likelihood that these laws will increase stigma, alienating people living with HIV.

These laws are completely at odds with the cultural reality and status of women in most African societies. Applying criminal law to HIV exposure or transmission is likely to: increase the risk of violence and abuse women of all ages face; increase gender inequalities further promoting fear and stigma; increase women's risks and vulnerabilities to HIV and to HIV-related rights violations; and have other negative outcomes for women.



Class exercise

Ask the participants to review the case study of Alice Mwangi and discuss how criminalisation of HIV transmission can have a negative effect on HIV prevention, treatment, care and support.

In August 2006, Alice Mwangi filed a case. She had gone for a routine appointment at an antenatal clinic when she was tested for HIV without her consent. The test was followed by the unauthorised disclosure of her HIV-positive status to her family members.

“I suffered stigma and discrimination both from my relatives and at my place of work. For example, I went for a tooth extraction and my father shouted to the dentist that I had AIDS. The dentist then refused to provide dental services. It was difficult for me and I had to find an alternative dentist.”

[In Kenya, HIV transmission is described as a criminal act in the HIV Act, 2006. If a person who knows his or her status infects another person willingly or intentionally, they can be charged in a court of law.]

“The impact of the criminalisation of HIV transmission has made me think about my own sexual behaviour and about protecting my partner and about discussing my partner’s own HIV status. It has made me develop a positive attitude towards people living with HIV. It has also made me think about confidentiality – after all, no one wants his or her status shared without her consent.

Do I think people living with HIV should disclose their HIV status before every sexual encounter? That depends on the person who they want to disclose to, and whether this person will give support. At the same time, they should insist on protection.

We should all be responsible for preventing the transmission of HIV, not only the people who are HIV-positive.

Laws addressing issues on HIV-transmission should be reinforced to curb the rapidly increasing number of HIV-positive people but, at the same time, it should not be used to victimise the people who are already HIV-positive and doing something about it to protect themselves and others. Stigma has undermined the ability of individuals’ families and society at large to protect themselves and provide support and reassurance to those affected.

Source: Behind bars: life stories of people affected by the criminalisation of HIV.

Older women’s rights in your country

In many countries, there are still laws that reinforce the gender inequality. They do this by denying women the right to divorce, the right to own property, the ability to enter into contracts, to sue and testify in court, to consent to medical treatment and to open a bank account – these are critical legal rights for women.¹⁶

In Swaziland, fathers are automatically granted custody of children¹⁷ which may make a woman less likely to leave an abusive situation that may place her at risk of contracting HIV.

In Tanzania, the legal age of marriage is 15 for girls, with increased risk for contracting HIV, as both age and marital status tend to affect whether someone can negotiate condom use.¹⁸

In Ethiopia, the law has changed to make marriage under the age of 18 illegal.¹⁹ The problem now is that the country has to enforce the new law.

These laws directly affect a woman’s risk of contracting HIV. If a woman has no right to divorce, she must stay with a man who may put her at risk of HIV, or if she cannot own property, she is more likely to have to engage in transactional sex to survive. While being a woman alone denies women their rights in certain countries, these limited rights can be restricted even further if a woman has HIV. In some countries, people living with HIV have little access to the formal legal system.²⁰



Class discussion

Read the following questions to participants and ask them to answer them.

- Do men and women have the same rights in your country?
- Are marriages arranged? Can women be forced into marriage at a young age?

- Can women own property?
- Do the laws of inheritance discriminate against women?
- Is polygamy legal? What impact does this have on women's rights?

HIV and older people in the work place

Although the majority of older people may not be working, their children and grandchildren may be prevented from working because of their positive HIV status.

Findings from pilot studies by the Global Network of People Living with HIV (GNP+) in Kenya, Nigeria and Zambia show that the most common right violated for people living with HIV of all ages is the right to work, with work being terminated or denied, owing to the person's HIV-positive status.²¹

The International Labour Organization (ILO) is a UN agency with 183 country members and sets labour standards and policies. Under the name ILO/AIDS, the ILO has created a *Code of Practice on HIV and AIDS and the World of Work*, which provides principles for "policy development and practical guidelines for programmes at enterprise, community, and national levels". These key principles have been adopted in most countries in the world.

Key principles of the ILO Code of Practice on HIV and AIDS and the World of Work.

1. **A workplace issue – HIV is a workplace issue because it affects the workforce, and because the workplace can play a vital role in limiting the spread and effects of the epidemic.**
2. **Non-discrimination – There should be no discrimination or stigma against workers on the basis of real or perceived HIV status – casual contact at the workplace carries no risk of infection.**
3. **Gender equality – More equal gender relations and the empowerment of women are vital to preventing the spread of HIV and helping people manage its impact.**
4. **Healthy work environment – The workplace should minimise occupational risk and be adapted to the health and capabilities of workers.**
5. **Social dialogue – A successful HIV policy and programme needs cooperation and trust between employers, workers and governments.**
6. **No screening for purposes of employment – Testing for HIV at the workplace should be carried out as specified in the Code, and be voluntary and confidential, and never used to screen job applicants or employees.**
7. **Confidentiality – Access to personal data, including a worker's HIV status, should be bound by the rules of confidentiality set out in existing ILO instruments.**
8. **Continuing the employment relationship – Workers with HIV-related illnesses should be able to work for as long as they're medically fit in appropriate conditions.**
9. **Prevention – The social partners are in a unique position to promote prevention efforts through information, education and support for behaviour change.**
10. **Care and support – Workers are entitled to affordable health services and to benefits from statutory and occupational schemes. In addition, care and support should be given to the employees who are caregivers to the family and friends of people living with HIV.**

Attitudes to HIV in older people

Session outcomes:

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

- recognise that HIV can bring about a new kind of discrimination for older people
- describe how fear and ignorance can put people in danger of contracting the virus
- recognise the changes in attitude peer educators must try to bring about

Common reactions to older people who are living with HIV

HIV has given rise to a new kind of discrimination for older people. Many people do not understand how HIV is transmitted. They are scared that they may catch the virus from someone who is living with HIV. Many people blame older people living with HIV and discriminate against them and against their families.



Small group exercise

Read the case study about Alfred to the participants and ask them to discuss:

- how discrimination and fear has hurt his family
- how the community has 'lost' because of its attitude to Alfred and his grown family

Alfred is a grandfather who is 65 years old. He lives with his son and his son's children. He is an active volunteer in his church and a popular community member. Alfred is living with HIV. Ever since people found out about his status, his neighbours no longer invite him to their homes. People he has known all his life do not greet him in the street. His granddaughter came home from school and told him that she is not allowed to sit with the other children and that nobody wants to play with her anymore. His son's wife says that people whisper when she goes shopping. Alfred and his son's family are thinking of moving to a different city.



In pairs

Ask participants to discuss why they think the community reacted to Alfred and his family in the way it did? Ask them what experiences they have had and what stories they have heard about people in a community reacting to people living with HIV.



In pairs

Ask participants to discuss how they would like to be treated if other people found out that they were living with HIV.



Small group exercise

Read the speech bubbles below to the participants. Ask them to discuss how fear and ignorance can actually put the people who hold these beliefs at risk of infection. Ask them to appoint a leader to feedback to the group.



HIV does not discriminate. It can infect anyone at any age. The virus does not care about religion, race, age, economic situation or gender (man or woman). It does not matter whether you live in a town or a rural area. Everyone is at risk of getting HIV and no-one deserves to have AIDS.

HIV knowledge in older people

Research in Africa into attitudes of people aged 50 and over found that they had lower levels of HIV-related knowledge and awareness than those aged 25–49. Older people are also less likely to have been tested for HIV and are less likely to have spoken to their partners about HIV. Women aged 50 and older show particularly low levels of awareness and knowledge compared with both younger women and with men aged 50 and older. Despite this, older people demonstrated a high level of willingness to care for family members who are living with HIV. Older people were also less likely to know that condoms were an effective prevention measure when used during every sexual encounter and had less knowledge of the prevention of mother-to-child transmission (PMTCT). They are also less likely to have been tested for HIV.²²

There are high stigma levels among older people and among older women in particular, and this could reduce the possible uptake of HIV testing programmes and can lead to people not seeking advice, services and support. Stigma is particularly important among older people who are often expected to take on caring roles for their children or grandchildren affected by HIV.



Group discussion

Ask participants to tell stories about ways to reduce stigma experienced by older people with HIV. These stories can be real-life examples or something that they have made up to explain their ideas.

What can communities do to protect older people against HIV infection?

Older women are more vulnerable to HIV infection than older men. This is due to a number of factors including that women are less able to negotiate safe sex, a woman's anatomy makes her generally more vulnerable to contracting HIV and more women probably engage in transactional sex. Older women are more likely to care for their grown-up children who are living with HIV and to take care of their orphaned grandchildren than older men. While all older people living with HIV are usually invisible, isolated and ignored, this is particularly true of women, who are often unable to disclose their HIV status even to family and friends and, certainly, their community.

Older people are often diagnosed with HIV at a late stage of infection, and often become ill with AIDS-related complications and die sooner than younger people with the virus. These deaths can be attributed to original misdiagnoses and immune systems that naturally weaken with age.



Communities can protect older women against HIV by:

- asking public sector, private sector and NGOs to run HIV programmes for older people at local clinics, churches or anywhere else that people gather. This will educate older people so that they can protect themselves against the virus
- making the community safer for older women – fighting against rape and sexual abuse
- teaching older women and men that women have the right to say 'no' to sex and to negotiate safer sex.
- encouraging religious leaders and traditional healers to become involved in the response to HIV. Asking them to talk openly about sex and HIV at churches and ceremonies.

The family unit



Class discussion

Ask participants what the roles and functions of the family are? Ask them if these have changed in any way during their lifetime and during their parents' lifetimes.

Ask participants what the importance of trying to change attitudes of people about HIV risks, stigma and discrimination is in the family of an older person.

People who are HIV+ need our support and understanding, not our criticism and blame.



Small group exercise

Read out the speech bubbles below and ask participants to fill in the empty one. Ask them what their story would look like if they told people at church they were living with HIV. What would they be saying? Ask them to appoint a leader to feedback to the group.

When I told people at church that I was HIV-positive, they started causing trouble for me. It got so bad that I had to leave and find another church.



When I told people at church that I was HIV-positive they were shocked but they were supportive. They wanted to find out more about the virus and how they could protect themselves. They supported me and told me that they were there for me.





Small group exercise

Now read the the example below to the participants and ask them to write down how they think the mother could have reacted in a supportive way.

When I told my mother I was HIV-positive, she told me I had brought shame on my family. She threw me out of her house.

When I told my mother I was HIV-positive, she ...



Small group exercise

If you tell someone you are living with HIV they can react in a number of different ways – either negatively (not giving support) or positively (giving support). Read the lists below to the participants and ask them what negative and positive reactions they can add to these two lists and what changes in attitude they want to bring about in people.

Possible reactions to someone who is HIV-positive

Negative reactions

- Denial
- Anger
- Blame
-
-

Positive reactions

- Understanding
- Support
-
-
-

Not all community members will change their attitudes to HIV and AIDS in general or towards older people with the virus. Many people will only change their attitudes over a period of time so peer educators should not expect to bring about changes immediately. Some people may even get angry with you. They may think that you are interfering with their personal lives. Focus your energy on those people who are willing to try and change their attitudes. Remember, ignorance breeds fear. To stop the fear, you have to give people as much information as possible. When they have information, they can make choices about their attitudes and their behaviour.

These are some attitude changes peer educators should try to bring about. You want people to:

- Recognise that HIV does not discriminate – anyone can get the virus, including older people.
- Realise that it is possible for them to get HIV if they practice unsafe sex or if their partner practices unsafe sex – even if they are older and no longer able to bear children.
- Increase their understanding and compassion for older people living with HIV and no longer judge them.
- Recognise the economic and community impact of HIV on older people and acknowledge that they can make a difference, and are helping by looking after orphaned grandchildren.
- Forget older people's embarrassment about going to a shop and buying condoms.
- Create a supportive environment for older people living with HIV so that others do not have to live a lie and can disclose their status without fear of rejection and discrimination.
- Put all fears aside, get tested and encourage others to get tested.

**At home: assessing attitudes**

Ask participants when they are at home tonight or among their friends and/or neighbours, to try and steer the conversation towards HIV. Ask them to find out what people's attitudes are towards:

- older people who are living with HIV
- older people who disclose their HIV status

They should talk openly and honestly to their family members and friends. They should ask them to imagine that someone they know well (for example, a sister, brother, wife, husband, friend) is living with HIV and ask how they would react and why they would react in this way. They should go back to the list of people's attitudes peer educators are expected to change. Ask them which of these attitudes do they think will be hardest to change and why.

Transmission of HIV and STIs in older people

Session outcomes:

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

- discuss and understand how HIV is transmitted in older people
- discuss and understand what ‘infectious amounts’ mean in relation to transmission of HIV in older people
- explain how the immune system works and what happens to a person as the disease progresses from HIV to AIDS in older people
- describe what an STI is, and its signs and symptoms in older people
- explain how STIs can increase the risk of people getting HIV in older people
- explain why it is so important to treat STIs quickly and why both the infected older person and his/her partner should be checked and treated

The major risk of transmission for older people in Africa is through unprotected sexual intercourse with a person who has HIV.



Small group exercise

Read the case study below to the participants. Ask them how Grace became HIV-positive and why she should have taken precautions. Ask them to appoint a leader and feedback to the group.

Case study

Grace was dating again. George, a close family friend she had known for a long time, was starting to stay overnight more and more often. Because she was past child-bearing age, Grace didn't think about using condoms. And because she had known George for so long, she didn't think to ask him about his sexual history. So, Grace was shocked when she tested positive for HIV.



Class discussion

Ask participants if they know other examples of HIV transmission in older people. Ask them to share their stories with the group.

Testing the participants' knowledge of transmission of HIV in older people

There are many facts and myths about HIV in older people. It is important that peer educators give people the correct facts. This means they first need to know how much knowledge they already have about the virus and then add to their knowledge.



On their own

Read out the following questions and ask the participants to answer 'yes', 'no' or 'I'm not sure' for each question.

Can you get HIV by...

- injecting yourself with a needle that a person living with HIV has used? **Y**
- getting a bite from a mosquito that has already bitten a person living with HIV? **N**
- swimming in a public pool with other people you know are living with HIV? **N**
- sharing a razor with a person living with HIV? **Y**
- kissing a person living with HIV? **N**
- eating at the home of a person living with HIV and using their plates, cups and cutlery? **N**
- having sex without a condom with a person living with HIV? **Y**
- shaking hands with a person living with HIV? **N**
- using a toilet when you know that the person who sat on the toilet seat before you is living with HIV? **N**
- hugging a person living with HIV? **N**
- being born to a mother who is living with HIV? **Y**
- standing next to a person living with HIV who is coughing and sneezing? **N**
- having a blood transfusion? **Y**
- mixing the blood of a person living with HIV with your blood through an open wound? **Y**
- drinking from a water fountain after a person living with HIV has used it? **N**

Older people and HIV transmission



In pairs, debate

Ask participants to debate in pairs with one person taking the position that older people are not at risk of contracting HIV, while the other takes the position that older people are at risk of becoming HIV-positive. They should debate this issue for two minutes, then swap.

There are several reasons why older people are at risk of HIV:

1. HIV prevention campaigns do not target older people.
2. Older people may not consider themselves at risk of HIV.
3. Healthcare providers may not consider the HIV in older patients attributing symptoms of HIV to 'normal ageing' and therefore may not suggest HIV testing.
4. Despite the stereotypes, many older people lead sexually active lives. Studies of sexual activity in people aged 50 and over showed that 81.5 per cent were involved in one or more sexual relationships, including sex with sex workers. It is believed that only a small minority of people over 70 consistently used condoms.
5. Older women may be especially at risk because age-related vaginal thinning and dryness can cause tears in the vaginal wall.
6. The increase in foreign travel makes access to countries with thriving sex industries easier.
7. The introduction and usage of potency drugs, such as Viagra, has extended the sex lives of many older men.

8. The stigma of HIV may be perceived to be greater in the older population, leading them to hide their diagnosis or avoid testing.

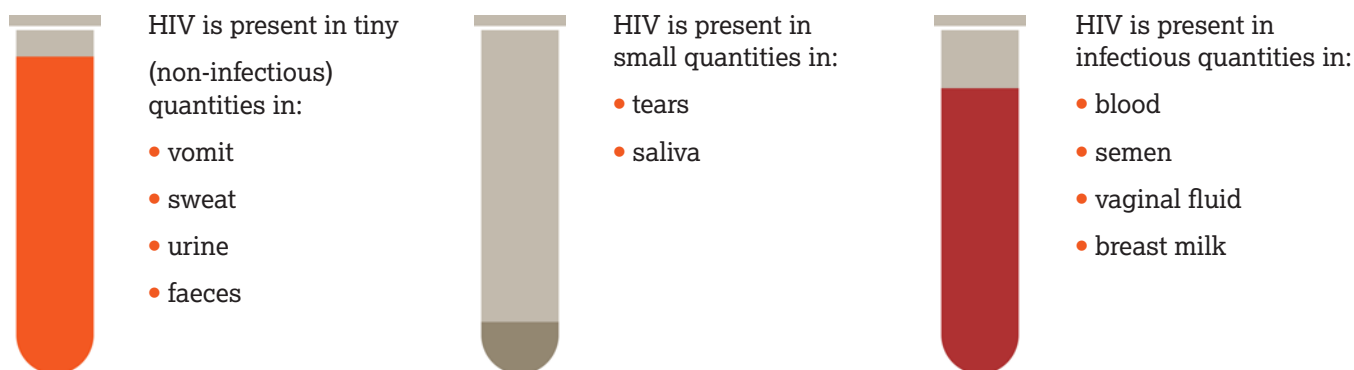
What are the transmission routes for older people?

The same conditions for HIV transmission are necessary for people of all ages.

- A person living with HIV
- An exit point (a hole – penis, vagina, nipples, broken skin or mucous membrane)
- Body fluid (blood, semen, vaginal fluid or breast milk) from a person living with HIV
- Unsafe behaviour or an unsafe act
- An entry point into an HIV-negative person (penis, vagina, rectum, mouth, broken skin or mucous membrane)

HIV in body fluids

All body fluids have HIV but only some body fluids have enough HIV to be infectious. Only the following body fluids can transmit HIV from one person to another.



