Activities for church and community groups to involve men and women in preventing parent-to-child transmission of HIV
Guardians of our children’s health

Activities for church and community groups to involve men and women in preventing parent-to-child transmission of HIV

Second Edition – revised and updated for the IMPACT programme – Improving parent and child outcomes

Written by: Peter Labouchere, Alice Fay, Hendrix Dzama and David Deakin, with contributions from Tearfund partners Nairobi Seven and Lusaka Seven.

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Front cover photo: Mike Tsang/Tearfund

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Artists: Rose Fay, Theodore Mugolola, Zenzo Ndlovu and Petra Rohr-Rouendaal.
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## Abbreviations and key terms

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<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>AFASS</td>
<td>acceptable, feasible, affordable, sustainable, safe</td>
</tr>
<tr>
<td>ANC</td>
<td>antenatal clinic</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral drug</td>
</tr>
<tr>
<td>CD4 count</td>
<td>CD4 cells are a type of white blood cell that fights infection</td>
</tr>
<tr>
<td>CT</td>
<td>counselling and testing (VCT in many countries)</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly-active antiretroviral therapy</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV testing and counselling (VCT in many countries)</td>
</tr>
<tr>
<td>IMPACT</td>
<td>The Improving parent and child outcomes Programme is a Tearfund programme currently running in Malawi, DRC and Nigeria</td>
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<tr>
<td>Master trainer</td>
<td>A person formally trained and approved by Tearfund to train others to use the Guardians of our children’s health training programme</td>
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<tr>
<td>NVP</td>
<td>Nevirapine – an antiretroviral drug often used to help prevent HIV transmission during childbirth</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase chain reaction – a laboratory test that can detect the quantity of HIV in a person’s blood. The PCR test can be used much earlier than the HIV-antibody test for detecting HIV in a baby</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission of HIV</td>
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<tr>
<td>PPTCT</td>
<td>prevention of parent-to-child transmission of HIV</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection (or sexually transmitted disease – STD)</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>VCT</td>
<td>voluntary counselling and HIV testing (HTC in some countries)</td>
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<td>World Health Organisation</td>
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Acknowledgements

Scripture quotations are from the *New Revised Standard Version* of the Bible © 1989 by the Division of Christian Education of the National Council of the Churches of Christ in the USA and are used by permission. All rights reserved.

Sincere thanks to everyone who has contributed to the development of this *Guardians of our children’s health* training programme, in particular:

- Nairobi Seven and Lusaka Seven members who have developed, shaped and piloted the training programme: Hope Siwale (Evangelical Fellowship of Zambia), Lazarus B Harawa (Livingstonia Synod AIDS Programme, Malawi), Felicien Maisha (Heal Africa, Democratic Republic of Congo), Teresiah Waguuthu Kamay (Christian Community Services, Mount Kenya East) Christopher Kanyankole and Canon Fareth Sendegeya (Anglican Church of Tanzania, Diocese of Kagera), Dr Kirere Mathe (Centre Médical Évangélique de Nyankunde, Democratic Republic of Congo), Rosa Magare (Kubatsirana, Mozambique), Alice Osuji and Caroline Onwuezobe (Faith Alive, Nigeria), Nehemiah Ghata (ECWA, Nigeria), Ginwell Yooma (Brethren in Christ Church, Zambia), Feston Chilewani (Evangelical Association of Malawi), Dr Isaac Tiembre (Groupe Biblique des Hôpitaux, Côte d’Ivoire), supported by Carina Winberg, Anne Mumbi and Joyce Mdlawuzo (Tearfund), Andy Bowerman and John Downing.

- Professor Andrew Tomkins for the contributions to the design and conceptualisation of the IMPACT programme as indicated in the references and source materials (*Appendix 2*).

- Those people living openly with HIV who have been willing to share their photos and comments.

- Participants who took part in workshops in October 2008 and March 2009.

- Dr Rena Downing and Professor Andrew Tomkins for comments, advice, support and preparatory work with Nairobi Seven and Lusaka Seven.

- Dr Abi Abiga, Calle Almedal, Roger Basungeli, Rachel Carnegie, Ros Kent, Mandy Marshall, Dr Mutiso, Rita Mwangi, Maggie Sandilands, Dr Manuel Sierra, Felista Wanjuguna and Peter Wangera.

- Canon Gideon Byamugisha, for a variety of contributions including the foreword, selected Bible studies and Activity 6: Personal HIV risk assessment.

- Artists: Rose Fay, Theodore Mugolola and Zenzo Ndlovu.

- Bridges of Hope Training who have provided a range of global-award-winning training activities and materials, which have been widely adapted and incorporated into this training programme.
Foreword

There are three important milestones we should thank God for in our individual and collective interventions against HIV and AIDS-related infections, illness and deaths.

**FIRST**: we now know how to effectively control new HIV infections and transmissions from our family members, friends, service providers and others who already have HIV, so that we can achieve our 2015 Millennium Development Goals on HIV and AIDS.

**SECOND**: we now know how we can look after, care for, treat and support loved ones, who are already living with HIV – in our families, communities and nations so they can live longer, safer, healthier, and more productive and fulfilling lives.

**THIRD**: we also know how we can effectively prevent parent-to-child transmission of HIV. However, for this knowledge to work more miracles on the ground, we need support to become more competent in defending, protecting and enhancing the life of both the living and those not yet born. This support is needed both for those of us who are already HIV-positive and for all those in our families, communities and nations who are vulnerable to HIV and AIDS infections, illnesses and deaths.

We need help to accelerate the defeat of HIV- and AIDS-related stigma, shame, denial, discrimination, inaction and misaction. These are six related evils that still frustrate increased HIV testing, disclosure and openness about people's HIV status, and treatment and positive prevention. Positive prevention behaviours, attitudes, skills, practices, actions, policies, programmes, partnerships, messages and prayers are all very important in helping those of us already living with HIV to succeed in not transmitting the virus to anyone else during our lifetime.

To be able to achieve the milestone of halting, reversing and eventually defeating the HIV pandemic, we need accurate information on how HIV is transmitted and prevented. We need appropriate attitudes that help us to recognise, appreciate and take action regarding our risks and vulnerabilities (both sexual and non-sexual) and those of our loved ones. We need communication, negotiation and programming skills and services to help us always adopt and maintain safe behaviour.

In our church groups, congregations and in our leadership positions, we are well placed to carry out this important and divine ministry of saving and improving lives in line with Exodus 3:7-10, Isaiah 65:17, Luke 4:18-19 and John 10:10.

I salute Tearfund for giving us this training, communication, negotiation, mobilisation and programming tools that will help us (as churches and communities) to learn and do more in the divine ministry of preventing parent-to-child transmission of HIV. When we do what we can in mobilising and involving men and women to increase the prevention of parent-to-child transmission of HIV, my belief is that our God will do what we cannot.

The Reverend Canon Gideon B Byamugisha
It gives me great delight to recommend to you *Guardians of our children’s health*. Knowledge is power – and even more so if brought forward as a practical toolkit to be worked through by families and church groups. God is so gracious to us. Let’s all get involved!

The good news is that this training programme is bringing new opportunities to us. Working together in groups and as families will empower women to overcome the shame and fear of being the one to carry the burden of being tested. It will enable men to explore their role as protector of the family, and it will enable church groups to support each other and people outside their communities. It will help in practical ways, such as what to tell in-laws and friends in response to the questions they might ask and how to protect ourselves and our children.

This is about freedom and healthy behaviour, not just for our children, but for us all.

I assure you that whether you are HIV positive or negative, knowing your status restores what the enemy could have stolen: life in abundance!

Be a part of this great miracle with Tearfund.

**The Reverend Patricia Sawo, Tearfund HIV Ambassador**

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**Guardians of our children’s health training programme aims**

- To promote a sense of identity and vision for men as equal guardians of the health of their families and to take a proactive role in parenting.
- To encourage men to get more actively involved with the healthy development of their children right from conception, childhood and beyond.
- To clarify how HIV can be transmitted from parent-to-child.
- To build the knowledge and skills of both parents in order to reduce the risk of HIV transmission.
- To encourage men and women to get tested for HIV, ideally with their partners.
- To address issues of stigma, discrimination and self-stigma and promote positive living approaches and attitudes of love and acceptance towards those living with HIV.
- To relate the issues addressed to various biblical contexts when using this training programme with church groups.
Introduction and background

In 2006, Tearfund brought together a group of seven partners which were implementing prevention of mother-to-child transmission (PMTCT) programmes. The partners became known as the Nairobi Seven. Led by Dr Rena Downing and Professor Andrew Tomkins, the partners undertook a research audit of their programme activity, looking at the use of their services. Where use or provision of service was poor, the research tried to identify why. Based on their findings they set about improving the programmes, and then repeated the audit to monitor their progress, looking at data across 12 months. A key finding was the need for men to be more engaged with the PMTCT process. Without their involvement, women have reduced access to services. The Nairobi Seven saw this as something that the church could and should engage with, but was not equipped to do so. They decided to address this gap by developing a training programme for churches and local faith-based organisations to enable them to engage men in the process. The partners unanimously agreed that in response to their key findings, the scope of PMTCT should be enlarged to the prevention of parent-to-child transmission (PPTCT). In this way, fathers as well as mothers are included.

With the biblical model of Joseph and Mary, the parents of Jesus, the church has a pattern of parenting which has application in all traditions. However, how they worked together as husband and wife may be quite different from the local traditions of users of this training programme. The role of the church is critical within the communities it serves, and when there is good reason, it can bring about positive changes in traditional beliefs. Preventing the spread of HIV is a key reason. The church should have a main role in leading this local, national and global task.

Today, with HIV so widespread, some existing traditions of parenting have been shown to be inadequate, increasing the vulnerability of both mother and child. HIV and maternal mortality have also been called the ‘two intersecting epidemics’ as HIV and complications related to pregnancy and childbirth are the two leading causes of death in women of reproductive age. Therefore, responsibility for the health of the child needs to become a shared task between man and woman.

Tearfund’s vision is to stop the spread of HIV and reverse its impact in the countries where partners are being supported to deliver comprehensive HIV programmes. One of such programmes incorporating these training materials is the IMPACT programme. This aims at ensuring that children are born free of HIV and that the best possible processes are followed to contribute towards a reduction in maternal, paternal and infant mortality and ensure that both parents and their families stay healthy. The vision of IMPACT is to see a generation free from AIDS, where every child is born free of HIV; where the risk to mothers in childbirth is no greater than those in the West and where children are born to live – not to die in their first years through preventable causes. This revised second edition takes into consideration partners’ experiences when implementing Guardians of our children’s health and some of the elements in the IMPACT programme have been included in Appendix 2.
Using the *Guardians of our children’s health* training programme

This training programme is designed for facilitating interactive and fun group sessions which help address the aims given on page 7.

The activities are designed for use with church and community groups and specifically people who are married or in relationships. But please consider adapting your language and methods to cater for those participants who may be single and unmarried or widowed, divorced or abandoned by their partner.

This programme can also be used effectively with a wide range of groups, including:
- groups of men, or mixed groups of men and women
- people of different ages, cultural backgrounds, character and lifestyle
- both literate and non-literate participants.

**Group size**

Most of these activities work best with groups of 10–30 participants, allowing everyone to participate. However, some activities can also be used successfully on a one-to-one basis and with groups of over 100 participants.

**Training programme materials**

In your training programme you will find the following items and materials:
- laminated card drawings of a man, a pregnant woman and a woman carrying her baby on her back (*Activities 1, 11, 12 and 13*)
- set of five masks (*Activities 9, 12 and 13*)
- set of 15 laminated activity cards (*Activity 3*)
- three laminated card symbols of a man, a woman, and the man and woman together (*Activity 3*)
- set of six laminated A4 photographs (*Activity 8*)
- two lanyards (cords to go round your neck, with a crocodile clip) (*Activity 11*)
- penis model for demonstrating condoms (*Activity 15*)
- ten male condoms (*Activity 15*)
- three female condoms (*Activity 15*)
- bag to carry all these items.

**Materials the facilitator will need to provide:**
- Bible
- packets of chewing gum (*Activity 5*)
- milk, lemon juice or other acidic drink, a cup/mug and a glass/plastic bottle (*Activity 13*)
- additional male and female condoms (Activity 15)
- A4 card or plain paper and scissors
- pens (one per participant, for literate groups)
- photocopied copies of the various Handout pages (translated, if necessary, into the local language)
- an umbrella (optional, Activity 14)
- a flip chart or board (optional, Activity 2)
- string, tape or chalk (optional, Activity 9 and 12)
- tissues or tissue paper (Activity 15).

Key requirements for running effective sessions
- good facilitation skills
- an open minded and non-judgmental approach
- knowledge of the basic facts about HIV, AIDS and the prevention of parent-to-child transmission
- fluency in a language that participants are comfortable with using
- an understanding of the Bible’s vision of family within different cultures.

Master trainer

Tearfund formally trains and approves facilitators who are experts in how to use this Guardian of our children’s health training programme. These people are known as master trainers and will be able to train and support you to make most effective use of the programme. If you would like to contact master trainers in your area please contact Tearfund or Bridges of Hope using these contact details: impact.gooch@tearfund.org and peter@boht.org.

Arrange chairs in a circle or semi-circle.
Teaching/preaching and facilitation

Facilitating is different from teaching or preaching. It has a very different approach, and is based on different assumptions and attitudes. Here are some of the main differences:

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<thead>
<tr>
<th>Teaching/preaching</th>
<th>Facilitation</th>
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<tr>
<td>The teacher or preacher is seen as the expert, with greater knowledge, insight or understanding than the participants.</td>
<td>The facilitator recognises that participants already have a lot of relevant knowledge, insight and experience to share.</td>
</tr>
<tr>
<td>The role of the teacher or preacher is to pass on their knowledge, insight or understanding to the participants.</td>
<td>The role of the facilitator is to enable the participants to explore and work out their own understanding of the issues and how to address them.</td>
</tr>
<tr>
<td>The preacher or teacher tells participants the answers.</td>
<td>The facilitator uses an activity or asks questions and guides discussion, which involves the participants and helps them to work out their own answers.</td>
</tr>
<tr>
<td>The preacher or teacher does most or all of the talking. Participants sit and listen.</td>
<td>The facilitator asks questions and does a lot of listening. The participants do most of the talking and are actively involved in exploring the issues.</td>
</tr>
</tbody>
</table>

All the activities in Guardians of our children’s health require facilitation. Even if you are a brilliant preacher or teacher, you will need to develop your facilitation skills before you can use this training programme effectively. You can also learn more in Tearfund’s HIV Umoja Facilitator’s Guide. The notes below will help you.