Sexual fluid

HIV is found in the semen (including pre-seminal fluid or 'pre-cum') or vaginal fluids of a person living with HIV of any age. The virus can be passed on to a partner through having unprotected vaginal sex (that is, when the man inserts his penis into a woman's vagina) or anal sex (where the penis is inserted into the partner's anus).



Small group exercise

Read the speech bubble below to the participants and ask them what information does this couple need to know?

We are both HIV-positive. We don't need to practice safe sex because we already have the virus!



Small group exercise

Read the speech bubble below to the participants and ask them what information does this couple need to know?

Even if a person already has HIV, it is possible for more of the virus or a different strain of HIV to be introduced into their system via any of the modes of transmission discussed above. This would result in an increased viral load (the amount of HIV in the blood) and further destruction of the immune system. This means that two sexual partners both of whom are living with HIV still need to practice safer sex in order to prevent re-infecting each other.

Blood and HIV transmission



Small group exercise

Ask participants to make a poster on how HIV can be transmitted by blood. The heading should say "Warning: you can contract HIV from blood by..." Under this heading, participants should list five ways HIV can be transmitted by blood.

HIV can pass from one person to another through his or her blood. People of any age who use drugs intravenously account for an increasingly high proportion of HIV cases. Drug users run a high risk of becoming infected. HIV is easily transmitted when needles are shared because drug users usually inject drugs directly into their bloodstreams. To make sure that the needle has hit a vein, the user first draws blood into the syringe before they inject the drug. A drop or two of blood always stays on the needle and it is this blood that enters the bloodstream of the next person who

uses the same needle. All prevention efforts concentrate on encouraging risk reduction among people who use injection drugs in general. Older members of this population have largely been ignored.²³

Many older people believe that they could get infected from caring for a person who is living with HIV. Though this is possible, it is unlikely as the infected blood must enter the carer's bloodstream through a cut or other entry point.

There is a low risk of HIV transmission as a result of blood splashes in the eye. Blood in the mouth carries an even lower risk. The lining of the mouth is very protective, so the only way HIV could enter the bloodstream would be if the person had a cut, open sore or area of inflammation somewhere in their mouth or throat (if the blood was swallowed). Even then, the person would have to get a fairly significant quantity of fresh blood (that is, an amount that can be clearly seen or tasted) directly into the region of the cut or sore for there to be a risk. HIV is diluted by saliva and easily killed by stomach acid once the blood is swallowed.

An older person could get HIV from a blood transfusion but the risk is very low as donated blood is 'screened' (checked for HIV and other infections). Blood transfusions are much safer than they were in the past.

HIV can be passed on through **contaminated sharp instruments** (instruments which are not properly cleaned) at hospitals or clinics where standards of medical hygiene are very low. Healthcare workers are at risk from needle-stick injuries. The virus can also be transmitted through contact with HIV infected blood at the scene of an accident.



A person of any age who shares razor blades and other sharp instruments that are not properly cleaned is at risk of becoming infected. HIV can be passed on through small amounts of blood that stay on a razor blade. It can also be passed on through tattooing and ear-piercing when the instruments that are used are not cleaned properly.

Mother-to-child transmission

Though older women do not generally fall pregnant, it is important to understand transmission from mother-to-child to prevent this occurring in your grandchildren or where older men have younger partners who are of child-bearing age.

Mother-to-child transmission (MTCT) of HIV is one of the major causes of HIV infection in children. The virus can be transmitted from a mother living with HIV to her baby:

- through the placenta during pregnancy (in some special cases)
- through blood contamination during childbirth
- through breastfeeding

The placenta is a thick mass of flesh containing many blood tubes which form inside the womb to join the pregnant mother to the unborn child. This means that during pregnancy it is possible that the mother's blood can mix with the blood of the unborn child if there is some injury or sickness.

During the normal birth process, there is a high risk of the mother passing HIV on to the baby. The lining of the vagina is very thin and can tear easily with the pressure of childbirth. The baby's skin is also quite sensitive and may get small tears or scratches during the birth process. Medical procedures (such as forceps delivery, vacuum extraction or fetal scalp monitoring) may cause small lacerations or cuts to the baby. If these things happen, then the mother's blood will mix more easily with the child's blood and the virus can be passed on.

Not all babies born to mothers living with HIV test positive for the virus but unless preventative measures are taken up to 40 per cent of children born to women living with HIV become HIV-positive themselves.

Preventing mother-to-child transmission (PMTCT)

Advanced stages of HIV – Women who require a combination of antiretroviral therapy for their own health must take the treatment every day for the rest of their life. It is also highly effective at preventing mother-to-



child transmission (MTCT). Women who require treatment will usually be advised to take it, beginning either immediately or after the first trimester. Their newborn babies will usually be given a course of treatment for the first few days or weeks of life to lower the risk even further.

Latent stage of HIV – Pregnant women who do not yet need treatment for their own HIV-positive status can take a short course of drugs to help protect their unborn babies. The main options are:

- Single dose Nevirapine – Given to the mother at the onset of labour and to the baby after delivery. This roughly halves the rate of HIV transmission. However, resistance to Nevirapine can develop from this single dose.
- Whenever possible, women should receive a combination of drugs to prevent HIV-resistance problems and to decrease MTCT rates even further.

Breast-feeding and HIV

About 30 per cent of the babies who are infected through mother-to-child transmission contract the virus during breastfeeding. In Africa many women in rural areas breastfeed their babies for up to two years. This increases the risk of transmission, especially if the mother has sores on her nipples or cracked nipples, or if the baby has sores in its mouth or thrush. You can tell that a baby has thrush by the white spots on the tongue or gums.

If a woman is on antiretroviral treatment and her viral load is suppressed, the risk of transmission reduces to one per cent. Breastfeeding is then a viable option and poses little risk of transmission.

It is important that women who want to have babies, pregnant women who are living with HIV and new mothers consult health practitioners for advice.

Shared breast-feeding

It is not unusual in Africa for more than one woman to breastfeed a child. Shared breastfeeding has now been found to be a risk factor for HIV transmission in infants. If the wet nurse is living with HIV, she can pass it on to the baby.

Care-giver of an infected baby

If the baby is HIV+ there is a risk of transmission for the care-giver. Standard precautions should be followed.



Many women are under pressure from their families to breastfeed their child. If your child is living with HIV, and not on antiretroviral treatment, support their decision should they decide not to breastfeed. Encourage older women not to pressurise young women who might be living with HIV to breastfeed their babies.



Class discussion

As a class, share your personal reflections on HIV and breast-feeding.

Sexually transmitted infections (STIs)

A sexually transmitted infection (STI) is any sickness that is passed on from one person to another of any age during sex. The number of older people getting STIs is on the increase worldwide.²⁴ If you have an STI, then your partner probably has it too.

A person with a sexually transmitted infection (STI) is more at risk of contracting HIV as the infection makes it much easier for the virus to get into the body during sex.



Small group exercise

Ask participants how many STIs they can name. Ask them to discuss then appoint a leader to feedback to the whole group.

How can you tell if you have an STI?

If you have an STI, you might have:

- a burning feeling when you pass urine
- swollen glands in the groin
- pain in the testicles
- sores on the vagina, penis or anus
- a smelly white, yellow or greenish discharge
- pain in the lower stomach.

Are sexually transmitted infections treatable?

Many STIs show no symptoms, especially in women but they can damage a woman's womb or ovaries and stop a woman from being fertile. STIs in men can also cause infertility. You can pass on an STI without knowing you have it. Most STIs can be treated easily. Research proves that treating STIs early and effectively reduces the amount of people who are becoming infected with HIV by 42 per cent. This means that reducing the spread of HIV by treating STIs is vitally important.

How do sexually transmitted infections increase your chance of becoming HIV-positive?

HIV is sexually transmitted and so the risk behaviour for HIV (having unprotected sex with a person) is the same as the risk behaviour for other STIs.

- Certain STIs can cause sores or ulcers that make it easier for HIV to enter directly into the body rather than having to be transported through the lining of the vagina or penis.
- The presence of sores or ulcers causes the body to send lots of white blood cells to that area to defend it against the infection. HIV prefers to infect white blood cells and when they are clustered around a sore or ulcer it becomes easier for HIV to infect them.
- If a person already has HIV and then gets sores or ulcers from an STI, a greater number of HIV-infected white blood cells are produced, which can then be spread to another person during unprotected sexual intercourse. It is therefore important to treat all treatable STIs promptly and effectively so that the risk of either spreading or contracting HIV is also reduced.

What do you do if you think you have an STI?

- Go to the clinic or doctor for treatment. Most STIs can be treated quickly and easily with antibiotics.
- Tell your partner they must get their STI treated.
- Keep taking the medicines until they are finished – even if you think the STI has gone away

before the medicine is finished.

- Go to the clinic for follow-up medicine if the doctor or nurse tells you to.
- Use condoms while you are taking your medicine for the STI. This will stop you from passing on the infection.

Traditional practices that spread HIV

A number of traditional sexual practices may be significantly assisting the spread of HIV across Africa. As an older peer educator and senior member of your family and community, you need to understand which traditions are dangerous and support changing these traditions to reduce the risk of HIV transmission.



Class discussion

Ask participants to discuss which traditions they believe are increasing the transmission of HIV and need to be changed. Ask them to suggest how they could be changed to reduce the risk of transmission.



Class discussion

Ask participants to discuss the following traditions that have been identified as increasing the risk of HIV transmission. Ask them if they are practiced in their community and how they could advise their peers on how to reduce the risk of transmission of HIV during these practices:

- **Dry sex** – This practice of drying out the vagina makes the skin more likely to split, increasing the risk of transmission. It will also increase the risk of the condom splitting - if one is worn.
- **Wife-sharing** – It is common practice in some countries to allow a guest to sleep with your wife. If the guest or the wife has HIV, this could result in transmission if a condom is not used.
- **Wife inheritance** – The widow of a man is encouraged to marry her brother-in-law. This practice was to ensure that the widow was not left destitute but when the cause of death for many men is now AIDS, and the woman carries the virus, she will often pass it on to her new husband.
- **Healer circumcision** – Ritual ceremonies for initiation into adulthood or circumcision for cultural habits and faith purposes are often done in groups. If healers only use one knife to cut everybody at the same time, there is a great risk of transmission of HIV and other blood-borne infections.
- **Female circumcision** – There is a strong advocacy movement highlighting the harmful effects of female circumcision, such that the term 'female genital mutilation' (FGM) is now widely used to describe the practice. FGM refers to the cultural practice of removal of part or all of the female sexual organs. FGM is practiced in Egypt, East, Central and West Africa. Girls often undergo FGM between the ages of four and eight. As with male circumcision, it is a group event, usually in the context of ritual ceremonies. Parents can also opt for their daughter to have FGM alone. The procedure is carried out by healers, traditional midwives, older women at home or at a specially designed place for initiation. During the procedure, girls are at risk of contracting HIV and other infections. FGM increases a woman's risk of infection due to the increased risk of broken skin during sexual intercourse.
- **Attending the delivery of mothers by older women** – Attending the home delivery of mothers who are living with HIV increases an older woman's risk of becoming infected. If she has open cuts or wounds she can contract the

virus from the newborn child or the mother, due to the large amount of blood present during the birth process.

- **Tattooing and body-cutting** – Scarification, tattooing and other sorts of body-cutting have their origins in ancient human history across the world. ‘Scarification’ is a permanent form of body decoration. It involves puncturing or cutting patterns and motifs into the dermis or upper levels of skin. When a sharp tool (needle, razor, knife, etc) breaks a person’s skin, blood and tissue fragments will adhere to the implement. Then, when the same implement is used again, the blood and fragment is directly transferred to the bloodstream of the next person and can result in transmission of HIV.
- **Rituals where blood is shared** – In Africa, several rituals require exposure to animal or human blood. One practice involves the exchange of venous blood following a small cut. Thereafter, people become a blood brother. Another involves two or many persons gathering in secrecy, cutting themselves slightly and sucking jointly the blood of each other. Sharing blood risks HIV transmission.
- **Polygamy and polyandry** – Polygamy and polyandry have the same consequence. They increase the number of sexual partners, thereby exposing people involved to increased risk of HIV transmission, unless condom use is consistent.
Source: Campaign against polygamy
- **Transactional sex** – Both practices are reinforced by poverty, specifically women’s poverty. Transactional sex means one partner has intercourse in exchange for money, material gifts or favours. The transaction could be initiated by the man or the woman. People involved in transactional sex are not necessarily defined as sex workers, even if the practices share many features. The difference is that the woman or man can have a few occasions of transactional sex to resolve a specific problem or need, without this becoming their job.



Small group exercise

Ask participants what transactional sex is, how it differs from prostitution and why it is a risk for HIV transmission in older men. Ask them to explain why wives of older men engaged in transactional sex are also at risk. Ask them to appoint a leader to feedback to the group.

The prevention of HIV in older people

Session outcomes:

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

- describe female and male sex organs
- describe risky sexual practices in older people
- discuss the prevention options for older people
- discuss the use of condoms to prevent the transmission of HIV in older people
- outline the changes in older people's behaviour that peer educators need to bring about

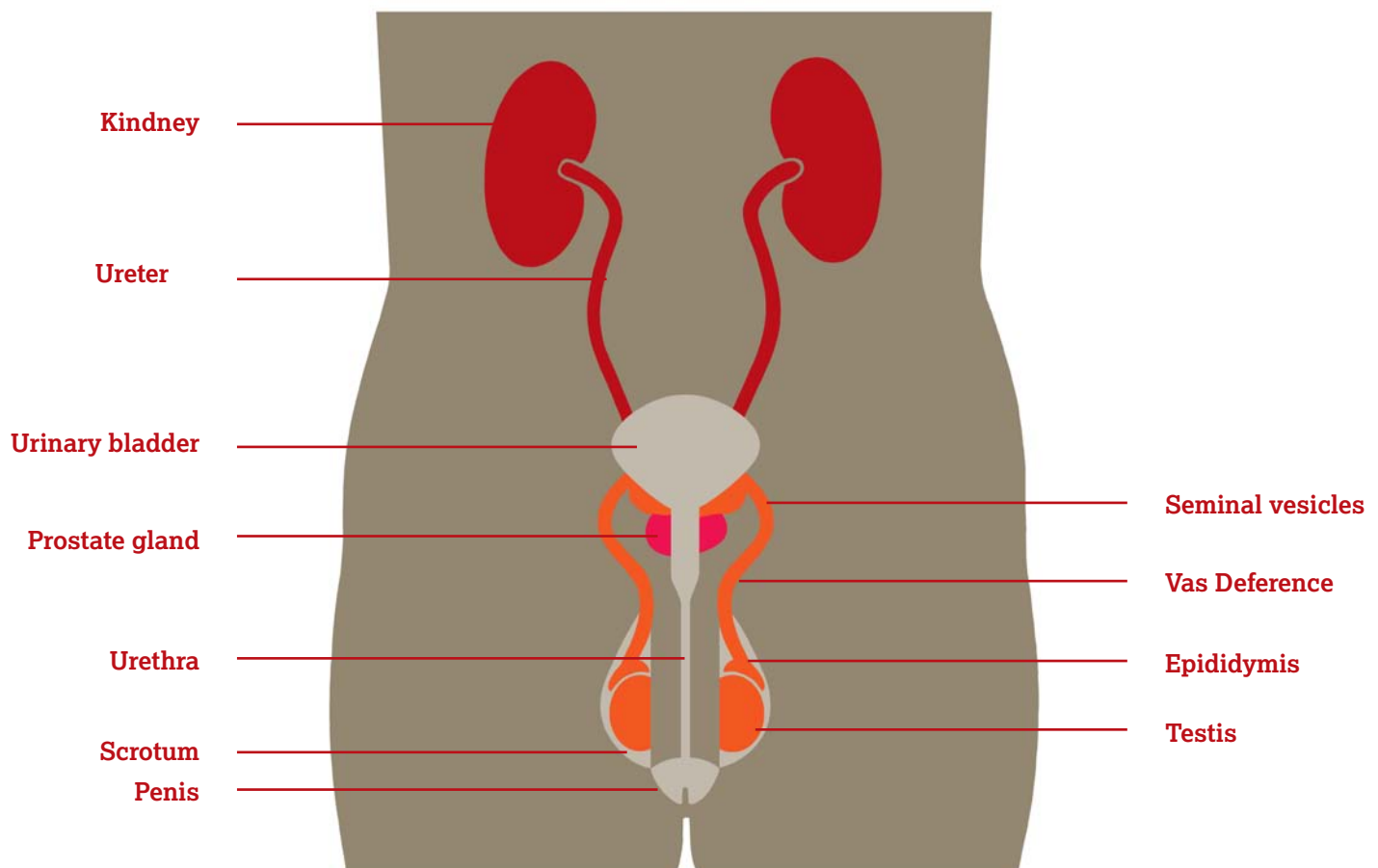
It is important to understand how the body works and be comfortable talking about different body parts to be able to prevent HIV transmission. It is also important to know where HIV is found within these organs and how HIV is transmitted.

Female and male sex organs



Small group exercise

Divide the participants into three groups. One group will study the section on male sex organs, the next the female sex organs and, the last, the mammary glands. Ask each group to give an explanation of how the organ works, where HIV is found and how it is transmitted.



Male reproductive organs

The testes (or testicles) and penis are the two organs that are visible from the outside of a man. The testes make sperm and produce testosterone. Each testicle produces more than four million new sperm per hour. Testosterone is the hormone that causes male secondary sex characteristics such as facial and pubic hair, thickened vocal cords and developed muscles.