How to be a good facilitator

Facilitation skills are something you can learn and practise – you don’t need to be an expert. Here are some suggestions and ideas:

Preparing before the session

- Find out what you can about the needs and issues of the participants. Who are they and how many will be attending? What do they already know about HIV and preventing parent-to-child transmission? What particular issues and needs do they have? What do they expect from this training? Answers to these questions will help you plan more effectively.
- Be clear in your own mind about what you want your participants to get from the session (the learning objectives).
- Read through the notes for the different activities. Select which activities you will use and plan each session. Think how you might adapt activities to make them more relevant to the needs and issues of your participants.
Practise what you will say, on your own or with a friend. Practise using and demonstrating the materials as well.

**Preparing materials and the training area**

- Make sure you have all the materials needed for the session.
- Before and after the training programme activities with a group, take the group through the **evaluation questions** in Appendix 4. The last evaluation should be conducted together with the master trainer. This will tell you what knowledge, skills and attitudes your participants have at the start and end of the programme. You should be able to see an improvement in knowledge and understanding.
- The master trainer will assist you in entering the data into a form that will be sent to the master trainer’s office and then on to Tearfund.
- Make sure that the master trainer’s office helps you to make photocopies of any other handouts you want to give out to participants a few days before conducting the training.
- Go to the training room or meeting place at least 15 minutes before the session is due to start.
- Set up the area where the training will take place. Push any desks or tables to the side of the room. Don’t arrange chairs or benches in rows like a classroom, but arrange chairs in a circle or semi-circle to create an informal, relaxed setting.

**At the beginning of the session**

- Greet each person as they arrive.
- Be friendly. Smile!
- Welcome participants and introduce yourself.
- If appropriate, open with a prayer.
- Explain the purpose of the session and what participants can expect to get from it.
- If this is the first session, conduct a participatory evaluation process using the **Guardians of our children’s health** evaluation form in Appendix 4.
- If this is a follow-up session, summarise the last meeting (some people may have missed or forgotten what was shared/discussed).
- Check that everyone understands the language you are using. If not, find someone to translate.
- Agree with your participants guidelines for working together, such as:
  - starting and ending on time
  - only one person speaking at a time
  - give everybody an opportunity to participate in discussions in a non-judgmental manner
  - keep confidential any personal issues discussed.
- Use an icebreaker or energiser to get participants relaxed and engaged (Appendix 1).

**During the session**

- Encourage participants to listen to and appreciate each other’s contributions.
- Guide the group and keep discussions focused on the subject of the session.
- Gently control those who talk too much and who may dominate.
Ensure that everyone has a chance to participate – encourage quiet participants to speak and get involved too, so that each participant feels that his/her contribution is important.

Encourage members of the group to explore the issues and work out answers themselves, by helping them to talk about ideas, feelings and experiences, rather than telling them what is right and wrong or criticising.

Show interest and respect for the views other people have, even if you personally disagree with them. If a participant says something you disagree with, ask the rest of the group what ideas others have to broaden the discussion.

Summarise the discussion from time to time to give an opportunity to pause and reflect, and at the end of a session.

Share leadership – a session often works better if there are two facilitators supporting each other and taking turns to lead.

Be honest and open when answering questions from participants and colleagues. If you don’t know something, say so – and then find out so that you can give correct information next time you meet.

If group members start to look tired or seem to be losing concentration, use an energiser from Appendix 1.

Ask open-ended questions that encourage group discussion, such as; ‘What are the different ways in which we can support people living with HIV?’ rather than closed questions like ‘Can we support people living with HIV or not?’

At the end of the session

Review the activities used and ask participants:

- What are the key things you have learnt?
- What will you do differently as a church/group?
- What will you each personally do differently with what you have learnt?

Get participants to identify specific actions they will each take as a result of their learning. For example, if they agree that HIV testing is very important, ask them what they will do about this and when. For example: ‘This weekend, I will discuss with my wife about going for an HIV test together.’

Good facilitators always invite and welcome honest feedback, because this helps them to improve and make their next session even better. Ask questions like:

- What did you like about the way this session was facilitated?
- What should we change to make it better next time?
- What questions or issues do you still have to do with HIV and the prevention of parent-to-child transmission, which this session has not addressed?
- Any other questions or issues?

Explain what will happen next. For example, will there be another session or a follow-up session? What support will be available to participants to implement what they have learnt?

Let participants know how they can contact you and/or a local HIV expert if they want further information or to discuss more in-depth issues.
Conclude and close: thank participants and other facilitators for their involvement. Close with a prayer if appropriate.

After the session

- Review and evaluate the session with others who observed or facilitated with you. Reflect on the feedback from participants. Discuss what worked well and what you could do to make it even better next time.
- Carry out any follow-up from the session. For example, find out about information you did not know when asked during the session.
- Plan and prepare for your next session.

Layout of the facilitation notes

In this training programme, the general notes for facilitating an activity are in normal type like this.

In some places, a sample script is provided in italics, like this. This gives you some suggestions for what to say when facilitating a session, but it will work best if you use your own words to share the ideas and examples using language that you and your participants are comfortable with.

Icebreakers, energisers and Bible studies

When you are planning activity sessions and training, consider including the following to vary the pace:

- **ICEBREAKERS AND ENERGISERS** (Appendix 1). Icebreakers are for use with a new group at the beginning of a session. They help participants to relax, become comfortable with you and each other, and engage with the session. Energisers can be used when the pace has dropped, when people are becoming tired or sleepy or when you want to change and liven up the mood of the group.
- **BIBLE STUDIES**: some of the activities include short biblical reflections which can be linked to that activity.

Flexible use of Guardians of our children’s health

The activities in this training programme follow a logical pattern. Most programmes will work best by working straight through from Activity 1 to Activity 16. If you work through all the activities with one group, it is likely to take between 8 and 12 hours in total (10 hours on average). So, if you meet once a week and spend about an hour doing two Guardians of our children’s health activities every week, it is likely to take you ten weeks to complete the whole programme.

However, the programme is designed so that it can also be used flexibly. Each activity can be used on its own or adapted and combined with other activities or used with other resources.

This is a user’s guide not a user’s rule book!
# Summary of activities

<table>
<thead>
<tr>
<th>Why do this activity? (objectives)</th>
<th>Time (approx)</th>
</tr>
</thead>
</table>

## Section A: A vision for my family

1. **My future with healthy children**
   - To imagine the future we each want, to help focus and motivate us to take action to stay healthy and prevent transmission of HIV to our children.
   - Time: 30–40 mins

2. **The parent I want to be**
   - To identify the characteristics of a good and responsible parent in your tradition – this exercise specifically targets fathers.
   - To develop a strong personal identity statement around parenthood, this will help each participant to maintain the health of them and their family.
   - Time: 30–40 mins

3. **Who does what?**
   - To explore perceptions and ideas about the roles of women and men and how these can change over time.
   - To develop ideas for addressing those roles.
   - To clarify that, to safeguard the health of their children, it is important for men to get involved with activities that have traditionally been done only by women.
   - Time: 30–40 mins

## Section B: Who is at risk?

4. **Bushfire**
   - To demonstrate how HIV and other sexually transmitted diseases can spread in a community.
   - To make participants think about the risks that HIV could have for them personally.
   - Time: 30–40 mins

5. **Chewing Gum Challenge**
   - To challenge participants to reconsider their attitudes to taking risks in their sexual behaviour.
   - Time: 5–10 mins

6. **Personal HIV risk assessment**
   - To help participants appreciate their vulnerability to HIV infection.
   - To clarify the various types of risk that can lead to HIV infection.
   - To clarify that HIV infection does not necessarily imply sexual immorality.
   - To help participants recognise the importance of HIV testing, condom use and other safer practices within marriage.
   - Time: 20–30 mins

7. **HIV testing and counselling**
   - To clarify what getting tested for HIV involves.
   - For participants to consider some of the issues about getting tested for HIV.
   - Time: 30–40 mins
### Section C: What if one or both of us are living with HIV?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Why do this activity? (objectives)</th>
<th>Time (approx)</th>
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</thead>
</table>
| **8 Can you tell?** | • To challenge the assumptions people make about whether a person is living with HIV.  
• To clarify what it means to ‘live positively’ and to learn that is possible to live a long and healthy life with HIV.  
• To emphasise the need to get tested in order to know your HIV status. | 30–40 mins or 60–90 mins with a speaker |
| **9 What happens in the body?** | • To clarify the difference between HIV and AIDS.  
• To demonstrate what happens to a person’s body and immune system once they are infected with HIV and how this can progress to AIDS.  
• To demonstrate, in simple terms, what antiretroviral drugs do (ARVs) and when someone should start taking them.  
• To clarify why adherence to ARVs is so important. | 20–30 mins |
| **10 My supporters** | • To demonstrate how easily we can stigmatise others, and the feelings the person being stigmatised may have.  
• To recognise the importance of providing support for others, and what happens when that support fails.  
• To identify ways of reducing HIV-related stigma and to support those living with and affected by HIV. | 30–45 mins |
| **11 Pregnant and positive drama** | • To build skills and strategies for being supportive and addressing the issues raised when your partner tells you they are HIV-positive or if you find out you are HIV-positive.  
• To encourage the disclosure of your HIV status to your partner.  
• To develop skills and strategies for addressing other relationship issues which affect parent-to-child transmission and its prevention. | 30–40 mins |

### Section D: Understanding prevention of parent-to-child transmission (PPTCT)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Why do this activity? (objectives)</th>
<th>Time (approx)</th>
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</table>
| **12 PPTCT during pregnancy and birth** | • To explain how both parents can help prevent HIV transmission to their baby during pregnancy, birth and infancy.  
• To clarify the importance of avoiding HIV infection/re-infection during pregnancy.  
• To clarify why, without treatment, there is a significant risk of HIV transmission during birth.  
• To explain how using ARVs can dramatically reduce the risk of infection during pregnancy, birth and breastfeeding. | 20–30 mins |
| **13 Infant feeding options** | • To provide basic information about the risks, benefits and issues involved for different infant feeding options.  
• To clarify how important it is to support the mother in sticking with the feeding option she chooses and to avoid mixed feeding.  
• To encourage pregnant women who are living with HIV and their husbands/partners to seek professional counselling and advice about the best feeding option for their baby. | 20–30 mins |
### Section E: Building skills and strategies to support PPTCT

<table>
<thead>
<tr>
<th>Activity</th>
<th>Why do this activity? (objectives)</th>
<th>Time (approx)</th>
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</thead>
<tbody>
<tr>
<td><strong>14</strong> The <em>Umbrella</em> story</td>
<td>• To clarify that using condoms is consistent with Christian principles and teachings around loving others and caring responsibly for your own health and the health of others.</td>
<td>45–60 mins</td>
</tr>
</tbody>
</table>
| **15** How to use a condom | • To clarify what condoms are, the different types available and how to use them.  
• To ensure that participants know where they can obtain condoms locally.  
• To give participants the skills and confidence to use a male condom properly | 20–30 mins |
| **16** Dramas to address other relationship issues | • To build skills and strategies for participants to address particular relationship issues which may relate to PPTCT. | 20–40 mins |
A vision for my family

Activity

1 My future with healthy children

Why do this activity?

To imagine the future we each want, to help focus and motivate us to take action to stay healthy and prevent transmission of HIV to our children.

Summary

Each participant imagines the future they want, which may include being a parent or grandparent with healthy and happy children/grandchildren. They then identify actions they will take towards realising this future vision, including ensuring the health of their children in the era of HIV.

Time

30–40 minutes

Materials

– A pen for each participant to use.
– Photocopies of Appendix 4: evaluation questions for participants.
– The laminated card drawing of a woman carrying her baby on her back, with her husband next to her.

How to prepare

Read the general notes on how to be a good facilitator (pages 11–14).
Make photocopies of Appendix 4 – enough to give one to each participant.

How to run this activity

Step 1 Use an icebreaker

Use one of the Icebreakers and energisers in Appendix 1. The icebreaker ‘My name is... and I like...’ is a good one to start with. Open with a prayer if appropriate.

Step 2 Introduce the Guardians of our children’s health training programme

Explain: Guardians of our children’s health is about achieving the dreams and visions we have for our families – of ensuring that children are born healthy and remain healthy. There are many things that both men and women can do to be effective guardians of our children’s health and men have
a vital role to play. By participating in the fun activities and discussions in this programme, you will learn how you can each help prevent transmission of HIV and ensure the health of you and your family.

**Step 3** Participants complete the question sheet

For each participant, hand round a copy of the evaluation questions in Appendix 4. Lend a pen or pencil to those who do not have one.

Explain: To help us evaluate the programme, we will ask you all to complete this questionnaire sheet both at the beginning and end of the programme. Please answer honestly all the questions on the sheet of paper and hand it in. Do not put your name on the paper – your answers are confidential.

**Step 4** Imagine the future you want

Explain: I want you each to imagine the future you want in five years’ time. What year will it be then? What would you like to be doing then? If you have young children already, imagine them now five years older, growing up strong and healthy. If you want to have additional healthy children (or grandchildren) in the next five years, imagine those young children being healthy and happy, maybe like this baby on her mother’s back, with the proud father next to them.

Get participants to relax as much as possible because the imagination works more freely when relaxed. If appropriate, ask them to close their eyes. In a relaxed voice, slowly read the following or use your own words.

Say: Make yourself comfortable and relax. You may find it helpful to close your eyes. Imagine how you would like your future to be, maybe five years from now. Imagine that you are there now. You and your family are all very healthy and everything in life is going well for you. What can you see? What are you doing? Who is there with you? How many children or grandchildren do you now have? What are they doing? What are they saying? If you have young children or grandchildren, imagine picking up one of them and holding them in your arms. How do you feel?

**Step 5** Participants share their future visions

Ask for one or two volunteers to describe to the whole group how they imagine their future. They should start by saying ‘It is now 2018...’ (or whatever year they have imagined).

Now ask all participants to try the same exercise.