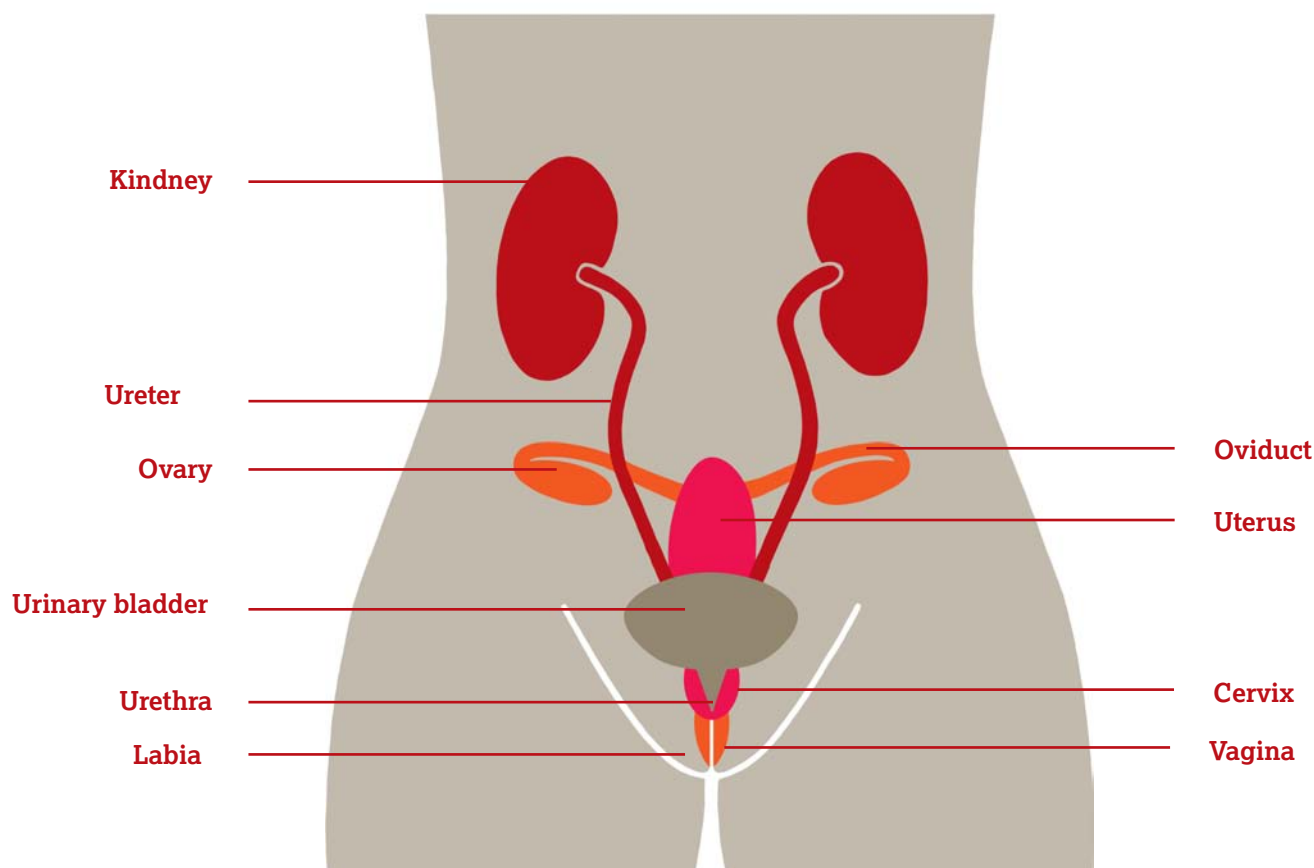
The testes are found outside of the main part of the male's body in a sac called the scrotum. They need to keep cool for the sperm to develop. It takes sperm about four to six weeks to mature, which they do as they travel from each testis to a coiled tube on the outer surface of each testis called the epididymis. Sperm, which are often compared to tadpoles in appearance, use their tails to travel, while the head contains the genetic material.

The penis is made of soft tissue that can expand or contract. When a man becomes sexually aroused, the penis becomes filled with blood and stiffens, becoming erect. During sexual intercourse, smooth muscles contract and propel mature sperm into the channel ready to be expelled out of the body. The sperm get mixed with nutrient-rich fluids from the seminal vesicles and a milky secretion from the prostate gland. This combination of sperm and fluids is called semen. When a man ejaculates, the sperm and fluids exit the body through a small slit at the tip of the penis.

Another important male reproductive organ is a tiny, pea-sized set of glands inside the body at the base of the penis, called Cowper's glands. During sexual excitation, and just prior to the ejection of sperm, this gland secretes a tiny amount of fluid that neutralises any traces of acidic urine that may be leftover in the urethra. It is also believed that these secretions are designed to lubricate the penis and female tract during sexual intercourse.

Female reproductive organs

Most of the female sex organs are inside the body. The two ovaries are the major female sex organs, the equivalent of the male testes. The ovaries make the eggs and produce the female sex hormone called oestrogen. Oestrogen is necessary for women to develop pubic hair, breasts, and for widening of the pelvis and deposition of body fat in hips and thighs. The ovaries are located in the abdomen.

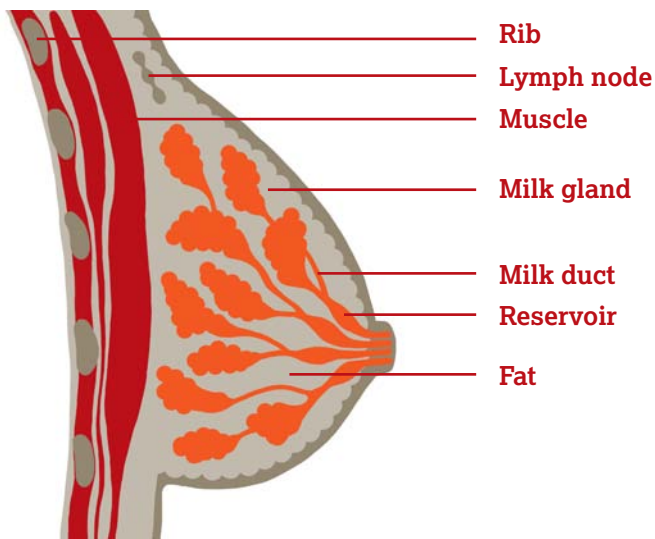


Eggs develop inside the ovary and are generally released every 28 days into the Fallopian tube. As the egg travels through the Fallopian tube, fertilisation can take place if sperm is present, and then the fertilised egg will continue to a muscular chamber called the uterus.

The uterus, or womb, is where a foetus develops. During pregnancy, the uterus stretches from the size of a pear to about the size of a football to accommodate the developing baby. The base of the uterus leads into the cervix. During pregnancy, the cervix is blocked with a thick plug of mucous to protect the entrance of the uterus. The cervix leads into the vagina, or birth canal.

The vagina connects the uterus to the outside of the body, and its opening is covered by sets of folded skin called labia. The vagina receives the male's penis during sexual intercourse and delivers the baby during childbirth. The vagina is normally narrow, but can stretch during intercourse and childbirth. There are two sets of glands located on either side of the vagina. The secretions from these glands lubricate the labial folds during sexual excitation and intercourse.

Female mammary glands (breasts)



The mammary glands are part of a woman's reproductive system. Their purpose is to secrete milk following pregnancy. A "nipple" is located near the tip of each breast and it is surrounded by a circular area of darker skin called the "areola". A mammary gland is composed of regularly shaped milk glands linked to milk ducts that lead to the nipple.

Unsafe sexual practices in older people



On their own

Read the following questions to the participants and ask them to write down their answers.

What is safe sex?

What is risky sex?

Different degrees of risk

Not all sexual behavior carries with it the same level of risk of passing on HIV. Ask participants to review the table below to understand the degree of risk by sex act.

No risk	Low risk	Some risk	High risk
<ul style="list-style-type: none"> • Abstinence • Erotic massage • Hugging and body rubbing • Petting • Kissing • Masturbation • Sexual fantasies • Thigh sex • Using own sex toys • Phone sex • Internet sex 	<ul style="list-style-type: none"> • Oral sex on a man (fellatio) who is wearing a condom • Oral sex on a woman (cunnilingus) with a latex barrier • Anilingus (oral-anal sex) with a latex barrier 	<ul style="list-style-type: none"> • Oral sex (on a man or a woman without a condom or a latex barrier) • Vaginal penetrative sex with a condom • Anal penetrative sex with a condom (it is safer to withdraw before ejaculation) 	<ul style="list-style-type: none"> • Vaginal penetrative sex without a condom • Anal penetrative sex without a condom (VERY high risk) • Swallowing semen • Sharing uncovered sex toys • Vaginal or penetrative sex with a condom if using a petroleum-based lubricant • Unprotected oral-anal contact if blood is present • Contact with menstrual blood

Concurrent sexual relationship

The term “concurrent sexual partnerships” is used to define a situation where partnerships overlap in time, either where two or more partnerships continue over the same time period, or where one partnership begins before the other terminates. A sexual partnership is considered to be concurrent if a person reports having two or more sexual partners in one month.



Small group exercise

Ask participants to discuss why they think it is dangerous to be part of a concurrent sexual relationship. Ask them to appoint a leader to feedback to the group.

It is a well-known fact that having concurrent sexual partners is one of the factors contributing to the rapid growth of the HIV epidemic because:

- When a person first contracts HIV, the viral load in their body spikes to one of its highest points. After about six weeks, this viral load count drops to a much lower level as the body recognises the foreign virus and attempts to fight it.
- People having sex within this period will almost certainly either contract or pass on HIV.
- By the very nature of concurrent sex, it is at this very time that one party will be at this stage of the virus.



Small group exercise

Ask participants to discuss what behaviours should be encouraged for older people. Ask them to develop a song or poem to share what they think.

The following need to be recognised as potential risk factors, particularly if consistent condom use is not practiced:

- having a main partner and other regular partners
- transactional
- intergenerational sex
- having more than one partner in the same month
- having overlapping sexual partnerships

Preventing HIV transmission

A way forward

There are many things older people can do to protect themselves from HIV.

Abstinence

One way to ensure that you do not get the virus is not to have sex at all or to delay sex until you have a permanent partner who you are sure does not have HIV.



In pairs

Ask participants to discuss if they think older people would agree to abstinence as a method that would prevent them from getting HIV. How practical is this idea?

Many people believe that although abstinence is the best way of preventing transmission, it is not a likely choice for many. Sex is part of our normal behaviour, in older as well as younger people. People of all ages have sexual needs. There are ways to relieve sexual feelings using safe practices that are still enjoyable:

- hugging, cuddling and body-to-body rubbing
- masturbating alone
- masturbating together
- erotic massage
- kissing
- sexual fantasies
- using personal sex toys
- thigh sex (a healthy skin provides a barrier against the virus).

Be faithful

A faithful relationship is when you only have one partner. You only have sex



with that partner and your partner only has sex with you. Safer sex in a faithful relationship means only having sex with your partner after you have both had an HIV test and found out you are both HIV-negative.

Condomise

Protected sex is crucial in preventing the transmission of HIV in older people. Protected sex is sex with a condom, however, it is not 100 per cent safe, either to prevent pregnancy or to prevent the spread of STIs. If you use a condom correctly, it does reduce the risk of contracting HIV.

For condoms to be effective, the correct lubricants should be used. Older women will have less natural lubrication than younger women due to changes that happen in their bodies during menopause. Only water-based lubrication should be used with condoms, for example, KY Jelly, egg white, saliva or water. Any lubricant that contains oil or petroleum in its formulation must be avoided:

- petroleum jelly
- grease
- hand lotion
- baby oil

Negotiating condom use for older women

It can be very difficult for older people to persuade their partners to use condoms, especially when they don't have a reason to use them for birth control. If an older woman feels her partner will abuse or leave her or if she feels her cultural traditions prevent her from insisting that the man use a condom, it is very difficult to introduce them into a relationship.

These are some excuses that might be made to prevent using a condom and some possible answers to them:

Excuse	Response
Don't you trust me?	Trust isn't the point – people can have infections without realising it.
I can't feel a thing when I wear a condom.	Maybe that way you'll last even longer and that will make up for it.
I don't stay hard when I put on a condom.	I'll help you put it on, that will help you keep the erection.
I don't have a condom with me.	I do.
But I love you.	Then you'll help us to protect ourselves.
Just this once.	Once is all it takes.



Class discussion

The male condom

Demonstrate how to use a male condom correctly using the pictures and descriptions below as a guide.



Use a new condom each time you have sex. Always check the expiry date on a condom. Use only latex condoms.



Just before you want to enter your partner, put the condom on the tip of your hard penis.



Press the tip of the condom when you put it on so you push any air out of the tip. Roll the condom down over your penis so that the whole penis is covered by the condom. Now you are ready to enter your partner.



Take your penis out after you have had sex. Hold the base of the condom while you take the penis out so that the condom does not fall off.



You must take your penis out of the condom before it gets soft. In some cultures it is common for women to assist the man to remove the condom.



Knot the used condom so semen cannot leak out. Wrap it in paper. Throw it in the dustbin or toilet.

The female condom

Using the description below as a guide explain to participants how to use a female condom correctly. Show the participants what a female condom looks like.



The open end covers the vagina. The inner ring is used to help you insert the condom and to make sure the condom is held in place.



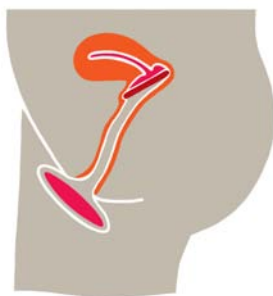
Hold the inner ring between your fingers and squeeze or twist the ring.



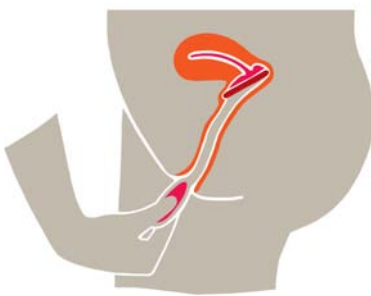
Push the inner ring into your vagina with your fingers (like you would insert a tampon).



With your index finger, push the inner ring up as far as it will go. Now wash your hand well with soap and hot water.



The condom is now in place and you can have protected sex. Guide the penis into the outer ring.



Before you stand up, take the condom out. Squeeze and twist the outer ring and pull gently to remove the condom. Wrap the condom in paper and throw it away.

Note: Never use the female condom and the male condom at the same time. The friction between them will cause both condoms to move out of proper position.

Circumcision



Class discussion

Ask participants to discuss what they have heard about circumcision and HIV. Ask them what circumcision is and how and why could it reduce HIV transmission?

Male circumcision involves removing the foreskin, a loose fold of skin that covers the head of the penis. The procedure can be carried out at any stage: during infancy, childhood, adolescence or adulthood. Many societies have been practising male circumcision for hundreds of years and circumcision is often seen as a mark of belonging to a particular tribal or religious group. It is estimated that up to a third of all men are circumcised, though rates vary widely around the world.

Scientific trials have shown that male circumcision can reduce a man's risk of becoming HIV-positive during heterosexual intercourse by up to 60 per cent. Circumcision is now recommended as an important HIV prevention intervention.

There are several possible reasons why circumcision has this effect. The foreskin creates a moist environment in which HIV can survive for longer in contact with the most delicate parts of the penis and the inner surface of the foreskin contains cells that are especially vulnerable to infection by HIV. Removing the foreskin also means that the skin on the head of the penis tends to become tougher and more resistant to infection. In addition, any small tears in the foreskin that occur during sex make it much easier for the virus to enter the body.

Properly carried out circumcision programmes have the potential to lower HIV prevalence among the male population, therefore reducing a woman's risk of exposure to men who are living with HIV. Even if a man has been circumcised, consistent condom use is still important.

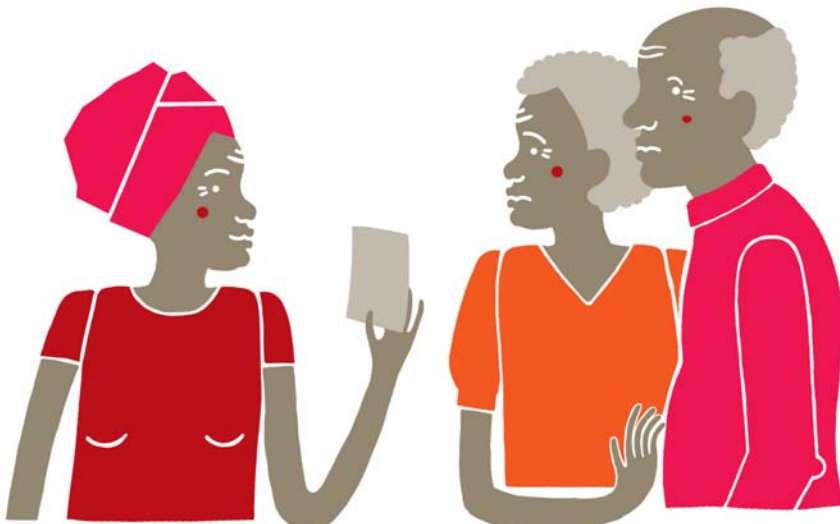
Discordant couples



Small group exercise

Discordant couples are partners where one is living with HIV and the other is not. Ask participants to discuss how this can happen if the couple have had sexual relations. How common do the participants think this is?

In southern Africa, 30 to 40 per cent of couples affected by HIV are couples where only one person is living with HIV²⁶. As a peer educator, you should tell your peers not to make assumptions about their status just because their partner is living with HIV. Their status may be different.



Same-sex relationships

Same-sex relationships and the law

A same-sex relationship is when two men or two women enter into a relationship. Consensual same sex acts between adults are illegal in about 70 of the 195 countries of the world (approximately 36 per cent); in 40 of these, only male–male sex is illegal.



Small group exercise

Ask participants if same-sex relationships are illegal in their country. Ask them to discuss what they know about same-sex relationships in older people. Do they have any older friends or relatives who have same-sex relationships? Ask participants to appoint a leader to feedback to the group.

Small group exercise

There are many myths and misconceptions that fuel homophobic behaviour (the fear or hatred of people having same-sex relationships). Ask participants to develop a list of five myths about same-sex relationships and five truths about same-sex relationships in older people.

Truth	Myth

Male same-sex relationships

As with heterosexual couples, relationships between men who have sex with men can be short-lived or long term. Although men who have sex with men can have multiple sexual partners, many choose to be in monogamous relationships. HIV prevalence is higher in men who have sex with men than the heterosexual population.

The primary mode of transmission of HIV between men is through anal sex without a condom. There can be challenges with practising safer sex including obtaining extra-strong condoms for anal sex, as some men may fear being seen buying these as it might disclose their sexual identity. Obtaining lubrication can also be a challenge. Also, sex education is rarely directed to men who have sex with men.

In a recent international study, men who have sex with men were found to be 19 times more likely to be living with HIV than the general population in low and middle-income countries but only one in 10 worldwide has access to HIV services²⁷. Stigma, discrimination and laws criminalising sex between men undermine access to information and to HIV and AIDS and other health services for men in same-sex relationships.

Female same-sex relationships

Generally, women who have sex with women are at low risk of HIV infection. However, sex between women is not always safe and women who have sex with women are just as vulnerable to certain sexually transmitted infections (STIs) as women who have sex with men. Women can protect themselves from HIV and many STIs by ensuring that infected fluids such as blood or vaginal fluid do not enter their body during sex. Precautions that can be taken include not sharing sex toys, or if doing so, using a new condom for each partner. Certain sexual activities are also considered to be lower risk, for example, hugging, touching, massage and masturbation.

Standard precautions



Class discussion

Ask participants to discuss what standard precautions are.

Standard precautions are techniques that were introduced following the emergence of HIV in the 1980s. People of all ages should practice standard precautions to prevent infection. Older people caring for loved ones or a child living with HIV should especially take note of these guidelines.

Standard precautions include:

1. Gloves: wear gloves to clean body fluid spills, soiled surfaces. If you do not have gloves then use a plastic bag to cover your hands.
2. Washing of hands: wash hands immediately on contact with body fluids and after removing gloves.
3. Cover wounds: with a waterproof dressing.
4. Bleeding: ask the person to self-apply pressure to the wound. Avoid direct contact with blood by using gloves or a plastic bag.



Dealing with body fluids

1. Treat blood or body fluid spills with caution.
2. Assume all persons and all body fluids have HIV.
3. Cover any cuts or sores with waterproof plasters. Wear plastic or latex gloves or cover hands with plastic bags tied at the wrists. Clean any blood on the skin immediately with hot, soapy water.
4. Soak the spill with absorbent material like paper and dispose of safely.
5. Wash the area with a disinfectant like bleach (one part bleach to 10 parts water).
6. The area can be washed with boiling water (HIV cannot survive in high temperatures).
7. The person doing the cleaning should always wear rubber gloves. If these are not available, any other barrier (eg, plastic packets) should be used.
8. Soiled fabric or clothing should be boiled in water for 20 minutes, placed in the sun to dry and then ironed.

Post-exposure prophylaxis (PEP)



Class discussion

Ask participants to discuss what PEP is.

Older people who come into contact with infected blood or bodily fluids should take post-exposure prophylaxis (PEP). Prophylaxis means disease prevention and post-exposure prophylaxis means taking antiretroviral (ARV) medications as soon as possible after exposure to HIV in order to prevent HIV infection. PEP is not a cure for HIV and it is only given to HIV-negative people to prevent them from contracting the virus.



It is very important that PEP is started as soon as possible after exposure but no longer than 72 hours (three days) after. The course lasts for 28 days and must be completed. You will need to go to the doctor, clinic or hospital for PEP.

HIV testing of older people

Session outcomes:

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

- explain why it is important for an older person to know their HIV status
- describe what the rapid HIV test involves
- explain what 'informed consent' means
- describe what fears and feelings an older person might have before testing and after a person's HIV-positive status is confirmed
- describe the implications of negative and positive test results



Class discussion

Peer educators need to encourage all people to have an HIV test and learn their status. Ask participants to discuss how they can encourage older people to have an HIV test? What are the barriers to testing?

How do you find out your HIV status?

The only way to find out if you are living with HIV is to have a test at a health clinic, at work, at a hospital, at a mobile clinic or on a home testing programme. HIV is a manageable chronic disease and it is better to know your HIV status than not to know.

Difference between HCT and VCT



Class discussion

Ask participants to discuss the difference between HCT and VCT?

HCT stands for HIV counselling and testing, and implies that the health worker offers the HIV test and it is up to the client to opt out. VCT stands for voluntary testing and counselling, and implies that the client requests the HIV test, and it is therefore up to the client to opt in.

Most African countries that have high HIV prevalence have adopted a health policy of HCT in an effort to identify people living with HIV early while they are still well, so they can start treatment to prevent the onset of AIDS.



Class discussion

Read the speech bubbles below to the participants. Ask them to discuss why it is a good idea for these people to go for an HIV test and why it is important to know if you are living with HIV.



I am 58 - I have been away from home for 3 months. I want my husband to have an HIV test before I will let him have sex.



I'm only 17. I have just found out that I am pregnant. To protect my child I need an HIV test.

I won't use a condom. I live my life to the full. I work hard and play hard. I only do drugs and booze at weekends. My friends say I'm crazy. They are all being tested so I thought I'd come along too, and do the test as well.



What happens if you decide to get tested



Class discussion

Ask the participants who has had an HIV test before and if they are willing to explain the process that they experienced. Ask them to include what happened before the test, during the test and after the test.

Pre-test counselling

The first thing that happens is that the healthcare worker talks to you. This is called pre-test counselling. The person testing you must explain the test to you and should discuss what the test result could mean. This pre-test counselling is given so that the person being tested can be fully prepared to have an HIV test.

Informed consent

It is important that you give what is called 'informed consent' before the actual test is done. This means that you either say clearly (verbally) that you want the test and/or you must sign a paper saying that:

- you know you are being tested for HIV and have given your permission
- you understand what the particular test used involves, it has been explained to you how reliable the test results are, and that a confirmation test is required for a positive result
- you understand what different test results mean
- you are aware of the possible implications of a test result (including the window period)
- you understand that pre-test and post-test counselling is available

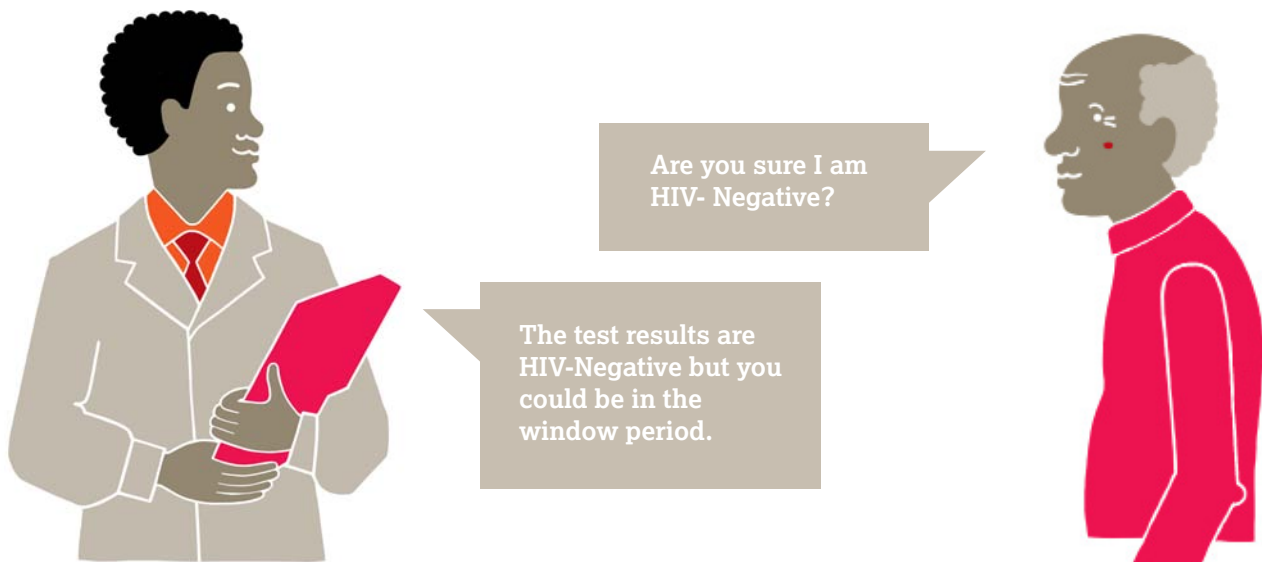


Class discussion

Ask participants to discuss why 'informed consent' is so important when someone has an HIV test.

Post-test counselling

After the HIV test, you should go for post-test counselling. This means that the person who tested you will discuss your results with you and tell you whether you should get tested again and talk to you about your HIV status.



What is a rapid test?

The rapid test

A rapid test is a screening test for detecting antibodies to HIV. It is done with a single sample of blood and it produces results very quickly (about 15 minutes). The person being tested can have both the test and the results in a single visit. Rapid tests are 99.7 per cent accurate.

The window period



Class discussion

Ask participants to discuss what the window period is.

HIV tests react to the antibodies in a person's blood. When the immune system detects the virus in a person living with HIV, it starts to build up antibodies to fight it. This process can take up to three months if the person has contracted HIV-1, and even longer if the person has HIV-2. This is called the 'window period'. It is the time it takes from the time of infection to the time when the antibodies are formed. Testing people for HIV before the body can produce antibodies will produce a false negative result.

Test results

If the first rapid test is negative, then the results are given to the client. If the result is positive, then another rapid test is done to confirm the result. If the confirmatory test is also positive, the result is given to the person.

What if the test is negative?

If the test is negative, then you do not have HIV in your blood. You must do the following:

- If you have recently had unprotected sex, then the virus may not have shown up in the first test (because of the 'window period'). Wait for three months and have another test.
- You must continue to have protected sex.
- Learn as much as you can about HIV and AIDS so that you can keep yourself and others safe.



What if the test is positive?

- You may feel a number of emotions – fear, anger, sorrow, guilt and disbelief. This is natural. Your counsellor will help you to cope with your feelings. Try not to panic. You can still lead a healthy and productive life for a long time with the virus in your body.
- Learn as much as you can about HIV and AIDS so that you can keep yourself healthy and others safe.
- Talk to others who are living with HIV so you don't feel so alone.
- Join a support group.
- Find out about treatment and your rights in the workplace.
- Come to terms with your positive status and try not to deny it.



Small group exercise

Read the thought bubbles below to the participants. Ask them to discuss what emotions this person is feeling. Do they think one person can experience all these feelings? Why are all these feelings normal? Ask participants to appoint a leader to feedback to the group.



Who will know the results of the test?

The results of the test are confidential. Only you and the health worker will know your status. The health worker cannot tell anyone the results – not your family, not your neighbours and not the people you work with. You can choose whether or not to tell anyone. The only time the health worker is allowed to talk about your results to someone else is when there is a need to speak to another health professional such as a doctor or a nurse.




Class discussion

Ask participants why they think confidentiality is so important when a person has an HIV test.


Who should you tell if you are living with HIV?

If you are living with HIV then it may take you some time to work through all of your feelings. When you feel ready to talk, tell someone you trust. Try talking to a close friend or a member of your family, a minister or a person that knows and understands about HIV.



I was too scared to tell my family but I needed to talk about my feelings to somebody. I talk to the counsellor about my feelings. This helps. Soon I will be able to tell others.

I spoke to a traditional healer about being HIV-positive. I know traditional healers cannot cure me. I needed to speak to someone who could understand my culture and beliefs.





On their own

Ask the participants to imagine that they have been tested and that they are HIV-positive. Ask them to think of a person that they would tell about their status and why they chose that person.

Peer educators and VCT/HCT



Our peer educator says we should go for HCT and be tested. But I know he hasn't been tested yet! Why should I believe in what he says if he doesn't practice what he says? Why should I believe anything else he says?



Class discussion

Read the speech bubble above to the participants. Ask them to discuss why this situation has come about.

Ask if they agree with this woman's point of view. Why or why not?

What is a peer educator's responsibility when it comes to VCT/HCT?



On their own

Ask participants to read the pledge. Ask them to discuss it with the group. Are they ready to sign the pledge? Ask them to do so now.

Personal pledge against HIV and AIDS

I, _____, hereby pledge my support to join the response against HIV and AIDS.

I understand the devastating impact that HIV will have on the community and the country, and so I pledge to:

- Wear a red ribbon or other symbol to show that I care. ☐
- Practice safe sex at all times. ☐
- Accept and support those living with HIV. ☐
- Carry out my peer educator duties to the best of my ability and promote the HIV education programme in my community. ☐
- Make every effort to inform myself about new developments in HIV and AIDS. ☐
- I will have an HIV test and know my status. ☐

This pledge is voluntary and I have not been under any duress or pressure from anyone else in this regard.

Signature _____ Date _____

Please
Pledge



Talking about HIV and sex

Session outcomes:

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

- explore the options of telling your children that you are living with HIV
- understand how to talk to your children or grandchildren about HIV and sex
- discuss parenting skills for grandparents caring for orphaned children

Do you tell your family you are living with HIV?



Small group discussion

Whether a person should tell their family they are living with HIV is a difficult decision and all people living with HIV have the right to make their own decision about whether they want to disclose their status.

Ask participants to make a list of reasons why a person would choose to tell their family that they are living with HIV and why they would not.



Why?	Why not?



On their own

Ask participants what they would do. Would they tell their family or not? Ask them to give a reason for their answer.



Small group exercise

Read the thought bubble below to the participants. Ask them to discuss how these family members feel. Ask them to explain why they think they feel this way.

My father doesn't care about me.

When I come to visit he doesn't even know I'm there. He never asks what I am doing or how the children are.

If he doesn't care, why should I?



Silence can be bad for everyone. Family members can sense if things are wrong. They worry when things are not out in the open and may blame themselves for your sickness or worries. This can affect them badly. Remember, you might be living with HIV but they are affected by it. If you are too scared to tell your family, then ask a friend or a counsellor to be there with you to give you support and to help you answer the many questions they will ask you.



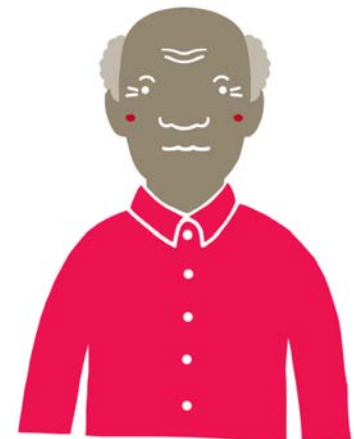
Small group exercise

When a person is living with HIV, it is often the people they love and care for the most who suffer the most. Ask participants to discuss the thoughts of the two people below and why this situation has come about.

I decided not to tell my family that I was HIV-positive. I did not want to worry them. And I didn't want them to treat me any differently. I just wanted to enjoy what was left of my life and try to be 'normal'.

Six months later

How could he do this to us? If he loved and cared for us he would have told us he was going to die. We didn't even get a chance to say a proper goodbye! What will we do now? I cannot even feel sad I am so angry with him. He couldn't have cared for us!



Some guidelines for talking to your family when you are living with HIV

- Tell them it's OK to feel angry or sad or-shocked. Help them to work through these feelings.
- Encourage them to talk about their fears. Listen carefully.
- Give them the correct information about HIV and AIDS. Remember, your family may have the wrong information. They need to know the facts.
- When you are feeling sick, depressed or just very tired – tell them. They need to know that they are not to blame. They need to be able to help you. Helping you will help them feel better.
- Tell them what to expect. Explain how living positively can help to prolong your life and that HIV is not an automatic death sentence.

Talking to your children and grandchildren about sex and HIV



Group discussion

Ask participants if they have ever had to explain sexual matters to children or teenagers in their family. Ask them to share with the class their experience of the embarrassing questions they asked and what they did.



On their own

Ask participants to think about what they would say and what words they would use if their 13-year-old granddaughter asked them what a sexually transmitted infection is.



On their own

Ask participants to think about what they would say and what words they would use if their nine-year-old grandson asked them what the difference is between HIV and AIDS.

Talking about sex and relationships

Many parents or grandparents feel uncomfortable talking to their children or grandchildren about sex and relationships but you need to overcome your nervousness and raise these important issues with your children. Remember they are exposed to other sources of information – sources that may not give them the correct information or may not include the values you want your children to have.



In pairs, role play

Ask participants to imagine that they heard their 12-year-old grandchild telling his younger brother “that only dirty people get HIV”. He says he knows that this is true because his best friend told him so. Ask participants to work with a partner to enact the conversation.

Create an open environment

Children want their parents or grandparents to discuss difficult subjects with them. They will look to you for answers only if they feel that you will answer their questions openly and honestly. It is up to you to create an atmosphere in which your children feel they can ask you anything without fear of you being shocked or punishing them.



Small group exercise

Ask participants to imagine that they are standing at a busy taxi rank. It is crowded and the taxi is about to arrive. At the top of his voice, their nine-year-old grandchild asks: “What’s a condom?” Ask them what they would say and do.

Communicate your values

Do not hesitate to make your beliefs clear. Research shows that children want and need moral guidance. Be the first person to talk to your children about tough issues like drugs, violence and HIV.



On their own

Ask participants what values they most want to pass on to their grandchildren. Ask them to share their ideas with the group.

Listen to your grandchildren

How many times do you listen to your grandchildren while you are cooking the dinner, reading the newspaper, watching TV or getting ready for work? Even though you are busy, you need to give your children your undivided attention. You need to talk to your grandchildren and children, not at them. Listening carefully and patiently to the child builds up their self-esteem by letting them know they are important to you, and that what they have to say is worth your attention. Listen with your ears, eyes and your heart.

Build their self-esteem

Praising children frequently, setting realistic goals and keeping up with their interests are effective ways to build self-esteem. Building self-esteem is important because when children feel good about themselves, they are much less likely to give in under peer pressure to have sex before they are ready, or to 'do drugs' because that is the 'in' thing. Children with high self-esteem are less likely to behave in ways that could put them in danger of becoming HIV-positive.

Teenagers, like adults, enter casual sexual relationships because of:

- loneliness
- a need for affection, caring and attention
- drug use or abuse
- pressure from their peers or the media
- alcohol





Small group exercise

Read the table below to the participants. These are some of the reasons why teenagers and adolescents choose to become sexually active. Ask them to add other reasons to this list. The reasons given have been taken from research carried out with teenagers.

Reasons for sexual activity in adolescents	
Girls' responses	Boys' responses
<ul style="list-style-type: none">• The girl wants to please the boy.• She wants to be fashionable.• She is afraid to say 'No' when pressured.• She feels she has to 'pay back' the boy for taking her out.• She is curious about what it feels like.	<ul style="list-style-type: none">• He is afraid the girl thinks that he does not like her.• He wants to prove his manliness.• He feels it is expected.• All his friends are 'doing it'.• There is nothing else to do.• He sees people on TV 'doing it' and he wants to feel the 'high' that they seem to feel.

Be prepared to talk about death

When you talk to children about HIV, questions about death may come up. Be ready to answer them.

- Explain death in simple terms. Explain that when someone dies they don't breathe, eat, feel hungry or sick ever again.
- Never explain death as 'going to sleep'. This may make your child worry that if they go to sleep, they may never wake up.
- Stress that while HIV is serious, it is treatable.