Say: Get into pairs and take it in turns to describe to each other the future you want. Describe it just as you imagined it, as though you are there now.
Step 6  People with visions in the Bible

Ask participants if they can think of a person in the Bible who had a vision or dream. If they cannot think of any, suggest some of the following:

- Abraham: to leave his land for Canaan (Genesis 12:1-4)
- Moses: to set the Israelite people free from Egypt (Exodus 3:2-12)
- Nehemiah: to rebuild the city of Jerusalem (Nehemiah 2:5)
- Solomon: to build the temple (1 Kings 5:3-5)
- Joseph: to become a ruler (Genesis 37:6-7,9).

Ask:  What did the different Bible characters do after having their dream or vision?

Explain:  Moses went to talk to Aaron. Nehemiah talked with the king about rebuilding Jerusalem. Abraham involved his wife and sons. We all need to do different things to make our dreams and visions a reality.

Step 7  Personal action planning

Ask:

- What steps do you need to take to reach your vision or dream?
- Who do you need to involve or talk to?
- What is the first thing you will do and when will you do it?

After allowing time to think, ask participants to get into pairs again and share with each other at least one thing they will do.

Step 8  Summarise

Emphasise:

- It is very important to have a clear vision of the future we want.
- It is also vital to plan and take action and involve others to ensure that we each reach our vision for our future.
**Activity**

2 The parent I want to be

**Why do this activity?**

– To identify the characteristics of a good and responsible parent in your tradition. This activity can be used to specifically target fathers.

– To develop a strong personal identity statement around parenthood which will help each participant to maintain the health of them and their family.

**Summary**

This activity discusses characteristics of good fathers and explores a role model of a ‘good and responsible’ husband and father in the Bible. Each participant creates and shares a statement reflecting the sort of father (or mother) they would really like to be.

**Time**

30–40 minutes

**Materials**

– A flip chart or board to write on (optional).

– Photocopies of Handout 1: Some thoughts on being a father.

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**How to run this activity**

**Step 1** Brainstorm characteristics of good fathers

**Say:** Think of men and women who are good fathers and mothers, or stories you have heard about good fathers in particular. What sort of things do they do or say? What words describe them?

If you have a flip chart or board available, write up the words participants use to describe good fathers. Otherwise, make a list on a piece of paper.

**Step 2** Biblical example of a good father and husband

**Explain:** One example we have from the Bible, of parents who have worked together in bringing up their child is Joseph and Mary.

Read Luke 2:16, 21-24, 33, 39-51 (or the whole chapter).

**Explain:** Luke 2 shows how, at the birth of Jesus and throughout his childhood, Joseph and Mary were there together, supporting each other and sharing the joys, responsibilities and anxieties of parenthood. In verse 33, “The child’s mother and father both marvelled at what was said about him” by Simeon when they took him together to present him to God.

When Jesus was 12-years-old, Joseph and Mary travelled together with Jesus for the Feast of the Passover in Jerusalem, but when he stayed on in Jerusalem his parents returned together to look for him. When they eventually found him, Mary says (verse 48) “Your father and mother have been anxiously searching for you.”
Ask:  What words would you use to describe Joseph in his role as a father?

Add any additional positive descriptions of Joseph to your good fathers list.

Step 3  Create a statement about the sort of parent you want to be

Explain that each participant is going to create a short statement about the sort of parent they really want to be.

Say:  Think of two or three words that best describe how you would like to be as a parent. These could be words like “loving”, “caring”, “responsible”, “brilliant”, “strong”, “proud”, and “dynamic”. You can also choose words that appeal to you from the good father list. (Read out this list.)

To male participants…

Say:  Create a statement using the words you have thought of, which goes “I am a ………… father.” For example “I am a strong, caring, responsible father.”

To female participants…

Say:  Create a statement using the words you have thought of, which goes “I am a ………… mother.” For example “I am a fantastic, loving mother.”

Clarify that, although the statement is about the sort of parent you want to become, it is good to express it in the present tense, eg ‘I am…’, not ‘I will be…’

Say:  Think of somebody you really admire as a parent. What words would you use to describe this person and their qualities? Those are the sort of words to consider using in your own statement.

Give participants about two minutes to create their own statement. For participants who have pen and paper, suggest they write it down.

Step 4  Share your statements with each other

Say:  Imagine that you have become the sort of parent that you really want to be. You have the children you want, all well and healthy. Stand up and form pairs. Then share your statements with each other asking: “Who are you?” The other one should reply with their statement about the sort of parent they would like to be. Then split up, walk around to form another pair and repeat this exercise.

Demonstrate this yourself to make it clear. Allow time for people to repeat this with four or five different partners.

Encourage participants to memorise their statement and repeat it to themselves regularly.

Suggest that they may want to write it in a place where they will read it often.

If you have made copies of Handout 1: Some thoughts on being a father, give these to male participants.
Some thoughts on being a father

Congratulations! Bringing a child into this world is a wonderful cause for celebration. Children are a blessing to their parents and a gift to communities.

But producing a child is one thing and being a father is something else entirely. Fathers have important roles in making sure that their children grow up to be healthy and well-adjusted socially.

Fatherhood begins before the child is even born. In order to care for his children – before and after they are born – a father must first care for their mother.

Pregnant women experience many changes which affect their physical, emotional, mental and spiritual health. A father should take interest and learn about the process of pregnancy and childbirth so he can share in the experience and offer support to his pregnant wife. Pregnant women living with HIV will need special care and support from their husbands as they follow all the steps to prevent transmission of HIV to their child.

Here are some practical ways that a father can support his pregnant wife:

- Go to antenatal visits with her.
- Get tested for HIV with her.
- Make sure she eats healthy food and gets enough rest.
- Make sure she has the ARV medicines she needs if she is living with HIV.
- Offer to help with the household chores.
- Discuss when you will make love. Sex in pregnancy is mostly safe, but if it is uncomfortable for your wife (as it often is during the last trimester), then stop. Remember that the birth canal is bruised during delivery and sex can be painful soon after delivery so it is best avoided for several months after your baby’s birth.
- Make plans together for the birth of your child, including an emergency plan in case something goes wrong.
- Talk about how you want to raise your child.
- Ask her about how she is feeling and listen to her response.
- Give her encouraging compliments.
- Spend time with her.

When the baby is born, life changes forever!

A father is now responsible to care for a new life. Some men may have learned how to be a good father from their own fathers’ examples, but other men did not have good role models and will need to learn about fatherhood from other sources.

There are no simple steps to becoming a good father. It takes a lot of time and patience. Here are some general guides to help men to be good fathers.

- Spend time with your son or daughter and get to know them. Every child has a different personality and the father will need to know his child in order to know how best to care for them.
Give your child physical affection from a young age. Take part in holding your baby, changing your baby’s diaper, feeding your baby and putting your baby to sleep. Children begin to develop attachments with their parents as soon as they are born, long before they are consciously aware of it. It is important that a child has physical contact with the father as well as the mother.

Keep a good sense of humour. Parenting can be extremely tiring for both the father and mother and laughter is very good medicine for this!

Be patient with your child, your spouse and yourself. It takes a lot of time and effort for all of you to grow and develop new skills.

Teach your child new things. Children whose fathers spend time with them grow up to be better prepared for life. It is never too early to stimulate and encourage your child. When they are very young, help them as they learn how to walk and practise new muscle movements. As they get older, help them to learn about the things that interest you or that you have found useful in life. For example, if you are a farmer, take them to the field with you and teach them how to farm in a way that is appropriate for their age. Or help them with their school work. Or teach them how to relate to other children, family members or adults in the community. By doing this you will not only give your children important skills for life, but you will also give them the gift of spending quality time with their father.

Talk to other fathers and men in the community about your experience of being a father and get advice from those who have more experience.

Discuss with your wife how many children you would like to have and make plans for this. Sometimes men would like to have many children; often more than their wives would like. Some men would even like a football team! But if pregnancies are not properly spaced, children are more likely to become ill and die. Mothers also suffer physically from too much strain on their bodies if pregnancies happen too frequently. There are many safe and effective birth spacing methods you can choose. Please listen to and consider your wife/partner’s wishes.

Remember that the best gift you can give to your children is to love their mother. Children observe the relationship between their parents and learn to copy the example of their parents as they relate to others. Loving their mother will also help her to be the best mother she can be.
Activity

3 Who does what?

Why do this activity?

– To explore perceptions and ideas about the roles of women and men and how these can change over time.
– To develop ideas for addressing those roles.
– To clarify that to safeguard the health of their children in an era of HIV, it can be important for men to get involved with activities that have been traditionally done only by women.

Summary

Participants place activity cards according to whether the activity is done by just men, just women, or both, and discuss issues that arise. This is done first as it was 40 years ago, then presently and lastly how it should ideally be in the future.

Time

30–40 minutes

Materials

– The three cards of a man, a woman and the man and woman together
– The 15 activity cards (gender-neutral drawings) like this one. If your participants will not understand the words ‘clinic’ (on this card) and ‘VCT’ (on another activity card) stick labels over these words and write what will be better understood.

How to run this activity

Step 1 Bible study – Mary and Martha

Ask a participant to read the following passage from the Bible: Luke 10:38-42.

Emphasise how Jesus rebukes Martha, saying: ‘You are worried and distracted by many things,’ and praises Mary for ‘sitting at his feet’. Jesus says that Mary chose the better part.

Ask: What had Mary been doing?

Explain: In this description, Mary is the student, Jesus is the teacher. This may not seem so strange to us. But in Jesus’ time, education, especially in the Jewish scriptures, was for men only. Women were not included at any level. Mary was stepping right outside cultural norms. She knew it. More importantly, Jesus knew that and affirmed it. “She has chosen the better part.”

With Jesus, customary gender roles are put to one side for a good reason – to include women in his teaching!
**Step 2**  Introduce the activity and distribute the cards

**Explain:** This activity is about exploring and understanding gender roles in our own culture and how they have changed over time. We will start by looking at the past, then the current situation, then how we would like things to be in future.

Distribute the 15 activity cards to 15 participants around the room. If there are fewer than 15 participants, give two activity cards each. If there are more than 15 participants, suggest that people share.

Lay out the three cards – a man, a woman, and the man and woman together – at the front of the training area.

**Step 3**  Participants place activity cards for about 40 years ago

**Say:** Think about how things were about 40 years ago in the communities you come from – your parent’s generation. Discuss and place your activity card as follows:

- If, 40 years ago, the activity shown on your card was always or nearly always done by a woman, put it next to the card of the woman.
- If, 40 years ago, the activity was always or nearly always done by a man, put it next to the card of the man.
- If, 40 years ago, both men and women often did the activity, put it next to the card showing both a woman and a man.
- If, 40 years ago, the activity on your card did not exist (eg using a computer and HIV testing), give your card back to the facilitator.

**Step 4**  Facilitate brief discussion about the situation 40 years ago and comment on the placement of the cards

**Ask:**
- Do you all agree with where the cards have been placed?
- Who did what type of activity 40 years ago?
- Which activities started only more recently?
Step 5  **Participants discuss and place activity cards for the present day**

Pick up all the activity cards and hand them out again. Ask participants to place their activity cards again, according to what currently happens in their family or community.

Step 6  **Facilitate a group discussion about the results using questions such as:**

- Do you all agree with where the cards have been placed?
- Which activity cards are now in a different place compared with 40 years ago? Why do you think this is?
- Is it different for your generation compared with your parent’s or grandparent’s generation?
- Can our culture change the roles of men and women?
- Has the Bible changed your culture at all? If so, how?
- Is a child regarded as the mother’s child, the father’s child or their joint child?
- At what age does the father start taking an interest in the child?

Step 7  **Ask participants to think about how things should ideally be in the future**

- What do you think of the way tasks are distributed between men and women?
- How do you think women would like it to be?
- How do you think men would like it to be?
- For men to be effective guardians of their children’s health, are there any activities that they should get more involved with?

Whenever a participant makes a suggestion for how it should ideally change and be different, invite them to come and move the relevant activity card to where they think it should be.
Who is at risk?

Activity

4 Bushfire

Why do this activity?

– To demonstrate how HIV (and other STIs) can spread in a community.
– To make participants think about the risks and implications that HIV could have for them personally.

Summary

This activity shows how HIV can spread in a community, using an unusual hand greeting to represent having unprotected sex. It introduces discussion about HIV transmission, personal risk and getting tested for HIV.

Time

30–40 minutes

Materials

– Plain paper
– Scissors

How to prepare

Cut up enough small pieces of paper for each participant. Make half of them in the shape of a square and the other half in the shape of a triangle. If there are less than 20 participants, write the number zero ‘0’ on two of the pieces of paper, the number ‘1’ on two pieces, and an ‘X’ on two pieces. (If there are more than 20 participants, write the number ‘0’ on four of the pieces, the number ‘1’ on four pieces, and an ‘X’ on two pieces.) Fold all the pieces and put them in a box, bag or bowl.

Make photocopies (for literate participants who would find this helpful) of Handout 2: HIV, AIDS and ARVs – basic information.

How to run this activity

Step 1  Hand out the pieces of paper

Hand round the container with the pieces of paper and ask each participant to take one and open it.

Step 2  Do the shaking hands exercise

Explain and demonstrate the following interesting, entertaining way of greeting someone.
Say: **Hold your nose or chin with your left hand, put your right arm through the gap created by your left arm, and shake right hands with somebody else doing the same thing.**

Demonstrate shaking hands like this with a co-facilitator or participant.

Say: **If you have a ‘0’ on your piece of paper, you must not actually shake hands with anyone, just wave at them to say hello. If you have a ‘1’ on your piece of paper, you can shake hands with just one other person. If your paper is blank or if you have an ‘X’ on your paper, you can use this new greeting to shake hands with a maximum of three other people. This is voluntary – you can refuse to shake hands with someone if you do not want to. Everyone walk around and start shaking hands now.**

When they have finished, ask all participants to move to the back of the training area.

**Step 3  Explain and discuss the meaning of this exercise**

Ask the two people with an ‘X’ on their piece of paper to come to the front of the training area.

Say: **Imagine that, for the purpose of this game, these two people were HIV-positive at the beginning. The rest of you were HIV-negative. In this game, greeting someone in this unusual way represents having unsafe sex with that person. So anyone who greeted one of us has, according to this game, ‘had unprotected sex’ and exposed themselves to the risk of HIV infection. Can those who shook hands with these people come forward and join us here at the front.**

Then turn to those still at the back of the training area.

Say: **Anyone else who greeted anyone now standing at the front, please also come to the front. According to this game, you have also been at some risk of HIV infection, having ‘had unprotected sex’ with someone who ‘had unprotected sex’ with someone who is HIV-positive.**

By now most participants should be standing at the front of the training area.