Living positively as an older person

Session outcomes:

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

- define what 'living positively' means
- give examples of the different 'crisis points' a person living with HIV may be expected to reach as their health deteriorates
- explain how a person living with HIV can keep mentally healthy
- discuss the need for good nutrition and exercise and describe how these can help people living with HIV live longer, more productive lives
- state why STIs and opportunistic infections should be treated quickly

What does 'living positively' mean?

While there is no cure for HIV, living with HIV is not an automatic death sentence. 'Living positively' means living your life in such a way that you stay mentally and physically healthy for as long as possible.



Just because I have HIV doesn't mean I am going to sit around and feel sorry for myself. I want to live as long as possible. I am going to do everything possible to keep myself healthy. I still have a life to live.

Keeping mentally healthy and boosting your immune system

Crisis points



In pairs, discuss

Read the list of 'crisis points' below to the participants. Ask participants if they were living with HIV which of these crises they think would be most difficult to deal with and why.

Older people living with HIV have crisis points:

- when they first discover they are living with HIV
- the first time they tell someone they are living with HIV
- the first time they are discriminated against because they are living with HIV
- when they have sexual problems
- when they experience relationship problems

- the first time they get sick with an HIV-related illness
- when their family starts experiencing financial problems
- when they watch their family struggling because of their illness
- when there is no one to look after the children in the family
- when they are unable to do the things they used to be able to do (for example, wash themselves or go to the toilet by themselves)
- when they realise they are in the terminal stages of AIDS
- when they are close to death

All the situations above are stressful. Stress causes the body to weaken, so older people with HIV (with an already compromised immune system due to age) should try to keep their stress levels down. Stress can lead to depression. Different people use different methods of coping with stress.



Small group discussion

Ask participants to share some of the ways they deal with stress in their lives. Appoint a leader to feedback to the whole group.

Support groups



Class discussion

Ask participants to discuss how joining a support group could help an older person deal with their HIV status and the difficulties they might face.

Different types of support groups

There are many types of support groups. Some are public and others are secret. It is important for members to decide early on if the support group is going to be public or secret. Many people may be keeping their status secret and may not want to be associated with an HIV support group.

Support groups that meet in a clinic

A doctor, nurse or social worker usually runs these support groups. They have a set timetable when they will see clients, a folder with the client's history, a set programme and a specific purpose. Members are usually people who have been diagnosed in the clinic but individuals may decide to come on their own as they believe there is some kind of confidentiality in the clinic.



Support groups that meet at church premises

These support groups are not different from the others as they have a similar purpose and a set programme. Religious ministers, a clinical psychologist or a social worker run these support groups. Members are people who will have had counselling sessions with the minister or have been referred by a clinic or a friend.

House gatherings

Some people living with HIV want to come together in a house because of the privacy. They feel comfortable with this arrangement. Most people who want to meet in a house would be people who want to keep their status a secret. Trained people living with HIV, clinical psychologists, social workers, nurses or doctors mostly run these support groups.

Informal support groups

Some support groups operate on an informal basis. Members come together, share their problems and discuss ways of helping themselves and each other. They do not get professionals or trained volunteers to run the groups but work out their own programme and way of doing things. This is often the type of support group that may start running at your workplace after a prevalence drive where quite a few people have been tested and diagnosed.

Buddy system

Some people living with HIV would prefer to be in a group with people that they have developed a rapport with. They start a support group which is defined by what they think is best for them. It may be a set programme or informal arrangement.

People on antiretroviral therapy can gain tremendous support from their group

The group can provide important information and support around antiretroviral therapy. Many people are fearful of taking the medication, thinking that antiretroviral therapy will make them sicker. Group members who have been taking antiretroviral therapy and who have seen their health improve can provide reassurance and support for those who are fearful.

When people first start taking antiretroviral therapy, they may experience a range of side effects such as upset stomach, tiredness and headaches. When people are experiencing these side effects they may wish to go off the medication. The support group can provide encouragement to continue or to at least be reassessed at a clinic, if the symptoms continue.

Many people find it difficult to keep to the strict antiretroviral therapy regimens. The group should discuss strategies to help people stay on the medication and take it properly. For example, a group member could share what has helped them remember to take the medication.

Physical health

Keeping physically healthy will boost your immune system



Class discussion

HIV weakens the immune system. Ask participants to discuss how older people can 'boost' their immune systems and keep themselves healthy and strong for as long as possible

Nutrition will boost your immune system

Good nutrition means eating many different foods to give you energy, strengthen and build your body.

Older people living with HIV (even those who still look healthy) are using up energy as their bodies try to fight off the virus. Their needs for body-building and energy-giving foods are much higher than an older healthy person without

HIV. There are three main food groups that will help to build up your immune systems and keep you healthy.

A. Foods that build the body

Beans, peas, lentils, eggs, meat, fish, chicken, milk, cheese and peanut butter.

B. Foods that give you energy

Starchy foods like bread, maize (pap, samp, mielie rice), potatoes, sweet potatoes, pasta, wheat, rice, oats, millet, sorghum and cereals. Sweet foods like sugar and jam. Fatty foods like sunflower oil, margarine, oil found in tinned fish, animal fat like bacon, butter, peanuts and avocado.



C. Foods that boost the immune system and help protect you from disease

Fresh fruit and vegetables like spinach, pumpkin, oranges, grapefruit, lemon, guava, mango and potatoes.

To help older bodies and boost your immune system, follow these guidelines:

- Increase the number of fresh fruit and vegetables you eat.
- These immune-boosting foods contain vitamins and minerals which protect your bodies.
- Eat whole grains like brown bread, oats, and mielie rice.
- Drink less caffeine (coffee, tea and colas).
- Cook all animal foods completely.
- Eat less refined foods (like white bread and white sugar).
- Eat food that is as close to its natural state as possible.
- Avoid frying foods (rather grill, steam or boil).
- Have some yoghurt every day. This will help you to digest your food.
- Eat as few processed, preserved, coloured and artificially flavoured foods as possible.
- Add small amounts of butter, oil, milk, peanut butter or nuts to your food. These will give you energy and will help to stop you losing weight.
- Eat several times a day and don't skip meals.
- Drink lots of water.
- Be careful with alcohol .
- Stop smoking.
- Smoking and drinking weaken the body making it easier HIV to attack the immune system.

It doesn't have to be expensive. Be clever when you shop. Compare prices.

Choose vegetables and fruit that are in season as this is when they are cheapest. If fruit is too expensive then eat more vegetables.

Remember that lentils, beans and soya mince are cheaper than meat and chicken. Use milk powder with the Real Dairy sign on it – this is cheaper than condensed milk and coffee creamers. Don't buy fizzy drinks – drink lots of water. Don't buy ready prepared food – be organised and plan ahead - make your own food at home.



Exercise and boosting the immune system of an older person

It is important for older people living with HIV to get enough rest and sleep and to keep fit by doing exercise.

Research has shown that regular exercise in older people:

- strengthens the heart and muscles
- increases the CD4 cell count
- improves weight gain
- helps people to develop coping skills
- helps to prevent and/or reduce mood swings.

Visit the clinic regularly

If you are living with HIV and are older you should visit the clinic for regular check-ups every three to four months. The healthcare worker will give you advice to help you deal with any problems you are having, and may recommend that you go to extra counselling sessions.

- If you are sick, go to the clinic. Any sickness (even a cold) makes your body weaker and less able to fight the virus.
- If illnesses are not treated quickly, they may get worse and make you very sick.

Opportunistic infections in older people



Class discussion

Ask participants to discuss what opportunistic infections are and to name five different opportunistic infections.

Opportunistic infections are illnesses that attack an older person living with HIV whose immune system is weakened by the virus. Examples of opportunistic infections are shingles, thrush, TB, pneumonia and cancers.

• Shingles

Shingles is a painful rash that appears as small blisters on the body or face. In the later stages of AIDS, there is a greater chance of repeated bouts of shingles and it may take longer for the marks to heal, in turn making the person more vulnerable to bacterial infections.

• Thrush

Thrush is a fungal infection that is caused by the yeast *Candida albicans*. People living with HIV are more susceptible to oral and vaginal thrush because of their weakened immune system. In the final stage of AIDS, the presence of thrush in the mouth can become so painful that the patient is no longer able to eat.

• Meningitis

Meningitis is a fungal infection of the membranes surrounding the brain (meninges). Symptoms include headaches, an altered mental state and fever. If left untreated, it can lead to seizures and brain damage.

• Cancers

In the latter stages of AIDS, various forms of cancer begin to manifest. Women usually suffer from cervical cancer, while Kaposi's sarcoma (a rare form of skin cancer that causes a painless reddish-brown or bluish-purple swelling on the skin and mucous membranes) and cancer of the lymph nodes are also common. The risk of cancer increases both with a lower CD4 cell count and with age. Even a modest decline in immune function may be enough to increase the risk of a range of cancers, so people living with HIV need to be particularly careful to have regular cancer screenings as they age.

• Tuberculosis (TB)

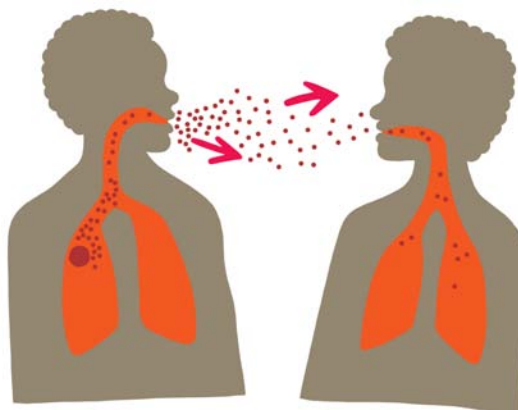
TB is a disease that mainly affects the lungs but can be found in any other body organ. It is caused by a germ called *Mycobacterium tuberculosis*. The germs are present in the sputum coughed up by those that have TB of the lungs. The germs usually destroy the soft tissue of the lungs and this causes cavities (holes) in the lungs, resulting in difficulty with breathing and blood can be coughed up. If untreated, TB can cause death.

The disease is passed on from person to person. When a person who has TB coughs, sneezes or spits, germs are spread into the air from where they can be breathed in. Fortunately, not all those infected contract TB. In most cases, the germs are sealed off in the body and they do not multiply.

However, if the body's defences are low (for example, in a person living with HIV), the person gets TB. This is why people who are living with HIV and have a compromised immune system are particularly at risk of contracting TB.

Signs and symptoms of TB include:

- a cough for longer than two weeks
- chest pains
- tiredness and weakness of the body
- loss of appetite and weight
- night sweats, even when it is cold
- coughing up blood



Any of the signs and symptoms mentioned may be an indication of the disease. Seek help at your clinic or hospital if you have these symptoms.

TB can be treated and cured. Medication must, however, be started as soon as possible and it must be taken regularly according to the instructions given at the clinic. It takes six months for TB to be cured completely but within two weeks of starting treatment the person will no longer spread the disease.

It is a mistake to stop taking medicines when a person feels better. All treatment and medicine must be taken for the full six months. If treatment or medicine is missed, the risk of a drug-resistant strain of TB is possible. This TB is very difficult to treat and needs more than 18 months of treatment and medicine, with a long stay in hospital.

Antiretroviral medication

The majority of people of all ages who are living with HIV are in the latent stage of the disease. It is important that people living with the virus have their CD4 cell count checked regularly to monitor their health and their need for treatment. In 2010 the World Health Organization amended its guidelines on antiretroviral therapy, recommending people living with HIV start treatment when their CD4 count reaches 350. Treatment access has dramatically improved over recent years but still not everyone who requires antiretroviral therapy is able to access it.



Class discussion

Ask participants to discuss what they have heard about the effectiveness of antiretroviral medication.

Antiretroviral therapy works as effectively with older people as with younger people.

Treatment at different stages of infection

CD4 Count	Treatment
1,500–350	Immune booster, vitamins and lifestyle
350 and below	Immune booster, vitamins, lifestyle, antibiotics and antiretrovirals.



Small group exercise

Ask participants to discuss why antiretroviral therapies are not taken by everyone who needs them.

There are many challenges in accessing antiretroviral therapy including: governments not having enough stock of ARV medicines or the trained staff to dispense them; not enough people knowing their status; those that do know their positive status being too afraid of the stigma attached to HIV to publicly access antiretroviral therapy; people not being able to afford the costs of getting to a facility offering ARV.



Small group discussion

Ask participants to discuss what resistance to antiretroviral therapy is and how it occurs. Ask them to appoint a leader to feedback to the group.

No matter what someone's age, it is very important that they take their ARV medication correctly. This means taking the medication at the right time and not missing a single dose. If a person does not do this HIV will mutate (change) and the medication will stop working. The patient can go onto a different combination of medication but it limits their treatment options.

If you have difficulty with a drug, don't just stop taking it. Speak to your doctor. There is usually something that can be done about it, such as changing to another drug, changing the dose of that drug or treating the side effect separately.

Many people of all ages find it difficult to take their ARVs as prescribed for the following reasons:

- lack of correct food
- lack of treatment literacy
- not having disclosed their HIV status to work colleagues, friends, lovers or family
- depression is a leading cause of non-adherence and is more common in women living with HIV than men
- current or past problems with side effects
- active substance use or alcoholism

- cultural beliefs
- homeless people and people in prison face additional barriers to accessing treatment

Side effects and ARVs

Side effects and toxicities of antiretroviral therapy occur more frequently in older patients who have other chronic conditions and have a higher chance of their antiretroviral therapy medication interacting with other medication they are taking. Remember:

- Side effects are most common in the first four to six weeks after starting a new medication.
- After your body gets used to a new drug, the side effects usually lessen or go away.
- Have doctor-recommended treatments for common side effects like diarrhoea and nausea.
- Let your doctor know if you are experiencing side effects, especially if you are taking a drug that may cause a particularly serious problem.

Women and side effects

Some side effects appear to be more common in women of all ages living with HIV than men. This may be due to the fact that women have higher levels of certain HIV drugs in their bloodstreams, even though they take the same doses as men. A woman's smaller body size, metabolism or hormones may cause the higher levels. For example, with the PI (protease inhibitor) Norvir, women seem to experience more nausea and vomiting but less diarrhoea than men.

- **Lipodystrophy** – This term is used to describe a number of body shape changes and metabolic problems that can occur in people living with HIV. While men and women living with HIV both experience body shape changes, women are more likely to experience fat gain in the breasts and stomach.
- **Rash** – A skin rash is a very common side effect. Rashes are more common and more severe in women.
- **Anaemia and fatigue** – Anaemia is a shortage of red blood cells that can be caused by some HIV drugs. Women are at higher risk of developing anaemia than men.
- **Menstrual irregularities** – Some HIV drugs may cause menstrual irregularities. If you are taking ARV therapy, watch out for any changes in your bleeding and be sure to tell your doctor if you have heavier, prolonged or more frequent periods.

Antiretroviral therapy (ART) in older patients

Although older patients are likely to have higher viral load and lower CD4 counts at the time of starting ART than younger individuals, the prognosis for patients aged 50 and over starting ART treatment is excellent. However, there is a shorter survival time and higher rates of progression to AIDS for older people.

Modern ART regimens are considerably less toxic and better tolerated than previously. The main strategy to avoid enhanced drug toxicities is to avoid co-prescribing drugs known to interact with antiretroviral therapy or to use alternative agents if possible. Where avoidance is not an option, co-prescribed drugs should be used with caution and patients should be monitored closely for adverse effects.

Antiretroviral therapy and traditional medicine



Class discussion

Ask participants to discuss their experiences with a traditional healer. Ask them to discuss whether a peer educator should encourage their older peers living with HIV to consult traditional health practitioners.

Holistic approach – Consulting traditional healers can be an important component of the comprehensive care for people living with HIV. Traditional healers tend to adopt a more holistic approach to health promotion and disease management. They can play a very important role in the latent period of HIV in boosting the patient's immune system and addressing the mental health needs of the patient. A holistic approach to living with HIV is known to be a key factor for success in living a longer, healthier life.

Antiretroviral therapy drug interaction – There are concerns that there could be interaction between antiretroviral therapy and traditional herbal medicines, and therefore patients should stop these medications when going onto antiretroviral therapy.

Common health conditions in older people

Session outcomes:

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

- define what 'living positively' means
- understand common health conditions experienced by older people
- discuss the effects of ageing on the body
- discuss non-communicable diseases, including high cholesterol, diabetes and high blood pressure
- understand mental health and ageing
- discuss menopause in men and women

Health and ageing



Small group exercise

Ask participants to use role play to demonstrate the common health conditions that can affect people as they age. They should include the loss of the senses – vision, hearing, taste, smell and touch.

The senses

Vision, hearing, taste, smell and touch all decline as people age. In general, people lose their ability to hear higher-pitched sounds which can make it harder to hear conversations, especially in noisy rooms. The awareness of certain types of pain can decrease with age as well and it may be harder to identify some flavours and odours. Certain medications, including HIV medications, can cause a change in taste.

After age 40, the need for reading glasses can occur either gradually or almost overnight. Eyes dry out as people age and are less responsive to light, especially in low light. Eye problems such as cataracts, glaucoma and vision loss due to macular degeneration must be monitored and can often be effectively treated.

Dry mouth is probably the most common dental problem seen in people with HIV. It can be caused by HIV medications or other drugs. Low saliva increases the risk of cavities which can lead to abscessed teeth, so regular check-ups are essential for everyone, especially those with dry mouth.

In general, teeth are tough, so it is gum disease that causes the greatest tooth loss in older people. Regular dental check-ups and good oral hygiene can prevent this. Also, the taste buds can change and become less responsive with age. This affects the desire to eat which can lead to unwanted weight loss.

Nervous system and mental health

The changes that occur in your brain mostly affect how the mind processes and uses information and remembers things. The risk of Alzheimer's disease increases with age but it is not an automatic part of the ageing process and is not the only condition that affects mental functioning.

Changes in brain function can make it more difficult to do more than one thing at a time (multi-tasking). It can be harder to remember names and numbers. Older people may find themselves

taking more time to search for the right word to use or to recall information but regular physical activity can help preserve brain function.

Nerve damage to the hands and feet (peripheral neuropathy), leading to pain or numbness, was common before HIV combination therapy became available. With better HIV treatments, it is seen less often but diabetes or other illnesses of ageing can cause similar symptoms. Pain medications and other treatments may be helpful.