Ask: **How many people did you shake hands with (in this exercise this represents having unprotected sex).**

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*The Bushfire activity involves greeting people in a new way.*
- If someone says 'nobody,' (eg those with '0' on their piece of paper), explain that they have either been 'abstaining,' or that they have always used a condom properly every time they have had sex. Ask them how they felt when refusing someone who wanted to shake hands.

- If someone shook hands with one person only (eg those with '1' on their piece of paper), say that they were ‘faithful,’ but they may still be at risk of infection if their partner ‘had sex’ with other people.

- Ask if anyone shook hands with ('had sex') more than three people (the maximum given in the instructions). What led to this? Was it because others were still doing it and they felt pressured to join in or because it was fun? Was it because they did not want to offend someone by refusing? How does this relate to real life?

**Step 4** Show the sexual networks from this activity

Say:  *Hold hands or touch arms with all the people who you shook hands with in this game. Now lift up your arms. This shows how we are all linked in the sexual network represented by this game.*

Ask/discuss:
- **How many people were originally “living with HIV”?**
- **How many are now at risk of infection?**
- **What does this tell us about how HIV can spread in our community?**

Explain:  *According to this game, sexual relationships have put many of you at risk of HIV infection. We have seen how HIV infection can spread like a bushfire. But you do not know whether you are actually living with HIV or not.*

Collect back the small pieces of paper you gave participants at the beginning of the activity.
HIV, AIDS and ARVs – basic information

How HIV is spread

The human immunodeficiency virus (HIV) lives in the human body. Here are the only ways that HIV can be transmitted:

THROUGH UNPROTECTED SEX
Sex is the most common way for HIV to spread in Africa. It can be transmitted during unprotected vaginal intercourse (without a condom) between a man and a woman. HIV can also spread between two men or a man and a woman having anal sex without a condom (when a man’s penis enters the anus of another person), or through oral sex (licking or sucking another person’s sex organs).

PARENT-TO-CHILD TRANSMISSION
Babies can get infected in the womb, during birth or through the breast milk if their mother is living with HIV. This does not happen every time, and there are many things that both men and women can do to reduce the risk of this happening.

THROUGH BLOOD
If blood taken from a person with HIV is transfused into an uninfected person, that person will also get HIV. Donated blood should always be tested for HIV and thrown away if it is infected.

THROUGH NEEDLES AND BLADES
HIV can also be transmitted through injection needles or blades that have already been used on another person with HIV, without being sterilised. HIV can also spread from traditional tattooing or circumcision ceremonies if the same blade is used for several people, one after another.

How HIV is not spread

Saliva, sweat and tears do not contain enough HIV to infect another person. HIV has to get inside another person to cause infection. HIV does not spread through kissing, hugging, holding or shaking hands, sharing toilets, going to school or working together, sharing clothes, sharing food and drink, sneezing, coughing or mosquito bites. HIV is only found in sufficient quantities to transmit HIV in blood, semen, vaginal fluid and breast milk.

Can HIV or AIDS be cured?

There are many things that someone living with HIV can do to stay healthy and live longer. However, there is no known cure for HIV that can kill and permanently remove the virus from the body through treatment and medication. The current antiretroviral drugs (ARVs) have to be taken for life to keep HIV under control.

Some traditional healers claim they can cure HIV and AIDS, and some church leaders claim they can cure HIV through faith healing. Although we cannot dismiss the possibility of such a miracle, there are no proven and scientifically confirmed or documented cases. We should always try to make the helpful distinction between ‘healing’ and ‘cure’ relating to HIV and AIDS. Healing can include various forms – psychological healing, emotional healing, spiritual healing, nutritional healing, immune system repair and restoration etc. All of these forms of
healing can resolve health problems that were being caused by constant worry, anxiety, chronic depression and deprivation.

When people pray, they seek health in mind, body and spirit. God has also provided for our health through food, water and medicines – including ARVs. When Christians pray and take ARVs they can lead healthy, fulfilling lives, although the HIV is still in their bodies. This is the difference between healing and cure. It is therefore very important that faith leaders do not discourage ARVs, but rather encourage their community members who are living with HIV or sick with AIDS – and their carers – to seek holistic healing through prayer, love, acceptance, mercy and forgiveness, care, support and ARV treatment. The God of spiritual and emotional miracles is the same God who is behind scientific discoveries that help us in preventing, postponing, and controlling diseases and deaths related (and not related) to HIV and AIDS.

The difference between HIV and AIDS

HIV (the virus) attacks and reproduces itself using particular white blood cells in a human body (CD4 cells). For several years after infection the person can look healthy and have no symptoms, as their immune system is still strong. However, HIV eventually weakens the body’s immune system to a point where other opportunistic infections and illnesses can easily enter and stay in the body. This stage is called AIDS (Acquired Immune Deficiency Syndrome). With ARV treatment and good nutrition, it is possible to return back from this stage to a state of living healthily with HIV.

Antiretroviral drugs (ARVs)

There are medicines which a person living with HIV can start taking when their own immune system is weakened or if they are pregnant. ARVs can help the body’s immune system to recover by reducing the amount of HIV in the body, sometimes to such a low level that HIV tests cannot detect it. However, HIV remains in the body and if the person stops taking the ARVs the HIV in their body will increase again.

Once someone has started taking ARVs, provided they continue taking them every day as prescribed, they can often stay strong and healthy for many more years. ARVs are usually given in a combination of three different types of drugs. This is called Highly Active Antiretroviral Therapy. Some common types are NVP (Nevirapine/Viramune) TDF (Tenofovir/Viread), AZT (Zidovudine/Retrovir) and 3TC (Lamivudine/Epivir).

By reducing the amount of HIV in someone’s body, ARVs also reduce the risk of HIV transmission to sexual partners and to their children during pregnancy, birth and breastfeeding.

ARVs for pregnant women

ARVs help to improve a mother’s health and also help to prevent transmission of HIV to her baby.

In recent years, ARV services have improved and continue to expand in parts of sub-Saharan Africa. Until recently, the common prevention of parent-to-child transmission in antenatal clinics has been to give a small amount of ARV to pregnant women living with HIV during labour and delivery. This only partially prevents transmission of HIV to the baby, but does not improve the mother’s own health. Now, the common practice is changing in many places to include the mother’s long-term health as well as to prevent transmission. Triple ARVs not only protect the mother’s health, but also are much more effective in preventing transmission.
The policies for this are different in each country, but more and more countries are adopting the World Health Organisation ‘option B+’ regimen which provides triple ARVs to every HIV-positive mother irrespective of CD4 count.

When a pregnant woman living with HIV receives ongoing ARVs for her own health, she is more likely to remain strong throughout her pregnancy and after her child is born. This will help her to care for her baby and other family members. It also helps to reduce the risk of transmitting the virus through breast milk while breastfeeding.

If ARVs are not available for ongoing treatment of the mother’s health, it is still very important for a pregnant woman to take ARVs during labour and delivery to prevent transmission to her baby.

There are different ways that ARVs can be taken during pregnancy and breastfeeding.

- The pregnant woman starts taking a combination of ARVs and continues for life. The baby also receives ARVs after birth.
- Particular ARVs are given to the mother early in pregnancy (from 14 weeks) and continued until a week after stopping all breastfeeding. The baby also receives ARVs after birth.
### Chewing Gum Challenge

**Activity**

**Why do this activity?**

To challenge participants to reconsider their attitudes to taking risks in their sexual behaviour.

**Summary**

The facilitator hands out pieces of gum to participants, collects the half chewed pieces and then offers them back to participants, who invariably refuse. This introduces discussion about attitudes to risk taking and sharing of different body fluids, including during sex.

**Time**

5–10 minutes

**Materials**

At least six pieces of chewing gum or bubble gum, though ideally enough pieces to give one to each participant.

---

**How to run this activity**

**Step 1** Hand out gum

Give participants pieces of gum to chew. Do not tell participants that this is part of an activity.

**Step 2** Collect gum back

Once participants have chewed their gum for a short while, take the container (a cup, bowl or piece of paper twisted into a cone) and ask them all to take out their piece of gum and put it in the container. You may want to give a reason for this, such as: *we need to discuss something now so your mouths should be free of gum.*

**Step 3** Offer the chewed gum back to participants

Offer the container with the chewed gum around, inviting each participant to remove a piece of gum from the container and chew it. Normally all participants refuse with expressions of disgust, saying that they will not put something in their mouth that may have been in the mouth of another person.

**Step 4** Discussion

Ask: Why are people so reluctant to get gum that someone else may have chewed (which has minimal health risks and effectively no risk of HIV transmission), but often so willing to exchange other body fluids that have a much higher health risk when they have unprotected sex?
Activity

6 Personal HIV risk assessment

Why do this activity?
– To help participants appreciate their vulnerability to HIV infection.
– To clarify the various types of risk that can lead to HIV infection.
– To clarify that HIV infection does not necessarily imply sexual immorality.
– To help participants recognise the importance of HIV testing, condom use and other safer practices within marriage.

Summary
The facilitator asks participants a series of questions about their past behaviour and experiences. Each participant secretly scores their responses according to whether or not their responses suggest a possibility of HIV transmission.

NOTE: Be sensitive or cautious when using this activity in sessions with couples, as it can provoke conflict in marriage. You may also want to provide counselling or prayer after this session as it may be difficult for some.

Time
20–30 minutes

Materials
A pen and a small sheet of paper for each participant. They can also score using their fingers or privately in their head as some participants may not want to share their answers.

How to run this activity

Step 1 Give out pens and paper to each participant (optional).

Step 2 Explain the instructions and rules
Say: I am going to ask each of you some questions about your past personal experiences. Score each answer with either 10 or 0. Either write down your score or, if you do not have a pen and paper, you can keep your score using your fingers. This exercise is strictly confidential – nobody should see what another person is writing and you should use a piece of paper which you can throw away later.

Each “Yes” answer scores 10 and each “No” answer scores 0.

If you are not sure whether the answer is “Yes” or “No” score 10.

Thinking back about your past life, answer the following questions honestly.
**Step 3  Ask the questions**

Go through all the questions, pausing between each one so that participants can think and note their score.

**Question 1**  
Were you born after 1981?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 2**  
Have you (or your sexual partner) ever had a blood transfusion?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 3**  
Have you (or your sexual partner) ever received injections from a non-professional person who may not have sterilised their equipment?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 4**  
Have you (or your sexual partner) ever shared skin piercing, skin penetrating or skin cutting instruments with anyone?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 5**  
Have you ever had sex?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 6**  
Have you ever had sex with someone (your wife, your husband or anyone else) who has already had sex with someone else?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 7**  
Have you ever had sex with more than one sexual partner?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 8**  
Have you ever separated from your sexual partner (due to business, education, travel, work, study, etc) and then resumed a sexual relationship with him or her after some time?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 9**  
Have you ever had a sexually transmitted infection (also known as STI) or sometimes also called a sexually transmitted disease (STD)?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 10**  
Did you have sex with anyone before were you married? If you are not yet married, have you ever had sex?  
If “Yes” score 10 (or lift one finger). If “No” score 0.

**Question 11**  
Did your sexual partner have sex with anyone else before you married him or her? If you are not married and have a boyfriend/girlfriend/fiancé(e), is there any possibility that he or she has ever had sex with anyone else?
If “Yes” score 10 (or lift one finger). If “No” score 0.

Explain: If you have scored 0 in every question so far, you do not need to answer Question 12 and your total score will be 0. If your total score so far is 10 or more, or if you have raised one or more fingers, answer the next question confidentially and honestly.

**Question 12** Have you ever had sex with your sexual partner without correctly using a condom?

If “Yes” score 10 (or lift one finger). If “No” score 0.

**Step 4** Summarise and discuss what participants have learnt

Say: Add up your score in private. If you were scoring on your fingers, multiply the number of fingers/thumbs you raised by 10, eg if you raised six fingers, your score is 60.

If you scored 0 for every question, you are not yet at risk of HIV infection.

If you scored 10 or more in total, or you have raised one or more fingers, you could be at risk of HIV infection. The higher your score the greater your risk. You could be living with HIV and spreading it to your loved ones. You need to go for an HIV test and establish the truth.

Pause for a minute for participants to reflect, then ask the following questions:

- How do you feel about this exercise?
- What have you learnt?
Activity 7  HIV testing and counselling

Why do this activity?
– To clarify what voluntary counselling and HIV testing (VCT) involves.
– For participants to consider the issues involved in VCT.

Summary
This activity helps participants to imagine what it is like going through the VCT process and clarifies what is involved. In some areas or countries, the process is also called HIV testing and counselling (HTC) and also counselling and testing (CT).

Time
30–40 minutes

Materials
– Plain paper
– Scissors

How to prepare
Cut up enough small pieces of paper for each participant. Make half of them in the shape of a square and the other half in the shape of a triangle. Fold all the pieces and put them in a box, bag or bowl. You can use the same pieces of paper as for Activity 4: Bushfire.

Make photocopies (for literate participants who would find this helpful) of Handout 3: Voluntary counselling and HIV testing (VCT).

Find out for yourself what VCT facilities are available locally and what procedures they use for counselling and testing for HIV. If possible, obtain leaflets about the services they offer to give to your participants. You might also try to arrange for one of the counsellors from a local VCT centre to come and talk. They may even be able to provide a counselling and testing service immediately after the session.

Get tested yourself, if you have not already! When explaining VCT, participants often ask the facilitator if they have also been tested themselves, so it’s much better if you have, and will add credibility and impact to the session.

How to run this activity

Step 1  Discuss HIV testing issues and concerns

Clarify that an HIV test is the only way of knowing for sure whether or not you have the HIV virus in your body.

Ask:
- What happens during VCT?
- What do you need to think about before having the test?
- How would it feel if your test result was HIV-negative?
- How would it feel if your test result was HIV-positive?
- Who would you tell and how might they react?
- Who is unsure or would decide not to go for a test?
Ask those who say they would not go for a test to give back their piece of paper and take a step back. Those who would go for a test should move forward, so the two groups are separate.

**Step 2  Imagine going for VCT**

Get participants to imagine going through the VCT process, describing it using your own words:

*Say:*  *I would like you to relax and imagine you are now going for VCT. You go for pre-test counselling, and then give a blood sample. The blood sample is tested and you are coming for the results. Your counsellor invites you into the counselling room and asks you to sit down. The counsellor asks if you still want to know your result. If you do not want to know your result, put your hand up.*

If anyone puts their hand up, ask them to give their piece of paper back and move to join the group at the back who have chosen not to go for VCT.