Depressive symptoms are often reported by older people. It can be difficult for doctors to diagnose depression because many of its symptoms are similar to common HIV symptoms like fatigue, poor appetite, weight loss, loss of sex drive and sleep difficulties. Also, certain medications (particularly hepatitis C medications) can lead to depressive symptoms.

Urinary system

Many age-related changes of the urinary system happen as a result of decreased kidney function. Medications, high blood pressure and diabetes can all place stress on the kidneys.

Impaired bladder function occurs in almost a third of those over 65. Older people may have problems with controlling urination or bowel movements, called incontinence. In women, this is often a result of reduced hormone levels and the thinning of the walls of the urethra. In men, it is often tied to changes in the prostate. Incontinence is treatable and does not need to be a part of ageing.



Class discussion

Ask participants if they have experienced any of these conditions. Ask them to discuss how they felt and what they did to manage them.

Chronic conditions and older people

Health changes that are a normal part of ageing can be similar to changes that happen in people living with HIV. Fatigue, lowered immunity, skin conditions and nutritional imbalances happen with ageing but can occur in people living with HIV regardless of their age. Some side effects to ARV, like the loss of fat in the face and limbs, also occur in some people as they age. So in older people with HIV, it can be difficult to pinpoint the cause of certain conditions and to find the best treatment.

Certain aspects of ageing are obvious: thinning hair, wrinkles, loss of height and so on but changes are also happening inside that you cannot see or feel. These changes involving internal organs happen at different rates and are different for each individual. They are affected by genetics, gender, medications, substance use, life stresses, quality of medical and social support, and other illnesses.



Class discussion

Ask participants to discuss what chronic or non-communicable diseases are and what causes them? Ask them to create a list of common non-communicable diseases (also called chronic conditions).

- A chronic condition is a medical condition or disease which is non-infectious. In other words, one cannot catch an NCD.
- NCDs are diseases of long duration and generally slow progression. They include heart disease, stroke, cancer, asthma, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease, cataracts and more.
- They are preventable and caused very often by behaviour choices of individuals. Major risk factors include tobacco (every year about 5 million people die from tobacco use), diet, and lack of

exercise²⁸ (about 2.8 million die from being overweight).

- High cholesterol accounts for roughly 2.6 million deaths and 7.5 million die because of high blood pressure.

HIV and non-communicable diseases

Older people (and people of all ages) living with HIV often have high rates of non-communicable diseases. The risk of developing a non-communicable disease increases in people over 40 years of age. With HIV programmes rapidly expanding, people with HIV are living longer and ageing, and are developing non-HIV-related chronic conditions similar to the rest of the population.

Risk factors for non-communicable diseases

The WHO's World Health Report 2002 identified five important risk factors for non-communicable disease in the top 10 leading risks to health. These are: raised blood pressure, raised cholesterol, tobacco use, alcohol consumption and being overweight.

High blood pressure



Small group exercise

Ask participants what raised blood pressure is and why is it a health risk in people aged 50 and above.

High blood pressure (also referred to as hypertension) is a chronic condition where your blood pressure is too high. In most older people who suffering from high blood pressure there is no medical cause, but sometimes there may be an underlying disease which is causing it.

High blood pressure often has no symptoms. This means that you can have high blood pressure for years without knowing it and during this time it can cause damage to the internal organs. Most people with high blood pressure feel fine and the disease is only picked up during a routine examination or an examination for some other problem. Sometimes older people who have been diagnosed with high blood pressure report headaches, dizziness, fatigue and pounding of the heart.

High blood pressure is caused by a number of things but some groups of older people are at greater risk: those who smoke, have a family history of high blood pressure, are stressed, have a poor diet with lots of fatty foods and red meats, do not exercise, are obese or consume alcohol.

Untreated, high blood pressure can lead to a stroke or heart attack. About half of all older people with high blood pressure can control it by changing their lifestyle to include the following healthy habits:

- losing weight
- exercising regularly
- limiting alcohol intake
- eating a low fat diet with plenty of fruit and vegetables
- limiting salt intake
- giving up smoking (or if you're not a smoker, not starting)



High cholesterol



Small group discussion

Ask participants what raised cholesterol is and why is it a health risk in people aged 50 and above.

Cholesterol is a fatty wax-like substance that the body needs to produce certain hormones and vitamins, to build cell walls and digest fats. In other words, cholesterol is essential for the wellbeing of the body. Your liver produces enough cholesterol for the body's needs and therefore it is not necessary to consume additional cholesterol.

There are two types of cholesterol: one that is "good" (called HDL cholesterol) and another that is "bad" (called LDL cholesterol). Too much cholesterol is bad for the body as it clogs the blood vessels and does not allow the blood to flow regularly. When there are high levels of LDL cholesterol in the body, a person is diagnosed with high cholesterol. Left untreated, high cholesterol can lead to a heart attack or stroke.

There are a variety of factors that increase an older person's risk of developing high cholesterol. Some can be controlled, others cannot. Factors that cannot be controlled include genetics, age and gender. Controllable factors include lack of exercise, poor diet and obesity.

An older person who is diagnosed with high cholesterol will be prescribed medication to reduce the cholesterol levels. Most importantly, though, the person should make certain lifestyle changes, including regular exercise, a healthy and balanced diet, and controlling their weight. Reducing the amount of saturated fat and cholesterol in their diet will also help to lower blood cholesterol levels. Someone suffering from high cholesterol needs to include plenty of fruits, vegetables, nuts, seeds, cereals and beans in their diet.

Smoking

Smoking is one of the biggest causes of death and illness at any age. Giving up smoking reduces your chances of getting heart disease and cancer and it may help you live longer. Most smokers find it hard to give up because they are addicted to nicotine.

About one-half of all smokers die of a disease that's caused by smoking. The big killers are lung cancer, heart disease and stroke.

Alcohol consumption

Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions in people of all ages. These immediate effects are most often the result of binge drinking (drinking large amounts of alcohol over a short period of time) and include the following:

- injuries due to the inebriating effect of alcohol
- violence, including partner violence and child maltreatment
- risky sexual behaviours, including unprotected sex, sex with multiple partners and increased risk of sexual assault or rape
- miscarriage and stillbirth among pregnant women or physical and mental birth defects in children that last throughout life
- alcohol poisoning that results from high blood alcohol levels that suppress the central nervous system and can cause loss of consciousness, low blood pressure and body temperature, coma, respiratory depression or death

Over time, excessive alcohol use can lead to the development of chronic diseases, neurological impairments and social problems in older people.

Obesity

Obesity is a condition that results from an excess of bodyweight being accumulated. Obesity can lead to various health problems and reduces a person's life expectancy. Research shows that overweight people are more susceptible to illness and disease, particularly heart disease.

Levels of obesity are increasing worldwide. Inactive lifestyles are the leading cause of obesity. Older people who are overweight are at risk of diabetes.

What is diabetes?

Diabetes mellitus (DM), commonly referred to as diabetes, is a metabolic disease of having high blood sugar. This is caused by either the body not being able to produce enough insulin or the cells in the body not responding to the insulin being produced. There are commonly three types of diabetes:

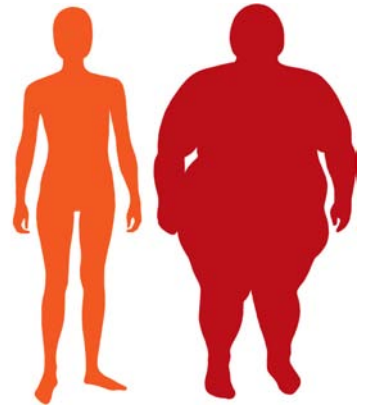
- type 1 diabetes
- type 2 diabetes
- gestational diabetes

Type 1 diabetes is also called juvenile diabetes or insulin dependent diabetes mellitus (IDDM). It occurs when the body fails to produce its own insulin in order to regulate the blood sugar levels. This means that the person will need to have regular insulin injections.

Gestational diabetes is a condition in which women who have not previously been diagnosed with diabetes develop high blood glucose levels during pregnancy (especially during the third trimester of pregnancy). Gestational diabetes can lead to type 2 diabetes.

Type 2 diabetes is also called non-insulin diabetes. It is the most common type of diabetes. Unlike type 1 diabetes, people who have type 2 diabetes can produce insulin but the pancreas does not produce enough insulin or the body cannot use the insulin produced properly. This is referred to as insulin resistance.

Many people are able to control their type 2 diabetes successfully by implementing healthy lifestyle changes such as cutting out fatty and sugary foods, and eating proper and regular meals to prevent feeling drained and worn-out.



Malaria



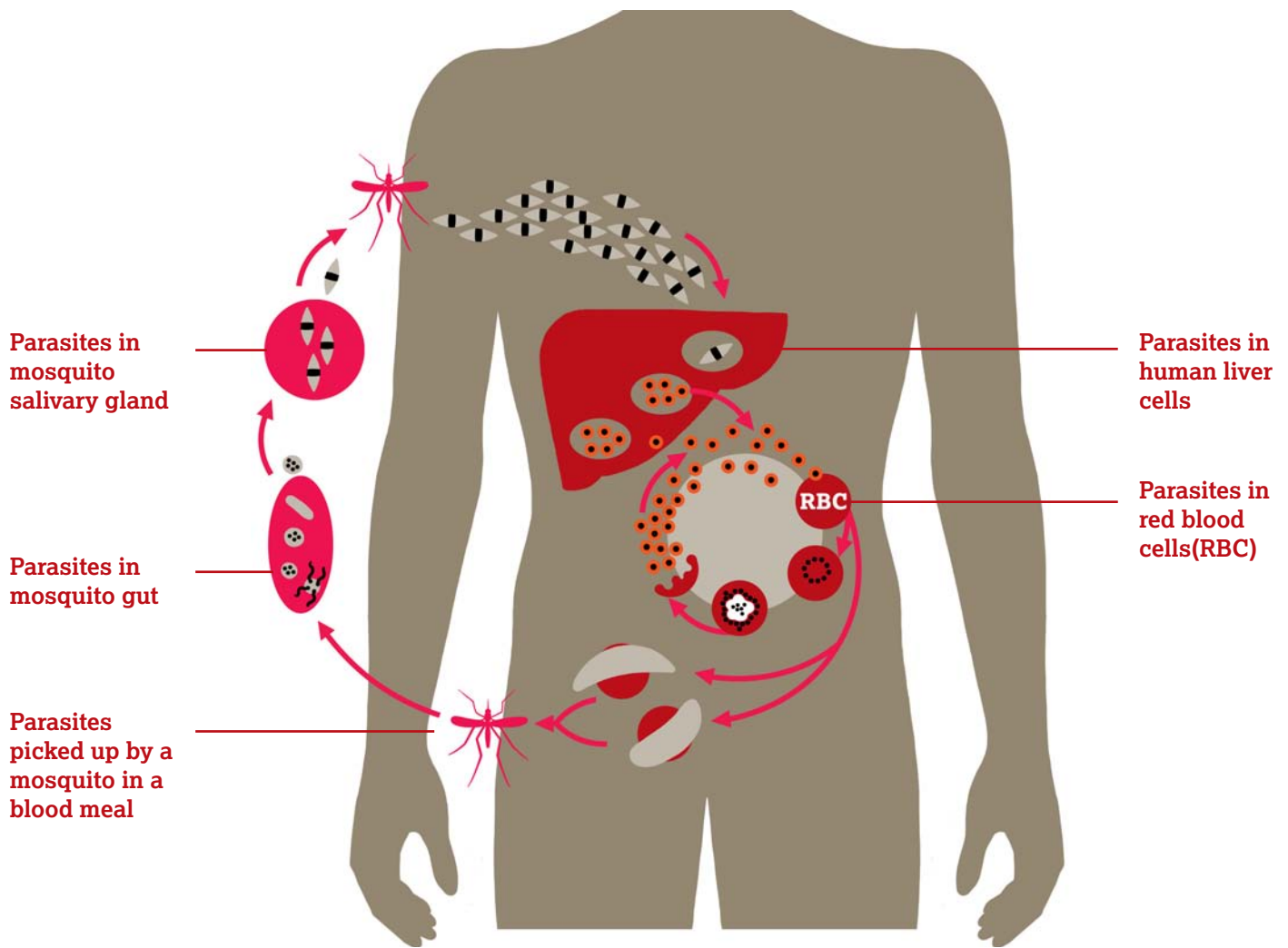
Class discussion

Ask participants to share their experiences of malaria. Ask them who has had malaria and to describe what it was like.

Malaria is a parasitic disease that involves high fevers, shaking chills, flu-like symptoms and anaemia. It is caused by a parasite that is passed from one person to another by the bite of infected mosquitoes. After infection, the parasites travel through the bloodstream to the liver, where they mature and release babies. The parasites enter the bloodstream and infect red blood cells.

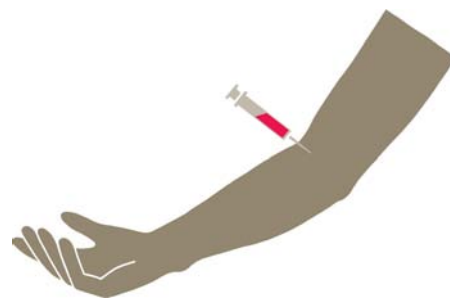
The parasites multiply inside the red blood cells which then break open within 48 to 72 hours, infecting more red blood cells. The first symptoms usually occur 10 days to 4 weeks after infection, though they can appear as early as eight days or as long as a year after infection. The symptoms occur in cycles of 48 to 72 hours.

The US-based Centre for Disease Control and Prevention (CDC) estimates that there are 300–500 million cases of malaria each year and more than one million people die from it. Older people are more at risk of contracting malaria and more likely to get complications. Another potential problem could be cross-reaction of the malaria drugs with other prescribed medicine.



Routine checks that should be done as you age

Diagnosing a health condition early will ensure that there is less damage to the body and the condition can be treated more successfully. Having a routine health check is one way to identify health conditions early.



Class discussion

Ask participants to discuss what kinds of check-ups or tests they have had to identify health conditions early.

The value of check-ups and their frequency depends mainly on your age and gender. Your personal and family medical histories are also important. The following exams, measurements and lab tests help identify treatable problems early.

Men: 40–65 years old	
Every year	<ul style="list-style-type: none"> • Physical exam for cancer (skin, thyroid, lymph nodes, prostate and rectum) • Dental exam • HIV test
Every 1-2 years	<ul style="list-style-type: none"> • Height/weight measurements • Blood pressure check • Stool sample check for blood • Vision and glaucoma check
Every 3–5 years	<ul style="list-style-type: none"> • Cholesterol check. • Blood sugar check. • Sigmoidoscopy after age 50 for colon cancer
Men: over 65 years old	
Every year	<ul style="list-style-type: none"> • Height/weight measurements. • Blood pressure check • Physical exam for cancers (skin, thyroid, lymph nodes, prostate and rectum) • HIV test • Stool sample check for blood. • Dental exam
Every 1–3 years	<ul style="list-style-type: none"> • Thyroid hormone check • Blood count • Cholesterol check • Blood sugar check • Hearing check • Vision and glaucoma check • Lab tests or urine sample
Every 3–5 years	<ul style="list-style-type: none"> • Sigmoidoscopy for colon cancer

Medical check-ups for women

Women should have the following tests:

- **Breast cancer:** Talk with your healthcare team about whether you need a mammogram.
- **Cervical cancer:** Have a smear test every one to three years until you are age 65, if you have been sexually active. If you are older than 65 and recent smear tests were normal, you do not need to have a smear test. If you have had a total hysterectomy for a reason other than cancer, you do not need a smear test.
- **Colorectal cancer:** Have a screening test for colorectal cancer. Several different tests, for example, a stool, blood test and colonoscopy, can detect this cancer. Your healthcare team can help you decide which is best for you.
- **Depression:** Your emotional health is as important as your physical health. Talk to your healthcare team about being screened for depression, especially if during the last two weeks you have felt down, sad or hopeless or you have felt little interest or pleasure in doing things.
- **Diabetes:** Get screened for diabetes if your blood pressure is higher than 135/80 or if you take medication for high blood pressure. Diabetes (high blood sugar) can cause problems with your heart, brain, eyes, feet, kidneys, nerves and other body parts.
- **High blood pressure:** Have your blood pressure checked at least every two years. High blood pressure is 140/90 or higher. High blood pressure can cause stroke, heart attack, kidney and eye problems, and heart failure.
- **High cholesterol:** High cholesterol increases your chance of heart disease, stroke and poor circulation. Have your cholesterol checked regularly if:
 - you use tobacco
 - you are obese
 - you have a personal history of heart disease or blocked arteries
 - a male relative in your family had a heart attack before age 50 or a female relative before age 60
- **HIV:** Talk with your healthcare team about HIV screening if any of these apply to you:
 - you have had unprotected sex with multiple partners
 - you use or have used injection drugs
 - you exchange sex for money or drugs or have sex partners who do
 - you have or had a sex partner who is living with HIV or injects drugs
 - you are being treated for a sexually transmitted disease
 - you had a blood transfusion between 1978 and 1985
 - you have any other concerns
- **STIs:** Talk to your healthcare team about being tested for STIs.
- **Osteoporosis (bone thinning):** Have a screening test at age 65 to make sure your bones are strong. If you are younger than 65 and at high risk for bone fractures, you should also be screened. Talk with your healthcare team about your risk for bone fractures.
- **Overweight and obesity:** The best way to learn if you are overweight or obese is to find out your body mass index (BMI) by consulting your healthcare team.



Female menopause



Group discussion

Ask participants to discuss what menopause is and what happens to women when they reach menopause?

The female menopause

Menopause is a normal part of a woman's life. Often called "the change of life", it is a series of bodily changes that can last from 1 to 10 years. Once your body has completed these changes and you have not had your period for 12 months in a row, you have passed through menopause.

Women usually experience menopause between the ages of 38 and 58. The average age is 51. There is some evidence that women living with HIV may experience menopause earlier. However, the symptoms of menopause appear to be the same for women irrespective of whether they are living with HIV.

The changes of menopause start when your ovaries naturally begin decreasing production of the female sex hormones, oestrogen and progesterone. When you near menopause, your oestrogen levels will drop. You stop having regular cycles and eventually you can no longer get pregnant.