**Step 3  Give test results**

Get each participant who says they want their test result to pick one of the folded pieces of paper.

*Explain:*  *Imagine the piece of paper you have picked represents your test result. Open it up. It is in the shape of either a square or a triangle. One means that your test result is HIV-positive, the other that your test result is HIV-negative. How would you feel if I told you that a square means HIV-negative result, and a triangle means HIV-positive result?*

*Ask:*  
- Those whose test results is negative, how do you feel?  
- Those whose test results is positive, how do you feel? What would you do next? Who would you tell?  
- Then ask how people would feel if the results were reversed?  

Include in the discussion those who decided not to go for a test or who did not get their result.

*Ask:*  *How do you feel now about not knowing your HIV status?*

**Step 4  Discuss where testing is offered**

Find out from participants whether they know where VCT is available in their area. Discuss what options might be available for participants to access VCT. Give participants the name, location, opening times and cost of VCT centres. Try also to provide details of centres in other towns outside the area, for people who want to be sure of confidentiality.

**Step 5  VCT counsellor presents information, answers questions and – if available – offers testing (optional)**

If you have a counsellor or representative from a local centre offering VCT, ask them to describe the services offered and answer questions from participants. If mobile HIV testing and counselling services have been arranged, they can also explain how participants can use these services.
Step 6  Bible study – The grace to face our fear

You may want to say to participants that they can reflect privately on these questions and issues or discuss things in small groups.

Read Philippians 1:12–14 and Matthew 26:36-42.

Discuss:
- How does Jesus describe his soul? Why do you think this is? Can you imagine how fearful you might feel going for a visit to the VCT centre? Perhaps you have been. Can you describe what it was like or might be like – the night before or on the day?
- Paul was imprisoned. Jesus was detained and about to be crucified. Each had his own reason for sorrow and fear. What is happening in our lives that causes us sorrow or fear? What about the lives of our community?
- How do we view God’s deliverance and grace? When we look at the life of Jesus, or of Paul when he was in prison, then grace does not always bring the change or deliverance we might expect. If it’s true that it does not always mean that our situations change for the better then what does grace change?
- When going for an HIV test, how will you or did you know that God’s grace and peace are with you?

Key message
- Jesus and Paul experienced extreme sorrow and fear. God does not always bring the change or deliverance that we might want or expect, but his grace is always with us to help us change our attitudes and how we address or face an issue or crisis.

Say together:  May the grace of our Lord Jesus Christ, the love of God and the fellowship of the Holy Spirit be with us all now and forevermore. Amen.
Voluntary counselling and HIV testing (VCT)

Some hospitals and clinics can test your blood to see if it contains HIV, and many African countries have specialist centres offering voluntary counselling and HIV testing (VCT). In many places this is now called HIV testing and counselling (HTC) or counselling and testing (CT).

When HIV enters the body, the body makes antibodies to fight against the HIV. It is difficult to find HIV itself, but the test can pick up these antibodies. If the test is positive, it means that the person has HIV in their body. It does not mean they have AIDS.

After the person first becomes infected with HIV, the HIV-antibodies can take up to three months to develop and show up on the test. This is called the window period. If your test result is HIV-antibody negative, it might be because you are in the window period and you should get tested again after three months to make sure.

Having an HIV test often brings out strong feelings and emotions, and it is very important to get proper counselling when you have the test.

How does voluntary counselling and HIV testing work?

Before going for an HIV antibody test, either alone or with your partner, you spend time with a counsellor, who will help you think about your issues and concerns, and will ask questions like:

- What will you do if the test shows you are living with HIV?
- What will you do if the test shows no sign of HIV in your blood?
- Are you sure that you want to go ahead with the test?

The counsellor will meet you again when you get the test result and help you think through the implications of your HIV test result and plan what to do next. These discussions are confidential. The doctor and professional counsellor should not tell anyone else about your test result or anything that you have said. Sharing the result is up to you. Some churches ask couples to get an HIV test before marriage. This is a good idea, as it is important for couples to discuss how they will cope if one or both of them are living with HIV, and also how they will protect each other if both test negative. However, people should not be forced to have tests. If a couple do decide to have the test, it is also their choice about whether to share the results.

Who should go for voluntary counselling and HIV testing?

Everyone. No one knows for certain that they don’t have HIV unless they have had a blood test. It is good to know your status – if you are negative you know you can protect your status and if you are positive you can be supported in the right ways and also protect others from infection.

Why go for VCT?

- If you know you are living with HIV, there are many things you can do to stay healthy, live long and still achieve your goals and dreams in life.
- You can enjoy sex while ensuring that you protect yourself from re-infection, and others from getting infected.
- If you are expecting a child, there are many things you can do to minimise the chance of HIV being transmitted to the child.
What if one or both of us are living with HIV?

**Activity 8 Can you tell?**

- To challenge the assumptions people make based on physical appearance about whether a person is living with HIV.
- To clarify what it means to ‘live positively’ and live a long and healthy life with HIV in your body.
- To highlight the need to get tested in order to know your HIV status.

**Summary**

Participants look at photographs of people and select who they think is living with HIV. They discuss the reasons for their choices. The facilitator then tells participants the actual stories of the people in the photographs, most of whom are living openly with HIV. These examples show that it is possible to live a long and healthy life with HIV, and that you cannot tell someone’s HIV status by their physical appearance.

**Time**

30–40 minutes (60–90 minutes if Step 3 is included – inviting a speaker who is living with HIV to share their story and experiences)

**Materials**

- Set of six A4 photos of people.
- Photocopies of Handout 4: Pictures and stories of people (optional).

**How to prepare**

If possible, arrange for a person living with HIV to join the session. Ask him or her to talk to and answer questions from your participants. This should be someone who is currently healthy and positive about life and open about their HIV status.

Make photocopies of Handout 4 – optional.

**How to run this activity**

**Step 1 Participants select who they think is living with HIV**

Lay out the six A4 laminated photographs of people. Ask participants to look at the pictures and say who they think is living with HIV and who they think is HIV-negative. Ask them to move pictures of people they think are living with HIV in one direction, those they think are not in the other direction, leaving the ones they are unsure about in the middle.
Step 2  Discussion

Ask participants to pick up the picture of someone they selected as either ‘living with HIV’, or ‘not living with HIV’. When someone says, for example, ‘He looks sad – he probably has HIV’ respond by asking them: ‘So if anybody looks sad, do you think they have HIV?’ In a similar way, if someone says, ‘He looks very religious,’ respond by asking: ‘So anyone who looks religious cannot have HIV?’ This gets participants thinking about the judgments and assumptions they make about people and their HIV status.

Select some of the pictures, one by one, and summarise the actual stories of these people using the information in Handout 4. When you are explaining about David Patient, highlight that he has been living with HIV for over 30 years and that many others have now lived for over 20 years.

Emphasise that it is impossible to know someone’s HIV status just by looking at them.

Step 3  Speaker who is living with HIV (optional)

If you have a speaker who is living openly and positively with HIV and who is happy to share their own experiences with the group – allow time for a presentation, questions and discussion.

Step 4  On the bank in the river

Ask participants to stand in a circle. Then explain the game.

Say:  *Where you are standing is the bank. There are some lions behind you and some crocodiles in the river in front of you. When I say, “In the river” you should all immediately jump one step forward. If, however, I say “On the river” you should not move. When I then say, “On the bank” you should jump one step back to the starting point. If, however, I say “In the bank” you should not move. If anyone makes a mistake, they will be eliminated from the game and must sit down.*

Start the game. Give the commands quickly. If anyone makes a mistake, ask them to leave the game and sit down. After a few minutes, stop and debrief.

Note that many people laughed when the first person had to leave the game. Ask the person or people who went out first: *How did that make you feel?*

Possible responses may be: embarrassed, angry and stigmatized.

Ask those who made mistakes and had to leave the game during the next few rounds: *How did you feel when, after laughing at the first person to make a mistake, you also made a mistake?*
Explain that this game shows us that we are all in the same boat. There is no separation between us and them. We are all potentially at risk, so we should not stigmatise or point fingers at those already affected by something – for example, those living with HIV or those involved with alcohol or drug abuse.

**Step 5  Bible verses on judging others**

Read out the following verses from **Matthew 7: 1-3**: 

_Do not judge, or you too will be judged. For in the same way you judge others, you will be judged, and with the measure you use, it will be measured to you. Why do you look at the speck of sawdust in your brother’s eye and pay no attention to the plank in your own eye?_

**Step 6  Personal action planning**

Say:  _Decide on one thing you will each do personally to ensure that there is love, support and justice for those of us who are living with HIV._

_If you know you are living with HIV, or think you might be, decide on one thing you will do differently to stay healthy and live longer._

**Step 7  Give handout with instructions**

Give out copies of **Handout 4: Pictures and stories of people.**

Explain:  _This handout is to remind you of the people and their stories. If you show this to your relatives, other church members or friends, first cover up the writing and get them to guess who is or is not living with HIV, so that they can also realise the assumptions they make. Then tell the actual story of each person._
Pictures and stories of people

**Patricia Sawo** tested HIV-positive in 1999. Patricia is a church leader and had previously stigmatised people living with HIV. Patricia now works with church leaders across the world to help them to end stigma. She says: “The church is the best placed organisation in these communities to overcome shame and to offer a place for them to go. In my work with church leaders, I ask them: ‘Do you use HIV and AIDS to control your congregation – or your congregation to control HIV?’ We need to provide accurate information, reduce stigma, provide care and support, and join with others who have been doing this pioneering work for years. Together we can do it.” Patricia has also mobilised her church to support people living with and affected by HIV, and helps them get back to better health and return to their communities. Patricia is an HIV Ambassador for Tearfund.

**Canon Gideon Byamugisha** found out that he is living with HIV in 1992 and first publicly declared his status in 1995. He works as an educator and campaigner of behalf of people living with HIV, both within Uganda and internationally. He comments: “So many people accept that AIDS is out there, but they don’t go beyond that and do anything about changing their own behaviour. To be really open about HIV and AIDS, you have to acknowledge that it could affect you personally, that you could be at risk. You must act accordingly and get tested.”

**Musa Njoko**, diagnosed with HIV in 1995, is a renowned inspirational speaker, HIV-positive activist, musician, educator, counsellor and entrepreneur. She is one of the first women to publicly disclose her HIV-positive status in South Africa and has made a remarkable contribution locally and internationally in the health field, especially on HIV, TB and women’s health. Musa is an HIV Ambassador for Tearfund.

**Sala Dube**, 34, is a gardener from Ntabazinduna in Zimbabwe. He is married and has a seven-year-old son. Sala had an HIV test when this photo was taken, and tested HIV-negative.

**Valencia Mofokeng**: “When I was first diagnosed with HIV I was angry, and for the first time in my life I thought of suicide. I think that by being silent I made myself very ill and depressed. Immediately after I told everybody, I was relieved and I began to live a normal life. But telling people was the hardest thing to do because you don’t know whether they are going to accept you or not. Some people said I was a loose woman who slept around. It was very painful because I was faithful to my husband. But each and every time I talk with somebody, I feel okay. As long as you accept it, it’s like other diseases. As long as you accept yourself, people will also accept you.” Though born while Valencia was already living with HIV, her child is HIV-negative.

**David Patient** was originally diagnosed with HIV in 1983, and so has been living with HIV for over 30 years. He is still strong and healthy and has co-written various books such as *Positive Health*, about how to stay healthy and live longer with HIV.
9 What happens in the body?

Why do this activity?
- To clarify the difference between HIV and AIDS.
- To demonstrate what happens to a person's body and immune system once they are infected with HIV and how this can progress to AIDS.
- To demonstrate in simple terms what antiretroviral drugs do (ARVs) and when someone should start taking them.
- To clarify why adherence to ARVs is so important.

Summary
This activity uses a short drama sketch to demonstrate and explain in a memorable way about HIV, AIDS, opportunistic infections, and ARVs. As the director/narrator, you need five people to help you (including members of your audience) who become characters called 'White Blood Cells', 'HIV', 'Infection', 'Another Infection' and 'ARV'.

The drama sketch involves actors demonstrating, in an area representing the human body, the interactions between these different 'characters' during the following stages:

Stage 1: Not yet infected
Immune system White Blood Cells is strong and able to fight off any infection.

Stage 2: Living with HIV, no symptoms
HIV enters the body. White Blood Cells pushes HIV down in one corner and remains strong and able to fight off Infections.

Stage 3: Living with AIDS
HIV weakens White Blood Cells, allowing Infections to dance freely round the body.

Stage 4: ARV Treatment
When ARV enters the body, it pushes HIV back into a corner, allowing White Blood Cells to recover and fight off Infections again.

Stage: Adherence to taking ARVs
If the person fails to adhere to the treatment, ARV leaves the body and when it returns it is no longer able to deal with HIV, because HIV has changed (mutated).

Time
20–30 minutes

Materials
- String, tape, chalk or other items to make the boundary to the 'body'.
- Five masks for White Blood Cells, Infection, Another Infection, HIV (double sided) and ARV.

How to prepare
- Make sure you are clear about what happens in each of the five stages.
- Read Handout 2: HIV, AIDS and ARVs – basic Information. Optional: photocopy these pages for participants.
- If you have co-facilitators, ask one or two of them to play key roles (e.g. White Blood Cells and HIV) – this gives you more control if some of the actors know what they should be doing.
How to run this activity

Step 1  Create an area representing the human body
Using sticks (as shown in the photos), string, tape, chalk, chairs, and/or walls, create or draw the boundary for an area on the ground about two-square metres. If the training area is earth or sand, draw the boundary with your foot. This will represent a human body.

Step 2  Get your five ‘actors’ and allocate roles for the drama sketch
Ask for volunteers from your audience or group to make up a total of five actors (including co-facilitators you have already briefed) to help you with a short sketch. Give each a different mask for their role. Ideally, a tough looking person should be White Blood Cells.

Step 3  Act out the drama sketch
Follow the notes on pages 48–51. Use the suggestions for what to say in the left-hand column, or use your own words. As you do so, ensure that the actors demonstrate what you are saying by doing what is written in the right-hand side. Stop briefly between each stage, so the different stages are clear.

Step 4  Review
When the drama is complete, thank the actors, ask them to return to their places and get everyone to give them applause. Ask if there are any questions about the drama and what it means. Ask participants what they have learnt from it.