Symptoms and conditions related to menopause

A woman can usually tell she is approaching menopause because her periods start changing. This time is called "peri-menopause" and may last several years. During peri-menopause, hormone levels rise and fall unevenly and you may experience symptoms such as:

- increasingly irregular periods
- different in frequency (how often)
- different in duration (how long)
- different in amount (lighter or heavier)
- hot flushes
- night sweats
- mood swings
- depression
- irritability
- vaginal dryness
- forgetfulness
- trouble sleeping
- fatigue
- lack of sexual desire
- skin changes, including thinner skin, wrinkling and acne

Women living with HIV who experience hot flushes at night may be misdiagnosed as having night sweats that are common with HIV. Vaginal dryness can be mistaken for a yeast infection. It is important to keep track of your cycles and report any changes to your healthcare provider to avoid a wrong diagnosis or hormonal treatments that may not be necessary.

Women living with HIV may experience irregularities in their menstrual cycles even if they're not going through menopause.

There are also some serious medical concerns that can develop after menopause, including:

- osteoporosis (bone thinning)
- cardiovascular (heart) disease
- urinary incontinence, including more frequent urination or involuntary loss of urine (leaking)

Some of the changes that occur to women's bodies during the menopause place them at increased risk of HIV infection. A thinning of the vaginal walls and less vaginal lubrication increase the risk of internal injury during sex and this increases the risk of being infected. Older women therefore need to be conscious of this increased risk as they age.

The male menopause



Class discussion

Ask participants if they think men also have menopause?

What is male menopause?

Since men do not go through a well-defined period referred to as menopause, some doctors refer to this problem as androgen (testosterone) decline in the ageing male or what some people call low testosterone. Men do experience a decline in the production of the male hormone testosterone with ageing but this also occurs with some disease states such as diabetes. Along with the decline in testosterone, some men experience symptoms such as fatigue, weakness, depression and sexual problems. The relationship of these symptoms to the decreased testosterone levels is still controversial.

Unlike menopause in women which represents a well-defined period in which hormone production stops completely, testosterone decline in men is a slower process. The testes, unlike the ovaries, do not run out of the substance they need to make testosterone. A healthy male may be able to make sperm well into his eighties or longer. However, as a result of disease, subtle changes in the function of the testes may occur as early as 45 to 50 years of age, and more dramatically after the age of 70 in some men.

Sexual relationships and ageing



Class discussion

Ask participants to discuss how ageing affects their sexual relationship. Ask them to share their experiences.

People want and need to be close to others. Many older people also want to continue an active, satisfying sex life but the ageing process may cause some changes.

What are normal changes?

Normal ageing brings physical changes in both men and women. These changes sometimes affect one's ability to have and enjoy sex with another person. Some women enjoy sex more as they grow older. After menopause or a hysterectomy, they may no longer fear an unwanted pregnancy. They may feel freer to enjoy sex.

A woman may notice changes in her vagina. As she ages, her vagina shortens and narrows. The walls become thinner and also a little stiffer. These changes do not mean she cannot enjoy having sex. However, most women will also have less vaginal lubrication. This could affect sexual pleasure.

Different people have different perceptions as to what is physically attractive. Some older people think things like gray hair and wrinkles make them more attractive to their sexual partner. Others may believe that looking young makes them more desirable and so may begin to worry about how attractive they are as they age. That might make sex less enjoyable.

A man may find it takes longer to get an erection. His erection may not be as firm or as large as it used to be. The amount of ejaculate may be smaller. The loss of erection after orgasm may happen more quickly or it may take longer before an erection is again possible. Some men may find they need more foreplay.

Impotence (also known as erectile dysfunction) is the loss of ability to have and keep an erection hard enough for sexual intercourse. Some common causes are alcohol and tobacco use, fatigue, liver or kidney failure, stroke, prostate or bladder surgery, diabetes, high blood pressure, certain medications and emotional problems with a partner. There are many treatments available if address-ing these causes. Medications, injections and surgery are all effective. The best treatment will depend on the cause of the problem, other conditions that may be present and other medications being used.

As men get older, impotence becomes more common. By age 65, about 15 to 25 per cent of men have this problem at least one out of every four times they are having sex. This may happen in men with heart disease, high blood pressure or diabetes either because of the disease or the medicines used to treat it.

Stress management and self-help techniques in older people

Session outcomes:

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

- explain why continual stress harms the individual's body and mind
- explain the need for personal boundaries in the management of stress
- explain living in wellness using body-mind practices
- discuss techniques to reduce stress

It is important to understand how the body works and be comfortable talking about different body parts to be able to prevent HIV transmission. It is also important to know where HIV is found within these organs and how HIV is transmitted.

The impact of stressful issues can be detrimental to your overall health and wellbeing. Stress not only negatively affects your body and mind, it can also further compromise your immune system. When you feel excessive stress, your T-cell count can lower. This is true for those without compromised immune systems as well. Yet, for a person living with HIV, the goal is to raise their immunity (T-cell count). How they handle stress can be counterproductive to this goal.



Class exercise

Ask participants for two volunteers: one plays being newly diagnosed with HIV, the other plays the older peer educator. The first person should tell their friend how they feel and what they are going through, having discovered their disease. The group should observe and give feedback after the role play. Ask them what the symptoms of stress are that the first person demonstrates during the conversation and how can the long-term stress of living with HIV affect a person's health.

What is stress?

Stress is a psychological (in the mind), physiological (in the body), emotional and behavioural response to internal (from inside) and external (from outside) demands. In short, there is a physical (body) and mental (mind) component to stress and it affects how people interact with their loved ones and work colleagues.

What are the consequences of too much stress on an older person?

Prolonged stress can affect the health of a person of any age adversely.²⁹ When stress overwhelms an older person's nervous system, the body is flooded with chemicals that prepare the person to "fight or take flight". While the stress response can save lives in emergency situations when a person needs to act quickly or needs great strength, it wears an older person's body down when constantly present in everyday life.

How does stress affect the body of an older person?



Small group exercise

Ask participants to discuss the effects of stress on the body of an older person. What do they think the long-term consequences of too much stress are, especially for a person who is living with HIV. How could it affect an older person's health and the rate at which the virus progresses?

The effects of stress on the body *(Source: The American Institute of Stress)*

Brain and nerves: headaches, feelings of despair, lack of energy, sadness, nervousness, anger, irritability, increases or reduces eating, trouble concentrating, memory problems, trouble sleeping or sleeping too much, panic attacks, depression.

Skin: rashes or acne can develop.

Muscles: tension in back and shoulders.

Heart: heart beats faster; increase in blood pressure and possible high cholesterol and increased likelihood of heart attack.

Stomach: increased heartburn, indigestion and weight gain.

Pancreas: increased risk of diabetes.

Intestines: diarrhoea, constipation and other digestive problems.

Reproductive system: irregular and painful periods, reduced sexual desire for women. In men, impotence and lower sperm count and reduced sexual desire.

Immune system: lower ability to fight or recover from illness.

Stress will increase the progression of HIV to AIDS related illness.

There are many healthy ways for older people to manage and cope with stress but they all require change. Coping methods fall into two categories: change the situation or change your reaction.

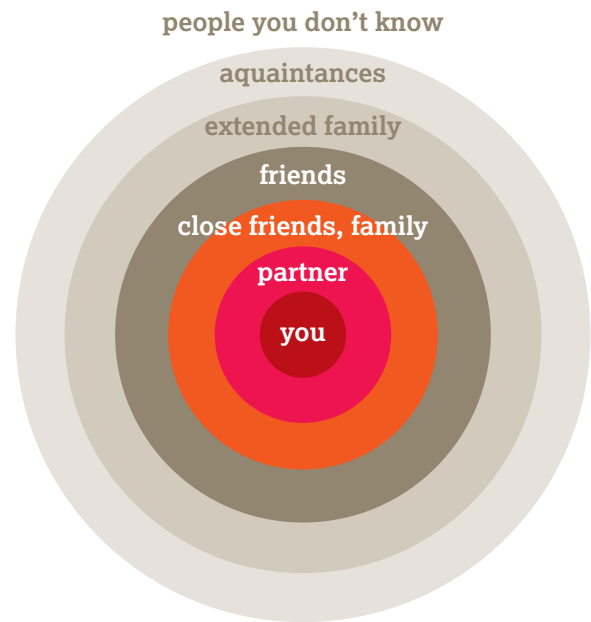
Better personal boundaries for older people

Not all stress can be avoided and it is not healthy to avoid a situation that needs to be addressed. Having better personal boundaries is one way to eliminate some of the stresses in life.

- Learn how to say “no” – Know your limits and stick to them. Refuse to accept more than you can handle. Taking on more than you can handle is a sure-fire recipe for stress.
- Avoid people who stress you out – If someone consistently causes stress in your life, limit the amount of time you spend with that person or end the relationship entirely.

What are personal boundaries?

Boundaries are the invisible lines that you draw between yourselves and other people. The purpose of setting boundaries is to protect and take care of yourself. Healthy boundaries are flexible because they allow you to get close to others when it is appropriate and maintain your distance when you might be harmed or disadvantaged.



Small group exercise

Setting boundaries is a very important personal skill and includes respecting the boundaries of others. This exercise demonstrates the experience of saying “NO” and also the experience of accepting what happens when others set their boundaries.

1. Ask for two volunteers; ideally one lady and one man.
2. Ask the lady to stand facing away.
3. Ask the man to stand a few feet away facing towards the lady.
4. Tell the lady to say ‘stop’ at any time but give instructions to the man to walk slowly towards the lady, stopping only when the facilitator claps their hands.
5. Discuss the feelings of both volunteers after the lady says ‘stop’.

Note: Remember to ask the participants about their feelings as the exercise progresses.

Questions to discuss in the debrief

Ask the lady: How did it feel when you were anticipating the man coming closer? How did you feel when you finally said ‘stop’? What made you say ‘stop’?

Ask the man: How did it feel when you were going closer and closer to the lady?



Class discussion

Ask participants to discuss why boundaries are important in peer education? Ask them to create a list of possible boundaries that an older peer educator should put in place with their peers.

When boundaries are not set, the consequence is disorder and stress. Without boundaries peer educators end up trying to solve all their peers’ problems, taking on too many responsibilities and creating a great deal of stress in their life.

In order to be an effective peer educator, you should keep yourself emotionally fit and well. As an older peer educator, your job is to make your peers aware of what stress is and how it affects everyday life (and their T cells if they are living with HIV) and to provide them with skills on how to manage stress in their lives.

Stress management techniques



Small group exercise

Ask participants to discuss how they react to stress and what might be the best strategy for them to respond to stress. Ask them to appoint a leader to feedback to the whole group.

You can control your stress levels with relaxation techniques that evoke the body's relaxation response, a state of restfulness that is the opposite of the stress response. Regularly practicing these techniques will build your physical and emotional resilience, heal your body and boost your overall feelings of joy and equanimity.

Prayer

Prayer and meditation are classic ways to deal with stress. Research shows that people who are more religious or spiritual are better able to cope with stress. They heal faster from illness and they experience increased benefits to their health and wellbeing. They stop trying to control things all alone. They understand that they are not responsible for everything that happens in life.

People who are more religious tend to become depressed less often. When they do become depressed, they recover more quickly.

Religion and faith provide social support, a consistent element of happiness and good health. Regular churchgoers not only get support from their community but they also give support to others and the altruistic activity promotes better health.

Faith attaches meaning to events. It gives people hope – the ultimate stress-reducer.



Home-based care for older carers

Session outcomes:

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

- define what 'living positively' means
- discuss home- and community-based care
- describe community projects that can help to prevent the spread or lessen the impact of HIV
- discuss different means of supporting children orphaned as a result of AIDS
- discuss what a person living with HIV should do while they are still healthy
- describe how to treat some common illnesses at home
- discuss the importance of making a will and keeping memories alive after the person's death
- describe the anxieties and needs of the carer and what type of support they need

Home- and community-based care

HIV is making huge demands on health services. These demands cannot be met by hospitals alone. A person who is living with HIV can live for many months or years. They may go from the home to the hospital and back several times within the course of their illness. In order to ensure comprehensive treatment, care and support for people living with and affected by HIV, a continuum of care is needed that brings together primary carers looking after people at home, secondary, community-based carers and health care professionals in health facilities. The following elements are crucial:

- care and support for the carers, people living with HIV and orphaned children
- care for people living with HIV where they choose to receive it, usually in their own home and community for as long as possible
- clinics and other healthcare support systems in the community providing advice and support
- hospital admittance when the condition of the person living with HIV requires that level of health care

What is home- and community-based care?

Home- and community-based care is the care given to people in their own homes when they are supported by their families, their extended families or carers of their choice.

The home-based carers need support from a range of people, from doctors, nurses, social workers, physiotherapists and health educators to traditional healers, religious leaders and their peers.

The aim of a home- and community-based care programme is to provide organisational structures, resources and frameworks that will enable the family to look after its members. Such programmes aim to:

- empower the community and the family to cope with the physical, psychosocial, socio-economic, legal and nutritional needs of the person living with HIV
- educate the community about the transmission and prevention of HIV
- support family members in their caring roles
- reduce the impact of the epidemic on the families and on the community
- set up a referral system to hospitals, hospices, clinics and other healthcare facilities in the community



Small group exercise

Ask participants to discuss the advantages of home and community based care and the potential problems associated with it.

Advantages of home- and community-based care	Potential problems associated with home- and community-based care
<p>If the person living with HIV is at home, family members can attend to their other responsibilities as well as giving care.</p> <p>Home-based care reduces the pressure on the national and provincial healthcare budgets.</p> <p>home- and community-based care, when properly supported in a continuum of care, can provide a ‘holistic’ approach to the care and support needs of people living with and affected by HIV.</p>	<p>Relying on family and community members to provide care and support assumes all people will have the people willing to care for them and overlooks issues like stigma.</p> <p>Carers often do not receive training and may not be able to provide effective care and support.</p> <p>Providing care can have a negative impact on the carers who are often not appropriately supported or paid for their work.</p>

It is important to realise that home- and community-based care can only be successful if carers are well trained and if ongoing support and advice is available.

The role of home-based care volunteers

Local community volunteers play a very important role in the home- and community-based care and can complement a peer education programme. These volunteers help people who are sick in their homes. They should:

- be trained in basic home-based care
- be chosen by community members
- have certain qualities (for example, commitment, reliability, get on well with people, respect confidentiality and so on)
- be members of the community and able to get to their ‘patients’ easily.

Not all volunteers need to have basic nursing skills. Many people may not feel suited to this kind of work but they are willing to read to the sick person, prepare food or do basic housework.

It is important to note that some people providing care and support in their communities choose to volunteer, but others would prefer to be paid. Carers are vital part of the response to HIV and their contribution needs to be recognised as work and supported appropriately.

The carer



Small group exercise

Read the thought bubbles below to the participants. Wendy is 60 years old. Her daughter has died and she has to look after her daughter’s two children. Ask them what problems and thoughts they think Wendy has when she thinks about the future. Ask them to appoint a leader to feedback to the group.



No one can cope alone. The carer must know when to:

- **ask for help:** friends, family members, neighbours, community members or the local church may be willing to help.
- **talk to others:** this is a worrying time. Carers need to be able to express their feelings and fears. Often, they feel they cannot talk about these to the person they are looking after. Other carers will know how they feel and may want to form a support group.
- **take time off:** caring is both physically and emotionally demanding. Carers need some time for themselves, away from the person they are caring for. Even if this means just visiting a friend, playing a game or going for a walk – carers need time off.
- **seek counselling:** many people take comfort in their religion. Carers should talk to religious ministers who have dealt with people living with HIV and their families before. Many clinics provide HIV counselling for both people living with and affected by HIV.

Protecting the carer and keeping the home clean

It is important to keep the house or the room where a person living with HIV stays very clean. Although the risk of being infected with HIV while caring is very low it is important that carers protect themselves as much as possible.

- Do not touch body fluids (eg, blood, urine or stool). Wear plastic gloves (or tie plastic bags on your hands) when you clean the sick person or wash their dirty laundry.
- Every time you wash or clean up after the person living with HIV, wash the gloves or plastic bags you wore in hot, soapy water.
- Keep all sores clean and covered. This means not just on the person who is living with HIV but also on all the people who share the house.
- Keep the person's mattress, sheets, blankets and pillows clean. Wash the sheets, blankets and pillows in soapy water as often as you can but separately from your other household washing. Hang them in the hot sunshine. Make sure the washing dries well.
- Cover the mattress with a strong plastic sheet. Wipe this regularly with a hot, wet cloth.
- Burn any bandages that cannot be rewashed.





Strong plastic sheets are very expensive. I can make my own. All I have to do is get some heavy duty plastic bags, like the 12kg mielie-meal bags and iron them together. If I put a cloth between the iron and the plastic then I won't get plastic sticking to my iron!



On their own

Ask participants if they chose to become a volunteer in their community, what they think they would do? Before they answer, they should think about their responsibilities to their own family, the free time they have available and so on.

Problems encountered when you are living with HIV and sick



Small group exercise

Read the speech bubbles below to the participants and ask them to discuss why living with HIV and being sick can be a frustrating, physically and emotionally demanding time for both the person living with HIV and the carer.



I can never get any work done. I seem to spend half my time in bed –either coughing or with thrush, skin infections or diarrhoea. It makes me feel so weak. I keep losing weight – but I'm not surprised. Some days I feel sick at the sight of food. My mother tries to make me eat and we end up in an argument. I worry about my children and how she will care for them when I die!



I am so tired at the end of every day. When John gets sick it makes so much more work for me. I spend all my time washing bedding and cooking meals that he doesn't want to eat. Why doesn't he eat? Does he want to get sicker and die? I'm not a trained nurse!

How am I going to cope with these children? They don't listen to me. I am too old to take on the responsibility of raising them!

Taking care of yourself

If you are older, living with HIV and sick, you must:

- continue to eat healthy food, even when you don't feel like eating. Both the person living with HIV and the carer need to eat healthily to build up their strength
- learn to treat some of the illnesses at home
- go to the clinic as soon as you feel sick
- if you are not getting better, then go back to the clinic for another visit.

Diarrhoea



Class discussion

Ask participants to discuss if someone just has a runny tummy or if they have diarrhoea. Ask them what 'dehydration' means.

If you pass more than two loose stools a day, then you have diarrhoea. Every time your tummy runs you must drink liquid to replace the liquid your body has lost. Drinking liquid will not stop the diarrhoea but it will stop your body from becoming dehydrated. You can drink any of the following:

- Thin soup made only from vegetables.
- Water that maize or rice has been boiled in.
- A mixture of sugar and salt water. This can be made at home. Follow the recipe below but make sure you only keep the mixture for 24 hours – after that you must throw it away.

Here is a recipe for home-made sugar-and-salt mixture



Measure one litre of clean water into a clean container



Add eight teaspoons of sugar



Add half a teaspoon of salt



Mix well

Drink one cup every time you have a running stomach

Drink one cup every time your stomach runs.

Do not keep the mixture for longer than 24 hours – throw it away.

Diarrhoea is very dangerous because it causes dehydration. People can die from dehydration, so watch out for these signs:

- Is your skin loose?
- Do you have a dry tongue and mouth?
- Do you feel dizzy or weak?
- Are you passing very little urine or none at all?

If these things happen, then you are dehydrated and will need medical treatment at the clinic or hospital immediately.

Coughs

If you have a cough, then do not take medicine to try to stop it. Coughing is a natural way of trying to unblock airways and get rid of the mucous. If you have a cough:

- drink tea with honey and lemon
- drink lots of water
- do gentle exercise, like walking
- fill a pot or basin with boiling water, cover your head and the pot/basin with a towel, and breathe in the steam for about 15 minutes
- make a home-made mixture of honey, lemon juice and clean boiled water.



Treat common sicknesses at home

Some common sicknesses like diarrhoea, mild coughs and skin infections can be treated at home. For other sicknesses, like thrush (a sickness that causes white spots in the mouth or inside the vagina), you can use home treatments that will not cure the sickness but will help to relieve the symptoms. It is important that you contact the clinic for most sicknesses, or if a sickness won't go away or seems to be getting worse.

Community projects



Small group exercise

Research shows that if people are involved in sport and other recreational institutions and projects, then they are less likely to become involved in risky behaviour. Ask participants to discuss why they think this is so. Ask them to appoint a leader to feedback to the group.

Taking responsibility



Small group exercise

Ask participants what sport or recreational facilities there are in their communities. How would they go about getting people interested in joining these (especially their grandchildren)? If they do not have any of these facilities available in their community, what could they do? Ask them to appoint a leader to feedback to the group.

Where will the children go?

The majority of children in southern Africa are cared for by their extended family, and specifically the grandparents.



Small group exercise

Ask participants how children orphaned as a result of AIDS are looked after in their community and how older people are coping. Ask them to appoint a leader to feedback to the group.

'Granny' programmes

In the Botha's Hill area of Durban, South Africa, a 'granny' model of foster care allows for a number of older 'grannies' to look after small groups of children orphaned as a result of AIDS. The children live together with the grannies. A church in a nearby wealthy suburb raises funds and collects food and clothing donations to support the children and to give the 'grannies' a small wage. The church asks for very specific donations of foodstuffs – ensuring that the children get the right nutritious diet. It also encourages volunteers from the community to help the 'grannies' and pays school fees and medical fees so that the children have good access to education and healthcare.



Class discussion

Ask participants to discuss the granny programme. What do they think are the advantages/disadvantages of this system?

What to do while you are still healthy?



Small group exercise

Describe the situations below to the participants and ask them why they think these things have happened.

(a)



Situation (a) has happened because:

(b)



I lived with Sipho, my grandfather, for six years. When he died I got nothing. I have to leave our home. Where will I go? How will I support my sisters and brothers?

Situation (b) has happened because:

(c)

I want the chest of drawers. It belonged to our grandfather. I am the eldest sister – I should get the chest of drawers!.

My brother said I could have his car. My son should have his guitar.

I know Daddy would have wanted me to have his guitar. Why should Uncle Mandla take it?



They are like hyenas. They will leave us with nothing! How can my family act like this? I never want to see them again.

Situation (c) has happened because:

Power of attorney

People living with HIV know they will get sick. They may get so sick that they cannot do important things for themselves. They will need to give someone 'power of attorney' – the right to carry out certain duties.



On their own

Ask participants to imagine that they are going to get very sick and die. They should think of someone they can really trust who would be able to do certain important things for them like:

- going to the bank
- paying rent and other debts
- collecting grants such as disability benefits
- signing claims from the burial society.



In pairs

Ask participants to explain to their partner why they have chosen that particular person to do all of these things for them.



Class discussion

Ask participants why it is important that people only give 'power of attorney' to someone they really trust. Ask them why they think it is important for someone to explain their choice of 'power of attorney' to their family members.

Sort out business affairs

While people are still strong there are things that they can do to make life easier for their family and those they love after they die. Most of these things have to do with money.

They should make a detailed list of:

- all the things they own
- all the people and places they owe money to
- all the people and places that owe them money
- the name and address of their employer and the benefits that their family can get from the company when they die
- their income tax number and, if they are married, their husband's/wife's income tax number
- any other important facts and numbers that their family will need to know. These could include:
 - ID number
 - passport number
 - burial society number.

They should put this list in a safe place and tell someone they trust where they keep the list.

Sort out the family

Many people have found that if they think ahead and plan for their families, then they have fewer worries than people who do not plan ahead. They should:

- Write down important information that can help, such as names, telephone numbers and addresses of relatives and friends. These are the people who will be able to provide emotional support to their family.
- Write a letter to their wife or husband and to each one of their children telling them how much they love them and remind them of things they have done together. These letters will be memories that they can hold onto and read and re-read.
- Make a memory book or box. This will help them to deal with their feelings and will help their children when they are gone. As they prepare this book/box, they will be able to remember all the good things that have happened in their life and to remind themselves that even though the end is near, their life has been worthwhile. Into this book/box they should put personal things such as photos or their favourite hat, school reports, a ball – anything that will remind their family of their life together. They can put their letters to their children into this book/box too. They should go through their memory book/box with their partner and children so that, together, they can remember all the good times.



On their own

Ask participants to make a list of some of the things that they would choose to put into a memory book/box for their children. They should think of things that mean a lot to them.

Making a will

A will is a legal document. It states who you want to leave your possessions to when you die. Your will helps to prevent family arguments, hurt and confusion after you are gone.

Many women and children lose everything when their partner or parent dies if that person has not written a will to say who should get their possessions when they die. This problem often affects **children** and **common-law wives** or women who are in a **customary marriage**. A written will can help to prevent this.

There are some other very important things to remember when you write a will:

- Everything must be written down. If you cannot write, then get someone to write for you but remember that person's name must not be in your will. Make sure it is someone you can trust.
- You must sign every page. If you cannot write, then you can write 'X' on the bottom of each page but a better idea is to get someone to sign for you. If you choose to get someone to sign for you, then you must do this in front of a witness, as required by the legal system in your country.
- Sign the will in front of two witnesses. These people must be adults and they must sign the will, too. All of you must sign in front of one another.
- A witness cannot be someone whose name appears in your will and who will benefit from your will when you die.
- Witnesses can only sign to say that they were there and signed your will at the same time you did.

Look at the example of a will below:

My will

Date:.....

I(my name) say that this is my will.

Identity number or date of birth:

Address:

Married or Single:

Partner's name and identity number:.....

Names, sex and ages of children:

1. This is my last Will, and it replaces any other Will I have.
2. I would like(name of person) to take care of my Will after I have died.
3. I would like:to be my Executor.
4. I would like to give my estate to (Estate means my home, belongings, money and everything I own):.....
(name and address of person/people)
5. I would like to give these special things (items) to these people:

My (item)towho lives at(address).....

My (item)towho lives at(address).....

My (item)towho lives at(address).....

My (item)towho lives at(address).....

Signature Witness 1:

Signature Witness 2:

My signature or initial:

Source: Soul City magazine "Living positively with HIV and AIDS"

Islamic law³⁰

Islamic Law requires that a person's estate is divided in accordance with the Shari'a. The basic principle is that a minimum of two-thirds of the estate must be distributed in fixed shares to relatives in accordance with whichever madhhab you follow. Specific items or sums of money can be specified as part of any particular relative's share. If, when it comes to the division of the estate, it transpires that the value of any specified item(s) is more than the value of the share to which the relative is entitled, then either the executors have to reduce or even ignore what has been specified, or the other relatives entitled to fixed shares may (but do not have to) agree to accept a diminution in their shares.

As regards calculating the shares, the basic principles are these:

The closest relatives (husband, wife, son, daughter, father, mother) will always inherit a share and will always have precedence over and exclude more distant relatives.

In the absence of the closest relatives, the more distant relatives (such as grandparents and grandchildren) will then be entitled to inherit fixed shares.

The remaining one-third can be bequeathed to a person, organisation or any charity. Based on Islamic guidelines, it is recommended that you bear in mind the following people, when you come to making a bequest or bequests:

- the poor and incapacitated
- orphans
- needy relatives



Small group exercise

Ask participants to discuss why it is important that if someone writes your will for you, their name must not be in it. Ask them to discuss why it is important that a witness cannot be someone whose name appears in the will or who will benefit from the will.

Near death

Near the end

Many people are deeply religious and involve themselves with their churches throughout their lives. Some people start to think about their spiritual lives only when they are facing a crisis. Most people think more and more about their spiritual life as they grow closer to death. They take comfort in prayer and talking to church ministers, traditional healers or tribal elders.

Many dying patients take comfort knowing that their friends and family are nearby. They need to know that they will not be abandoned or left alone. They need to have confidence in their healthcare worker. It is important that during the dying process, the person is free from pain and anxiety and is treated with dignity and respect. A calm atmosphere will help them to accept dying and death, and will help family members cope with the passing of their loved one.

Many very sick people and their families often want to, and need to, talk about dying. This is a good and natural thing. Keeping silent about death often creates more fear and anxiety in both the sick person and their loved ones.



Coping with loss³¹



Small group exercise

Ask participants to develop five suggestions on how to cope with the loss of a loved one.

The older person or child that has been left behind when a loved one dies needs to work through a process of grieving. It will take time to accept and make sense of the loss, and work through the pain. Advise them of the following:

- Let yourself feel the pain and all the other emotions, too. Don't let anyone tell you how to feel and don't bottle it up.
- Don't judge your emotions or compare yourself to others. No one has the right to tell you how you should mourn and when to stop.
- Show your feelings. Let yourself cry. Both are needed for healing.
- Get support. Talk about your loss, your memories, and your experience of the life and death of your loved one. Ask others for what you need. Find and talk to others who have lost a loved one.
- Try to maintain your normal lifestyle. Try not to make major changes while you are healing.
- Look after yourself. Eat well and exercise.
- Avoid drinking too much alcohol or using other drugs. This can harm your body as well as dull your emotions. It is likely to slow your recovery.
- Forgive yourself for all the things you did or didn't say or do. Compassion and forgiveness for yourself and others is important in healing.
- Give yourself a break from grief. You must work through grief, but you do not need to focus on it all the time.
- On special dates like a birthday, decide if you want to keep certain traditions or create new ones. Do something to honour the memory of your loved one.
- Join a support group.
- Start keeping a journal or make a scrapbook. Plant flowers or trees when you feel overwhelmed.

Family changes

When a loved one dies, it affects all their family members and loved ones. Each family needs to find their own ways of coping with death. A family's attitudes and reactions are shaped by cultural and spiritual values as well as by the relationships among family members. It will take time for a bereaved family to regain its balance.

It is important that each family member is able to grieve with one another to help the family cope. Each person will experience the loss differently and have different needs. As hard as it may be, it is important for family members to be open and honest when talking with each other. This is not the time for family members to hide their grief to protect each other.

The loss of one person in a family means that roles in the family will change. Family members will need to talk about the effects of this change and work out the shift in responsibilities. This time of change is stressful for everyone. This is a time to be even more gentle and patient with each other.

How do children cope with death?



Class discussion

Ask participants to discuss how they think children cope with the death of a loved one and how older people can help them cope.

Many people believe children cannot understand the meaning of death. The age of the child will play a role in the understanding of death. Children under five usually think death is short-term and reversible, that is, the person will come back. Between the ages of five and nine, children can understand that the person is gone but see it more as a separation. After about 10 years old, they begin to understand that death is final and it is very traumatic.

Children grieve but they do not always have the ways to cope that adults do. They often have

feelings like sadness, anger, guilt, insecurity and anxiety. Children sometimes show anger toward surviving family members. They may start misbehaving. They may think the death is their fault, especially if they had once “wished” the person dead. Or they may start having nightmares or acting younger than their age. Sometimes they may seem unaffected by the loss and then express grief at unexpected moments.

Talking about death will help children deal with their fears:

- Explain what happened in a way they can understand. Children know when you are hiding something so be honest.
- Encourage them to talk. Listen and accept their feelings, no matter how hard it may be.
- Answer their questions in brief and simple terms. Telling them they are too young to understand only avoids dealing with the problem and may be even more upsetting for them. It is OK not to have all the answers.
- Tell them that they will still be loved and taken care of.
- Tell them how you feel, using words they will understand and in a way that won't be overwhelming. For example, it is OK to let them know that you hurt, too. If you try to hide your feelings, they may think they shouldn't share theirs.

Attending the funeral helps children understand that death is final. Explain to children that a funeral is the way you say goodbye to the people you love. Depending on their age, attention span and how much adult supervision they need, children may take part in all of the ritual or only some of it.

If children will be at the funeral, they should be prepared for what they will see and hear. Tell them what to expect. If there will be a viewing with an open casket, the child needs to know that. Depending on how young they are, it might be useful to talk about what it means to be dead. Explain that people will come to the funeral home to visit with the family and offer their sympathy. Also explain any other routines or rituals that will be followed.

Planning a peer group intervention for older people

Session outcomes:

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

- plan the implementation of their peer group's activities
- support peer education initiatives
- monitor and evaluate peer group activities



Small group exercise

Ask participants how they are going to develop a plan for implementing peer education.

- Do they know who their coordinator is and what their plan is?
- Do they know who they are going to educate, where, when and how?
- Who should they discuss this plan with?
- Who is going to assist their access to their peers?

Peer educators' reporting

Peer educators complete regular reports on the topic covered and submit these to their supervisors.

Below is an example of a monitoring form that you will have to complete and submit to your supervisor.

Peer Education Monitoring Form

Name of peer educator _____ Date _____

Community meeting/Formal training

Topic _____ Community meeting ☐ Training ☐

Number attended

Males < 50 ☐ Females < 50 ☐

Males > 50 ☐ Females > 50 ☐

Discussions/household visits

Name of household _____

Tick topics covered

- | | | |
|--|---|--|
| 1. Introduction <input type="checkbox"/> | 5. Traditional practices <input type="checkbox"/> | 9. Opportunistic infc. <input type="checkbox"/> |
| 2. What is HIV and AIDS <input type="checkbox"/> | 6. HIV testing <input type="checkbox"/> | 10. Common health cond. <input type="checkbox"/> |
| 3. HIV in older people <input type="checkbox"/> | 7. Safety precautions <input type="checkbox"/> | 11. Other topics <input type="checkbox"/> |
| 4. Transmission <input type="checkbox"/> | 8. Living positively <input type="checkbox"/> | |

Record number attended

Males < 50 ☐ Females < 50 ☐

Males > 50 ☐ Females > 50 ☐

Record if any referrals were given (tick the box)

Treatment ☐ HIV testing ☐ Counselling ☐

Record number referred:

Males < 50 ☐ Females < 50 ☐


Males > 50 ☐ Females > 50 ☐


If condoms were distributed/handed out, record how many:

Male Female


The supervisor will summarise the monthly peer educator activity and provide the HelpAge/the coordinating organisation with a summary of the peer educators' activities.

Summary of peer educators' activities





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PEER EDUCATORS' MONTHLY MONITORING FORM

Name:.....

Code:..... MONTH:

Sub county: Parish.....

	Sensitization			Psychosocial Counseling			VCT Referrals			Clinical referrals			Networking (CBOs, NGOs, Government) - specify	Social events/ community meetings attended (specify)	Other (specify)
	M	F	T	M	F	T	M	F	T	M	F	T			
WK 1															
WK2															
WK3															
WK4															
TOTAL															
Challenges:													Follow up action(s):		

This summary should be captured into a monitoring system that can be designed to meet the needs of the individual peer education programme. HelpAge International uses a web-based monitoring system found at <http://helpage.epicentre.org.za>. A user name and password is issued by HelpAge International.

Reviewing and evaluating a peer education intervention

Evaluation and review is standing back and reflecting on what peer educators have been doing. This reflection is a critical part of learning.

An evaluation of a peer education programme considers the overall programme effectiveness, how cost-effective the programme was and what the costs were versus the benefit.

A review considers whether the planned outcomes have been achieved. Was the target group reached, were the timeframes met, was the programme of lessons completed and were one-to-one contact sessions achieved?

How to develop the criteria?

To evaluate and review the peer group programme, it is important to look at inputs, outcomes, outputs and the impact of the intervention.

Inputs

Number of peer educators recruited and scheduled for training.

Outcomes

1. Number of peer educators who have been trained and certified as peer educators as measured by the training results.
2. Number of males and females by age group, reached by the peer educators in informal and formal sessions: as measured by the peer educator monitoring forms.
3. The review should include a self-assessment by the peer educators and the supervisor. Were the objectives met? Were issues or problems followed up and resolved? Did fellow peer educators and the supervisor deliver against their tasks? What could have been done better? What lessons have been learned and what should be done differently next time?

Outputs

Changes in peer educator knowledge as measured by a pre- and post-training test.

Changes in the target groups' knowledge, attitudes, practices and behaviour as measured by the baseline knowledge, attitudes, practices and behaviour (KAPB) survey and post-intervention KAPB survey or focus groups interventions.

Impact

Changes in behaviour such as condom use, number of partners and people knowing their HIV status as measured by the baseline KAPB survey and post-intervention KAPB survey or focus groups interventions.

Using the results

The evaluation and review should be presented to the funders, the steering committee and other stakeholders. The results should be used to inform future interventions.



Class discussion

Ask participants to discuss how their peer group intervention will be evaluated.

Sustainability

For peer education to be sustainable, it is important that your needs as a peer educator for personal growth and job satisfaction are met. It is also important that you get involved in designing the intervention with your supervisor to ensure that these needs are met. Peer education programmes need to develop short, medium and long-term strategies for sustainability.

Generating financial resources and support is critical to the sustainability of peer education programmes. It is seldom the case that payment for peer educators is included in the programme design, although many peer education programmes do generate income from food gardens, bead work, sowing, condom sales, t-shirts or comic books.

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