Check that participants have clearly grasped all the key messages below.

Give out Handout 2: HIV, AIDS and ARVs – basic Information.

Key messages

- Living with HIV does not mean you are living with AIDS. HIV and AIDS are not the same thing.
- If you are living with HIV, it is possible to stay healthy for many years with a strong immune system before needing to start ARVs.
- Get tested so you know your HIV status and can start taking ARVs before your immune system gets too depressed. This helps keep you healthy and reduces the risk of transmitting HIV to sexual partners and to your unborn or breastfeeding children.
- Take your ARVs without fail every day as instructed.
Notes  Facilitating the 'What happens in the body' drama sketch

Masks reference

<table>
<thead>
<tr>
<th>White Blood Cells</th>
<th>Infection</th>
<th>Another Infection</th>
<th>HIV</th>
<th>ARV</th>
</tr>
</thead>
</table>

Suggestions for what the facilitator says:  What the facilitator and 'actors' should do:

Stage 1: Not yet infected with HIV

<table>
<thead>
<tr>
<th>Inside this area represents a healthy human body. In this human body are millions of White Blood Cells – normally between 600 and 1,200 in every microlitre of blood. Their job is like a policeman or soldier, to guard and fight off any infections that enter the body. It is part of the body's immune system. Let's welcome and give White Blood Cells a round of applause.</th>
<th>White Blood Cell steps into the area representing a human body and looks tough, flexes his/her muscles, adopts a strong man/body building/fighting pose.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally the White Blood Cells are strong and can fight off almost any infection. Here comes an infection, such as one which causes diarrhoea or maybe pneumonia or TB.</td>
<td>Infection enters the 'body'. White Blood Cells attacks Infection and after a brief fight, pushes it out of the body.</td>
</tr>
<tr>
<td>Here comes Another Infection.</td>
<td>Repeat with Another Infection.</td>
</tr>
<tr>
<td>The body's immune system is able to deal with many infections and common illnesses and get rid of them fairly quickly.</td>
<td>White Blood Cells flexes muscles, shows his/her strength.</td>
</tr>
</tbody>
</table>
### Stage 2: Living with HIV, no symptoms

<table>
<thead>
<tr>
<th>Suggestions for what the facilitator says</th>
<th>What the facilitator and ‘actors’ should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>One day, HIV enters the body. In most cases, it does this through unprotected sex with another body where HIV is already living. White Blood Cells fight off HIV and pushes HIV into one corner, but White Blood Cells cannot get rid of HIV completely.</strong></td>
<td><strong>HIV enters the body and attacks White Blood Cells. White Blood Cells pushes HIV down into one corner of the body.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suggestions for what the facilitator says</th>
<th>What the facilitator and ‘actors’ should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>As well as keeping HIV at bay, White Blood Cells remains strong and effective at fighting off other infections. The immune system can stay strong for many years after infection with HIV – normally 5 to 10 years and sometimes over 20 years. Healthy eating, a positive attitude to life, and focusing on the future you want can all help to extend this period.</strong></td>
<td><strong>Infection enters again and White Blood Cells once again pushes Infection out of the body. If HIV starts to stand up or move out of the corner, White Blood Cells pushes HIV back down into the corner.</strong></td>
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### Stage 3: Living with AIDS

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<tr>
<td><strong>In most cases HIV eventually gets stronger and manages to attack and take over most of the white CD4 blood cells, so the body’s immune system is severely weakened.</strong></td>
<td><strong>HIV stands up, attacks and gets both arms of White Blood Cells locked behind his/her back so that White Blood Cells cannot fight infections.</strong></td>
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<td><strong>When other infections enter the body now, the white blood cells can no longer fight them off. The immune system is now very weak and can be attacked by any opportunistic infection. Infections are free to run and dance all round the body and the White Blood cells can no longer stop them. The body now has AIDS – Acquired Immune Deficiency Syndrome, and without treatment will normally die within one to two years. However with treatment of HIV and the opportunistic infections, provided such treatment is not left too late, there are very good prospects for getting healthy again.</strong></td>
<td><strong>The two Infections enter the body, dancing round the other characters. HIV continues to hold White Blood Cells.</strong></td>
</tr>
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Stage 4: Antiretroviral treatment (ARVs)

People living with HIV whose number of white CD4 blood cells drops to less than 500 cells per millilitre and all pregnant women living with HIV may start to take a combination of ARVs (see WHO guidelines 2013 and WHO Option B+ regimen). ARVs can suppress HIV, but they cannot get rid of HIV completely. They allow the white CD4 cells to build up again, so that they can once more fight off infections. The person’s CD4 count increases, the viral load drops and they return to a state where they are living with HIV, but no longer have AIDS.

The person in this drama waited until they were quite sick before they got tested for HIV and started taking ARVs. It is actually much better to get tested regularly so you know your HIV status and can start taking ARVs much earlier, before developing AIDS and suffering infections.

A pregnant woman who is living with HIV may start full life-long ARV treatment even if her immune system is still strong, regardless of how high her CD4 count is. As well as keeping the woman healthy, this can dramatically reduce the risk of HIV transmission to her baby and also to her sexual partner.

Stage 5: Adherence to taking ARVs

This body is strong again and the person thinks: “I am well again. Why should I carry on taking these ARVs?” So they stop for a while.

ARV leaves the body.

Without the ARVs to constrain it, HIV is able to develop and mutate – it can change its form slightly, in a way which may then be resistant to the combination of ARVs being used.

Take the HIV mask off the person wearing it, turn it round and put it on again, showing the opposite side with a different ‘mutated’ image of HIV.

HIV regains strength, and attacks and weakens the body’s immune system again, allowing other infections to freely infect the body.

HIV attacks and holds White Blood Cells again. Both Infections enter and dance around the body again.
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<tr>
<td>The person starts taking ARVs again. However, HIV is now resistant to that combination of ARVs and they no longer work. HIV continues to suppress the immune system, allowing more infections to move freely around the body. A different combination of ARVs may be considered, though this may be less available/more expensive; it may have other side effects and it may not work. It is therefore vital to stick to taking ARVs every day, exactly as instructed.</td>
<td>ARV enters the body again, but this time HIV ignores or pushes ARV away. HIV continues to hold White Blood Cells. Both Infections continue to dance around the body.</td>
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**Activity**

10 **My supporters**

**Why do this activity?**

- To demonstrate how easily we can stigmatise others and to understand how the person being stigmatised may feel.
- To recognise the importance of providing support for others and what may happen if that support fails.
- To identify ways of reducing HIV-related stigma and to support those living with and affected by HIV.

**Summary**

Participants are divided into groups of seven to ten participants. Each group stands in a very close circle. Individuals take turns standing in the middle and allowing the rest of the group to support them as they lean outwards. After several people have tried, group members are told to withdraw their support for the next person in the middle.

Participants discuss how the person in the middle feels when well supported, and when support is withdrawn. This highlights the importance of having support from friends, family and community, and of accepting and not stigmatising or stereotyping someone because they are living with HIV or for any other reason.

**Time**

30–45 minutes

**How to prepare**

As well as reading and understanding the facilitation notes yourself, you will need to brief other co-facilitators to help you with this activity. You’ll need one to work with each group of seven to ten people – depending on the overall group size.

**How to run this activity**

**Step 1** **Introduce the activity and arrange the groups**

Welcome everyone and explain that they will be participating in an activity called ‘My supporters’ where each participant is expected to be supportive of others in the group.

Divide participants into groups of seven to ten. Because this activity involves physical contact, arrange participants into single-sex groups if you think your participants will find mixed sex groups embarrassing.

Ask: *When you think of "supporters" what do you think of? At a football match, what do the supporters do for the players?*

Some responses may be that they cheer, encourage, motivate and inspire the players.

Say: *We are going to create a support system for each other. Are you ready to support each other in your groups?*
Step 2  
**Facilitators teach their groups how to be good supporters**

A facilitator should supervise each group and demonstrate this activity by starting off in the middle themselves. If you are the only facilitator, run one group at a time, with the other groups watching. Carefully follow these steps:

1. Each facilitator stands in the middle of their group and gets the participants to make a tight circle round them, shoulder to shoulder.
2. Tell the participants that you are going to ask them to literally ‘support’ you and keep you from falling to the ground as you lean in their direction.
3. **Emphasize that this exercise needs everybody’s focus and attention to make it safe.**
4. Show participants how to stand with one foot in front of the other, knees slightly bent, leaning forward, arms up and slightly bent. This is the strongest position to catch someone.
5. Stand in the middle of the circle, very straight with your feet together, arms folded across your chest and your hands on your shoulders.
6. Ask the check-in question; ‘Are my supporters ready?’ When they all say ‘Yes’, check they are ready, then say, ‘Leaning now’.
7. Select a section of the circle and lean gently towards them. Everyone in that part of the circle should help to catch you, and push you gently back up so you are standing straight and vertical again. There should always be at least two people catching the person in the middle.
8. Do not move your feet and keep your body straight like a broomstick. Lean in one direction and then another, so that you give each person a chance to help catch you. Encourage the group members if they are doing well. Tell them this is a serious activity with real dangers if they drop someone.
9. Continue until you are confident that the group has mastered the skill of supporting someone.

Step 3  
**Group members take a turn in the middle**

Encourage group members to take a turn in the middle of the circle and be ‘supported’ by the rest of their group. Ask for the first volunteer to come into the middle and stand with their feet together, their arms folded across their chest, and hands on their shoulders. The facilitator now moves to being one of the supporters.

The group members get into their support positions, starting with their hands very close to the person in the middle. Remind everyone to keep their knees bent and body loose to act as a ‘shock absorber’ for the person leaning.

Before starting to lean, the person in the middle should ask the check-in question: ‘Are my supporters ready?’
When all the group members in the circle have their arms up in the ready position and reply ‘Yes’ the person in the middle can say: ‘Leaning now’ and then start leaning.

Encourage the person in the middle to close their eyes as they lean. Encourage several people to take a turn in the middle, but only if they want to – do not pressure them to do this.

**Step 4 Facilitate a discussion with the whole group**

- **What did it feel like to be in the middle and be supported?**
  Look for answers like safe, supported and comfortable.

- **Who are the people in your life that act as “supporters” for you?**
  Possible responses include: friends, husband/wife, other family members, neighbours, fellow church members and religious leaders.

- **What did it feel like to be one of the supporters?**

- **Who are the people in your life that you support? In what ways do you support them (including your husband/wife)?**

**Step 5 Demonstrate how it feels when support is withdrawn**

Invite one group to join you to do the activity again and make a circle where everyone else can observe. Ask for a volunteer to stand in the middle and ask the ‘check-in’ question. Then stop the activity, explaining that you are going to make some changes.

- Tell two or three of the supporters to put their hands down and hold them behind their backs.
- Tell two or three other supporters to take a big step backwards.
- Tell two or three other supporters to leave the circle and return to their seats.

Ask: The person standing in the middle:

- **Are you happy to continue with the activity now and start leaning, with only a couple of people left who are still ready to support you? They will undoubtedly refuse.**

- **Why are you refusing?**

- **How do you feel?**

Ask: All participants:

*Is this what can happen when people find out that a family member, friend, church or work colleague is living with HIV?*

- **Some people no longer offer support.**
  (Point to the people with their hands behind their backs).

- **Some people distance themselves from the person living with HIV.**
  (Point to those who took a step back).

- **Some people may reject that person and break off contact with them.**
  (Point to those who have left the circle and sat down).
Explain that these are all examples of external stigma – treating someone else differently or unfairly because of a label such as HIV-positive that has been attached to them.

**Step 6** Discussion: How can we better support those living with HIV?

Ask/discuss:
- What are some of the reasons that people reject, judge, avoid and victimize those living with HIV?
- If you found out that you are living with HIV, would you feel comfortable telling others in your church and seeking support from them? If not, why not?
- Would your family members, friends and fellow worshippers feel comfortable telling you that they are living with HIV? If not, why not?
- What needs to be changed? What can we do, both individually and as a church, to be more welcoming and supportive of people living with HIV?

**Step 7** Put good support into practice

Say: We do not want the person in the middle to be left feeling unsupported. So can the group who withdrew support come together and this time provide really good support for the person in the middle?

**Step 8** Explain self-stigma and that we do not have to accept the stigmatising attitudes of others

Ask: Do the stigmatising actions of the supporters change the person in the middle?

Explain: It probably will affect how the person in the middle feels, but it does not have to. The actions of the supporters will only affect the person in the middle if he or she accepts the stigmatising attitudes of the supporters. This is called self-stigma or internal stigma.

There will be no self-stigma if their response is something like: “I’m still a good person, wonderfully created and loved by God, whether or not I have some HIV in my body. If that is your attitude to me then that is your problem, not mine.”

**Step 9** Stigma and the Lost Son

Get participants to read Luke 15:11-32.

Jesus’ parable of the lost son gives examples of stigma, self-stigma and acceptance without stigma.

Ask: Who in this story demonstrates self-stigma?

Explain: The younger son returns saying, ‘Father, I have sinned against heaven and against you. I am no longer worthy to be called your son.’ If he keeps saying to himself things like, ‘I am worthless’ this creates self-stigma. He needs to accept the forgiveness of his father and that he is wonderfully created and loved by the Father, despite the sins he has committed.
Think to yourself: Do you have self-stigma because of things you have done or said or that have happened in the past? Or do you accept that you are wonderfully created in the image of God, who loves and cares deeply for us and will forgive when we repent?

Ask: Who in this story stigmatises another person?

Explain: It is the older son, who refuses to go in to greet his younger brother.

Ask: Who is accepting without stigma?

Explain: The father, despite knowing that his younger son had squandered his wealth in wild living, including with prostitutes, had compassion and welcomes him back. He does not even wait for his son to reach the door – he runs to him, throws his arms round him and kisses him.

Ask: Who are we like, individually and as a church, toward people we know or suspect may be living with HIV, in the way we judge their sexual behaviour? Are we like the elder son or are we like the father? How can we be more like the father?

Step 10 The Good Samaritan

Either read the story of the Good Samaritan in Luke 10: 25-37 or summarise the story if your participants know it well.

Remind the group that in Jesus’ time, the Samaritans were despised and outcast by the Jews. They were thought of as sinners because of their origins. In this story we see someone who is rejected by society being the very person to help another human in need.

Ask: Are there examples of this in our own community?

Encourage participants to reflect:

Ask:
- Would you be prepared to do what the Samaritan did, or would you prefer to pass on the other side of the road?
- Think of one thing you could do in the next week as a Good Samaritan.

Step 11 Close in prayer

Close the meeting with a prayer, praying for wisdom and courage to put into practice ourselves the approach shown by the Good Samaritan and also by the father in Jesus’ parable of the Lost Son.
Activity

11 Pregnant and positive drama

Why do this activity?

– For men to build skills and strategies for being supportive and addressing the issues raised when their pregnant wife or partner shares that she is HIV-positive.
– To encourage disclosure of HIV status to your partner.
– To develop skills and strategies for addressing other relationship issues which affect parent-to-child transmission and prevention.

Summary

The facilitator presents a short play in which a pregnant woman tells her husband that she has tested HIV-positive. The actor playing the man reacts in a way which clearly shows that he is unable to support his wife or deal with the issues. The actors perform their play once through to the end. They then act it again, but this time the audience is invited to interrupt the play and make suggestions for what the man could do or say differently. The play then continues using these suggestions.

Time

30–40 minutes

Materials

– Two ‘actors’ (either participants or co-facilitators), preferably one man and one woman.
– The laminated card drawings of a man and a pregnant woman.
– Two lanyards (cords with a crocodile clip).

How to prepare

Before the start of the session ask two people (either participants or co-facilitators) to be the two actors. Brief them about how this activity works:

– One will play a pregnant woman who is upset and worried, having recently got a positive result from an HIV test. She tells her husband (the other actor) about the test result.
– The husband should react in a way that is very unsupportive of his wife, and clearly shows that he is not willing to get tested himself or able to address the issues raised. He should say and do things which are very clearly wrong, unhelpful or inappropriate.

If possible, watch them as they practise, to make sure they are doing it as you want it. Make sure the man does and says things that your audience will definitely think are wrong. The play should be short – it should have only one scene and last between 1–3 minutes.

Explain to them that the second time, they must act the play exactly the same until someone from the audience stops the play and will be invited to take the place of the man. Brief the ‘wife’ to be quite upset about her test result, so that other ‘husbands’ (from the audience) are challenged to support her and gently introduce ideas around positive living. She should also tell her husband that he should get tested and that she has been told they should use condoms (but she hates condoms as she thinks they are sinful and give no pleasure). This again challenges the ‘husband’ to convince her that they should use condoms together, giving positive reasons.
How to run this activity

Step 1  Outline the scenario

Say: Imagine this situation: You are a man. Your wife is pregnant. She goes to the antenatal clinic. When she returns home, she tells you that she had a test for HIV and it was positive.

Ask:  
- What would you do? What would you say?
- What is a common response amongst men in your community?

Facilitate brief discussion around the responses.

Step 2  Perform the play the first time

Introduce the short play that your actors are going to perform. Put the lanyards with the cards of the pregnant woman and the man round the necks of the actors.

The actors perform the short play for the first time straight through to its end.

When it is finished, encourage the audience to applaud.

Ask:  
- What did you think of the way the man behaved?
- What should the man say or do differently?

Step 3  Act the play again, with audience involvement to change the outcome

Say: The play will run again, starting off exactly the same, but you (the audience) can get involved with changing what the man does and says so he will be more supportive and will maintain a good relationship with his wife. As soon as the man does or says something that you think is wrong or unsupportive of his wife, put your hand up and say “Stop!” to stop the play.

As soon as a member of the audience lifts a hand or says “Stop!”, clap your hands and say “Cut!” Ask those who stopped the play why they have done so, and what suggestions they have for how the man can change what he says or does in order to improve the outcome.

Invite them to come and take over the role of the man, and demonstrate what the man should say and do differently, to support his wife better and address the issues he now faces around testing himself and using condoms. Transfer the lanyard with the laminated card of the man from the original ‘husband’ to the new ‘husband’.

Ask the actors to rewind the scene a little and do it again. Once again, invite the audience to put a hand up and say “Stop!” to stop the play if they think the new person playing the man could improve what they are saying or doing. If others (either men or women) stop the play with such suggestions, get them also to take over the husband’s role and demonstrate what they mean. This can continue, trying out different suggestions and developing and changing the play several times until it has a better, but still realistic ending.
Step 4  Identify what strategies are working well

Ask:
- What have we learnt from this activity?
- What are the strategies that worked well in this situation?
- How would these strategies help to prevent parent-to-child transmission?

Step 5  Practise in pairs

Split participants into pairs.

Explain:  This is your chance to try out some of the ideas you have developed. Follow these steps:

- Act the play again, with one person taking the role of the person disclosing their HIV-positive test result. The other person acts as their husband/wife, doing the best they can to address the issue in a good way.

- When they finish, the person who discloses their status should give feedback to the other person, telling them what they did well, with suggestions for how they could improve what they do or say.

- Swap roles and repeat the previous two steps.
SECTION D

Understanding prevention of parent-to-child transmission (PPTCT)

Activity

12 PPTCT during pregnancy and birth

Why do this activity?

– To explain how to minimize the risk of transmitting HIV to your baby during pregnancy and birth.
– To clarify why it is so important to avoid HIV infection or re-infection during pregnancy.
– To clarify why, without treatment, there can be a significant risk of HIV transmission to the baby during birth.
– To explain how using ARVs can dramatically reduce the risk of HIV transmission to the baby during pregnancy and birth.
– To show that if a pregnant woman knows her HIV status she and her partner can do various things to look after her health and prevent HIV transmission to their child.

Summary

This activity uses a short drama sketch involving participants to act different parts and things inside a pregnant woman. It demonstrates and explains in a memorable way about the risks of mother-to-child transmission during pregnancy and birth and how to minimize these risks. The drama sketch involves demonstrating and discussing what happens in four scenes:

Scene 1: Pregnancy
Scene 2: HIV Infection or re-infection during pregnancy
Scene 3: Birth without treatment
Scene 4: Pregnancy and birth with treatment

Time

20–30 minutes

Materials

– About 12-15 co-facilitators or participants to play various roles in the drama
– The laminated card drawing of a pregnant woman.
– The HIV and ARV mask:

[Image of masks]

– String, tape, or chalk to make the birth canal for the baby (optional)

How to prepare

– If your audience is literate, make copies of Handout 5: Preventing parent-to-child transmission to give to them at the end of the session.
– Find out what your country’s policy is on PPTCT (or PMTCT). This varies between countries.
– Read the notes on how to involve and mobilise male partners on pages 66–67 and think how you can best apply these ideas and suggestions in your situation.
How to run this activity

Step 1  Reflect on the miracle of creation

Ask someone to read out Psalm 139: verses 1, 13–16. Comment that mothers among the participants will never ever forget the pains and the joys of childbirth (Isaiah 49:15).

Thank God for the miracle of a child developing from conception to birth in their mother’s womb. Pray that what we learn today will increase our knowledge of the risks of HIV transmission to babies, and what both men and women can do to prevent this happening to their baby.

Step 2  Explain how HIV can be transmitted from parents to their child

Show participants the card of the pregnant woman.

Ask:  If this pregnant woman is living with HIV, does it mean that her baby will also have HIV?

Answer:  Not necessarily. In fact, even without treatment, the child is more likely to be HIV-negative than HIV-positive.

Ask:  If there are 10 pregnant women, all living with HIV, in how many of these 10 cases is HIV likely to transmit to the baby?

Once someone has answered.

Explain:  Without treatment, normally 3–4 out of the 10 women will have babies infected with HIV. The other 6–7 babies will be HIV-negative. With appropriate knowledge, treatment and care, involving the mother and father, the risk can be reduced much further so that only one or none of the 10 babies will be infected.

There are three stages where there is a risk of parent-to-child transmission of HIV: during pregnancy, childbirth and infant feeding. The risk of HIV transmission to the baby at each stage can be dramatically reduced if both the father and the mother (and other family members and friends) understand and take action to safeguard the health of the child.

This activity focuses on preventing the transmission of HIV during pregnancy and birth. The next activity will address issues around breastfeeding and infant feeding options.

Step 3  The drama sketch

Either read what is written or use your own words and a language that participants are comfortable with. As you do so, ensure that the actors demonstrate what you are saying. Stop briefly between each scene so that the different stages are clear.
Scene 1: Pregnancy

Say: Imagine that this training area represents the body of a woman who is living with HIV. We need you to play the roles of different things inside her body. The woman is pregnant, and she is carrying inside her a small baby or foetus. Can I have a volunteer to be the Baby?

Get the person volunteering to come into the middle of the room and sit or crouch down in the fetal position or sit on a chair.

Ask: Can I have about 8 to 10 more volunteers to protect the foetus by making a circle around it?

Get about 8 to 10 more participants to form a tight circle around the Baby, holding hands or with arms linked.

Explain: Those now surrounding the Baby represent things that protect the baby, including the strong uterus wall, a protective bag called the amniotic sack and the placenta. The placenta is like a tea bag – it lets the important substances through to the baby from the mother, like food and nutrients to help the baby develop, but it holds back HIV and other infections (like the tea leaves!) In most cases the placenta stops HIV from the mother entering the baby. However, if the mother is very sick, it is easier for the placenta to tear and a leak to occur. This can also occur if the mother has an accident and her placenta is damaged.

When a child is conceived it always starts off HIV-negative, even if one or both of the parents are living with HIV. HIV cannot get inside the eggs of a woman who is living with HIV. The semen from a man who is living with HIV contains both sperms and HIV particles, but the HIV cannot get inside the sperms.

Get someone (a co-facilitator or participant) to play the role of HIV. Give them the HIV mask to wear.

Tell HIV to try to push through the protective uterus wall to touch the Baby. Get those forming the protective wall to stand close together and prevent HIV getting through and touching the baby.

Explain: HIV tries to touch and infect the Baby, but it is difficult for HIV to get through the protection around the baby. If the woman is healthy, her strong immune system keeps the virus under control, so there are not many HIV particles in her body. The baby has its own blood and heart, separate from the mother, and in this situation the risk of HIV passing from the mother to her baby during pregnancy is low.
Scene 2: Infection or re-infection with HIV during pregnancy

Explain: If the pregnant woman has unprotected sex and gets infected with HIV or re-infected with another strain of HIV, lots more HIV particles will develop in her body. This greatly increases the risk that HIV will infect the baby.

Get three more participants to be HIV with ‘horns’ (hands to their forehead, forefingers pointing forward) so there are now four of them trying to get through the Uterus and touch the Baby (as shown here.) They will probably now succeed.

Say: As you can see, it is very important that a pregnant woman avoids getting infected or re-infected with HIV. How can she do this?

The answer should be: either abstain from sex or use a condom correctly each time.

Say: Let’s imagine that this woman and her husband or partner have gone to the medical centre, had an HIV test and she knows that she is living with HIV. During her pregnancy she and her husband have either abstained from sex or have used a condom each time. She has not been re-infected and the amount of virus in her body has remained low, minimising the risk of transmission to her unborn baby.

Get the three extra people playing HIV to return to being part of the audience, leaving just the original person with the mask playing HIV.

Scene 3: Birth without treatment

Lay down the two sticks or branches or pieces of string to represent the vagina / birth canal for the Baby.

Explain: During birth, the baby has to leave the protective safety of the uterus and pass through the tight channel of the vagina, represented by the gap. The muscles around the uterus contract and push the baby out. With the bleeding that normally occurs, if HIV is not controlled, there are significant risks of HIV from the mother finding a way to enter the baby.

Get the Uterus to ‘contract’ and push the Baby out through this channel. HIV waits by the gap representing the vagina and touches the Baby as it passes through to be born.

Explain: HIV transmission is more likely to occur if there are problems with the delivery, such as prolonged labour. The baby’s skin is easily damaged in prolonged labour and the baby can more easily be infected by blood from the mother. It is therefore vital that mothers living with HIV deliver in a health facility with professionally trained staff and equipment present.
Scene 4: Pregnancy and birth with treatment

Get the Baby to return to being inside the Uterus.

Say: Now let’s go back to the woman being pregnant. However, this time the woman has tested and knows that she is living with HIV. She has learnt how she can reduce the risk of transmitting HIV to her baby.

During pregnancy and when her labour starts, she takes particular types of antiretroviral drugs (ARVs). These ARVs attack and hold HIV, preventing it from touching and infecting the Baby during the pregnancy and in particular during the birth process.

Get another participant to be ARV. Get ARV to hold HIV or to stand in its way, so that HIV cannot touch the Baby in the Uterus or during birth, as it comes out through the vagina as shown here:

When the Baby has been born, explain that the woman is still living with HIV, but her baby has been born with minimal risk of HIV infection.

The Baby should now be outside the area representing the body of the woman.

Explain: In case a little HIV has still managed to get into the baby during birth, the baby is given some ARVs (eg Nevirapine syrup within 3 days of birth) to prevent the HIV taking hold and developing.

Get ARV to go and brush down the newborn Baby.

Step 4  Review the drama

When the drama is complete, thank all the actors and get everyone to applaud.

Ask: Are there are any questions about the drama and the issues it raises?

Explain: HIV transmission is more likely to occur if there are problems with the delivery, such as prolonged labour. The baby’s skin is easily damaged in prolonged labour and the baby can more easily be infected by blood from the mother. It is therefore vital that mothers living with HIV take the ARVs as prescribed and deliver in a health facility with professionally trained staff and equipment present.

To check whether the baby has remained HIV-negative, a special test call a polymerase chain reaction test may be used when the baby is 6–12 weeks old. This looks for HIV in the baby’s body. The HIV-antibody tests normally used for babies are not reliable until the baby is 18 months old.

If participants are literate, give them a copy of Handout 5: Preventing parent-to-child transmission.
How likely is it that the child of an HIV-positive pregnant woman will also be HIV-positive?

It is possible for HIV to pass from an HIV-positive mother to her child during pregnancy, during childbirth or through breast-feeding.

Without any treatment at all, the chance of transmitting HIV from mother to child is roughly 35 per cent. In other words, for every 100 HIV-positive pregnant women, on average only 35 will have a baby who is HIV-positive and 65 will prove to be HIV-negative. With care and treatment involving both parents, this risk can be almost eliminated.

It is better to talk about prevention of PPTCT rather than prevention of mother-to-child transmission to make it clear that fathers should be involved too and can play a key role in preventing HIV transmission to their baby.

Primary PPTCT

This is about ensuring that prospective parents remain HIV-negative and encouraging parents who are living with HIV to go for further counselling on PPTCT at government clinics in coordination with community health volunteers.

Secondary PPTCT

This is about what to do when the mother or both parents are already living with HIV and she becomes pregnant.

There are various ways of reducing the risk of HIV passing from mother to child, once the mother knows that she is living with HIV. That is why it is very important for a pregnant woman (and her husband) to get tested for HIV. This is normally offered as part of their antenatal care.

Women who become infected or re-infected with HIV while they are pregnant or breastfeeding have a greater risk of passing HIV to their babies than women who were infected with HIV earlier. This is because there is more HIV virus in the body during the first three months after infection. It takes this time for the body to create antibodies to the virus, which control and reduce the amount of virus in the body. It is therefore very important for a woman who is pregnant or breastfeeding to avoid the risk of HIV infection or re-infection.

Using antiretroviral drugs during pregnancy, labour and while breast-feeding is one of the most effective ways of reducing the risk of HIV transmission.

How should an HIV-positive mother feed her infant?

The decision on whether an HIV-infected mother should breastfeed or use ‘replacement feeding’ (e.g. a breast-milk substitute) depends on various factors. Further advice can be sought from local healthcare professionals. Recommendations from the World Health Organisation on nutrition can be found within the sources in Appendix 5.
Why is male partner involvement important?

It is very important to mobilise and get male partners/husbands involved for various reasons including:

- risk of woman being negative at start of pregnancy and then being infected by a partner – the viral load is very high for up to three months following infection, which increases the risk of transmission
- the man is usually the main decision maker
- studies shows a 40 per cent reduction in HIV transmission to the baby when the male partner is involved

How to mobilise and get male partners more involved

This training programme gives guidance in particular for fathers/male partners on caring for their family’s health. But how does a facilitator encourage men to get involved in the first place?

The facilitator needs to explore what is appropriate for mobilising men in their particular settings. Some may be in rural areas; others are in cities. Some may work through a hospital or antenatal clinic, while others are not closely linked to a clinic. Some may already have outreach programmes set up for men, while others do not have these established networks.

Here are some suggestions for how to mobilise men:

For antenatal clinics:

- Require pregnant women to attend the first prenatal visit with their husbands. Give the woman an invitation to give to her husband. It is important for him to know that the invitation is an official invitation from the clinic and not just a request from his wife!
- Give men priority treatment when they attend the clinic. Remember that some may feel uncomfortable walking into what is normally seen as a woman’s territory.
- Offer home-based counselling and testing for men.
- Encouraging TB screening for men.
- Provide antiretroviral drugs (ARVs) for men who test HIV positive or, if this is not possible, provide a link to a clinic where ARVs are available.
- Ensure that male partners living with HIV are well supported to take their ARVs regularly.
- Ensure that the clinic keeps efficient, confidential records on rates of male partner HIV testing, rates of HIV positive tests among those tested and the number of men receiving ARV treatment.
- Assign staff and volunteers to work specifically with male partner involvement.
- Develop clear guidelines for advising HIV discordant couples (where one partner is HIV positive and the other is HIV negative).

For community settings:

- Offer training for men on the prevention of parent-to-child transmission in churches and other places of community gathering. Take initiative to think creatively about how to reach men in the places where they tend to gather.
– Introduce the training in a way that makes them feel inspired and interested. For example, say, ‘we are offering a course for men to support them in their important role as leaders in their homes. Would you like to come?’ Don’t say something that may sound judgmental or scolding, eg ‘men need to be more involved in the health of their families. It is important for you to learn how to do this so we are offering a course to help you with this.’

– Target faith leaders who are influential among men to encourage them in their role as husbands and fathers.

For any setting:

– Where possible, give men incentives (for example, T-shirts labelled 'Caring Dad') or a smaller gift to thank them for their involvement.

– Encourage women to support men in their roles by giving them love notes or preparing their favourite meal before speaking with them about their involvement with the family.

– Facilitate support groups led by men.

– Use text messages on mobile phone to send tips, reminders and encouraging words to groups of men.

– Encourage men to volunteer their time to provide counselling and support for other men.

– Offer training courses geared towards men on how to raise a child. Use humour and practical demonstrations to make it fun and playful. For example, involve men in key roles in the participatory training activities in this manual or ask a male volunteer to demonstrate how to feed a baby or change a diaper.

– Organise father and son/daughter activities that are only for men and their children.
Activity

13 Infant feeding options

Why do this activity?

– To provide basic information about infant feeding options if the mother is living with HIV.
– To encourage pregnant women who are living with HIV and their husbands/partners to seek professional counselling and advice about the best feeding option for their baby.
– To clarify that it is important to stick to either exclusive breastfeeding or exclusive formula feeding during the first six months.
– To emphasize the importance of taking antiretroviral drugs as prescribed while breastfeeding.

Summary

The different infant feeding options when the mother is living with HIV are discussed and a physical demonstration done to emphasise how important it is to avoid mixed feeding during the first six months.

Time

20–30 minutes

Materials

– The card character pictures of the pregnant woman, the woman carrying a baby on her back and the man.
– The HIV mask and the ARV mask.
– A glass or a clean, clear plastic bottle.
– A cup or mug.
– A small amount of fresh milk – about 20ml (about four tablespoons).
– Lemon or other acidic juice (eg a lemon/orange fizzy drink or the juice from one large lemon squeezed into the cup or mug). You need about the same amount of acidic juice as milk for this to work well, eg about 20ml – four tablespoons.

How to prepare

– Read Handout 5: Preventing parent to child transmission (PPTCT).
– Put four tablespoons of fresh milk in a clean, transparent clear plastic or glass bottle.
– Put four tablespoons of acidic juice in a cup or mug.

How to run this activity

Step 1 Introduce the activity

Explain: We have addressed issues of transmission during pregnancy and birth, and this activity will focus on the third mode of possible transmission – how to feed your infant baby in a way that will best ensure its health and minimise the risk of HIV transmission through breastfeeding.

It is important to discuss options and plan how to feed your baby during the pregnancy, before the baby is born and to get proper professional advice. It is also important for fathers (and if possible, close relatives) to be involved with such discussions, so that they fully understand and can support
the agreed feeding plan. They can also help ensure that the mother takes her antiretroviral drugs throughout the period of breastfeeding, to minimise the risk of HIV transmission.

**Step 2  Feeding a baby if the mother is HIV-negative – benefits of breastfeeding**

Show participants the card character of the pregnant woman. Get participants to give her a name, eg Tendai.

**Ask:** *If, when Tendai goes for HIV testing and counselling, she finds that she is HIV-negative, what is the best way for her to feed her baby?*

Listen to the responses, then explain and emphasize the benefits of breastfeeding:

**Explain:** *Breast milk is the perfect food for babies. It provides effectively all the nutrients, vitamins and minerals that an infant needs to grow and develop and it also helps to build the baby’s immune system. If Tendai knows for sure that she is HIV-negative, and remains HIV-negative, exclusive breastfeeding for the first six months and complementary feeding from six months to 24 months or beyond is the best option for the health of her child.*

**Step 3  Options for feeding a baby if the mother is HIV-positive**

Show participants the card characters of the woman carrying a baby and the man. Get participants to give them a name, eg Patience and Chuma.

**Explain:** *Chuma and Patience went together to the clinic when she was pregnant and both tested HIV-positive. They are both healthy and they love and support each other. They took the advice and antiretroviral drugs provided by the clinic during the pregnancy and their baby was born HIV-negative. How do you think they should feed their baby?*

Listen to the responses, which will tell you how much the audience knows about the subject.

**Main feeding options if the mother is living with HIV (as recommended by the World Health Organisation):**

- **Either 1:** Exclusive breastfeeding for the first six months, then continue breastfeeding with other foods up to 12 months
  
  For the first six months, the mother gives her infant only breast milk and the child receives no other food or drink – not even water. The only exception is medicine prescribed at the health facility.
  
  From six up to 12 months, continue breastfeeding, but introduce other age-appropriate foods as well. Breast milk is still very important at this stage for the child’s development and for preventing other illnesses.
Breastfeeding should only stop once a healthy balanced diet without breast milk can be provided.

- **Or 2: Replacement feeding from birth**

Avoid breastfeeding altogether and stick to exclusive formula feeding for up to six months, then introduce other age-appropriate foods.

As Patience is living with HIV, there will be some HIV in her breast milk, and breastfeeding will have a small risk of infecting her baby. If she is healthy and taking antiretroviral drugs as prescribed, the risk of transmitting HIV to her baby is extremely low – almost zero.

Exclusive formula feeding is for many hard to maintain and expensive, and if not done properly and consistently, can result in the child getting ill or dying. Exclusive breastfeeding also has many benefits and in most cases is still the best option for the health of the baby.

With professional advice and counselling, Chuma and Patience should have chosen the option most suitable to their situation before their baby was born. It is very important for Chuma to go with Patience to learn about and discuss their options, so that he understands and agrees with the choice, and he can then support Patience in ensuring they put into practice what is best for the healthy development of their baby.

### Step 4  Demonstrate the dangers of mixed feeding during the first six months

**Explain:** *Whichever option Patience and Chuma choose, it is vital that they stick to their choice – either exclusive breastfeeding for the first six months, or exclusive formula feeding. If the baby gets a mixture of breast milk and other food and drink during the first six months, this creates a much higher risk of HIV infection. I will now demonstrate this.*

Show participants the glass or bottle with some fresh milk in it. Say that this is breast milk. Tip the glass or bottle slightly to one side and then back to upright again, so that the milk runs down one side.

**Say:** *See how the milk is smooth and covers the inside of the glass/bottle with an even layer. That is what happens in the stomach of the baby. The milk creates a smooth fatty layer lining the inside of the baby’s stomach, which helps prevent any HIV entering the baby’s bloodstream.*

Now let’s see what happens when we add and mix in the liquid from this cup, which represents baby formula milk or any other food or drink.

Pour the lemon or other acidic juice from the cup into the glass/bottle with the milk. Within a few seconds it should curdle and go lumpy.

Again, tip the glass/bottle to one side and back again. This time it should leave a lumpy pattern on the side of the glass. Take the glass/bottle round so that participants can see.

*This is an example of what can happen when you feed a baby a mixture of breast milk and baby formula milk or other food and drink. This food or drink destroys the fatty protective layer lining*
the inside of the baby’s stomach. It leaves holes through which the HIV from the breast milk can now quite easily enter into the bloodstream of the baby.

Whether exclusive breastfeeding or exclusive formula feeding, it is therefore vital for a mother who is living with HIV to stick to one option or the other for the first six months.

Step 5  
Explain and demonstrate the importance of taking antiretroviral drugs (ARVs) properly for minimizing the risk of transmitting HIV through breastfeeding

Ask for three volunteers. Give one the HIV mask, another the ARV mask and ask the third to pretend to be a breastfeeding Baby.

Tell HIV to stand in the middle of the training area. Say that the training area represents Patience’s breast, and as she is living with HIV there is a small amount of HIV in her breast milk.

Tell the person playing the Baby to stand at one side of the training area and that they represent a baby who is sucking at a breast.

Say:  The HIV is being drawn very slowly with the breast milk towards the baby.

Get HIV to move very slowly towards the Baby.

Say:  Now let’s see what happens if the mothers takes ARVs as instructed.

Get ARV to hold and suppress HIV, so HIV cannot move.

Explain:  As demonstrated in the previous activity on preventing HIV transmission during pregnancy and birth, if the mother takes ARVs as prescribed, they suppress HIV and normally prevent HIV from infecting the baby. The same applies during breastfeeding. If Patience is living with HIV and takes the ARVs as instructed, the amount of active HIV in her blood and in her breast milk will normally be so low that there is virtually no risk of it passing to her baby. ARV syrup may also be given to the breastfeeding baby.

Ask:  What might happen if Patience forgets to take her ARVs for a few days?

Get ARV to let go of HIV and move away. Tell HIV to stand up, look strong again and change their face mask around so the other side of the mask is facing out.

Explain:  Failing to take the ARVs every day may result in the HIV getting stronger and changing its form (mutating) so that the ARVs may not work anymore, and the baby is more likely to become infected with HIV. It is vital for both the mother and baby to take ARVs exactly as instructed.

Thank the three actors and get them to sit down.

NOTE: If you want to highlight and demonstrate further the importance of adherence to ARVs, do Activity 9: What happens in the body.
Explain: *The World Health Organisation recommends that all pregnant and breastfeeding women who are living with HIV should take ARVs, either permanently for the rest of their life or at least from week 14 of the pregnancy until a week after they have stopped breastfeeding their baby.*

**Step 6** Summarize and recommend infant feeding counselling

Emphasize: *All pregnant women and their husbands are advised to get tested to find out their HIV status. If HIV-positive, they should seek professional advice and counselling during the pregnancy about options for feeding their baby, and for getting antiretroviral drugs (ARVs) to reduce the risk of transmitting HIV to the baby while breastfeeding.*

*It is strongly recommended that the husband/father gets involved and attends the infant feeding counselling as his support is vital.*

**Key messages**

- Use either exclusive breastfeeding or exclusive formula feeding for the first six months.
- Get proper counselling and advice from a medical centre on how best to feed your baby, depending on your situation.
- Take any ARVs as prescribed, as these can reduce the risk of HIV transmission to the baby.
- The father of the child should get involved and understand the issues too.

**Recommendations on infant feeding from the World Health Organisation**

1 **Ensuring mothers receive the care they need**

Mothers known to be HIV-infected should be provided with lifelong antiretroviral therapy or antiretroviral prophylaxis interventions to reduce HIV transmission through breastfeeding.

2 **Which breastfeeding practices and for how long**

Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first six months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life.

Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.

3 **When mothers decide to stop breastfeeding**

Mothers known to be HIV-infected who decide to stop breastfeeding at any time should stop gradually within one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped.
Stopping breastfeeding abruptly is not advisable.

### 4 What to feed infants when mothers stop breastfeeding

When mothers known to be HIV-infected decide to stop breastfeeding at any time, infants should be provided with safe and adequate replacement feeds to enable normal growth and development.

**Alternatives to breastfeeding**

- For infants less than six months of age:
  - Commercial infant formula milk as long as home conditions outlined in recommendation section five below are fulfilled.
  - Expressed, heat-treated breast milk.
  - Home-modified animal milk is not recommended as a replacement food in the first six months of life.

- For children over six months of age:
  - Commercial infant formula milk as long as home conditions outlined in section 5 are fulfilled.
  - Animal milk (boiled for infants under 12 months), as part of a diet providing adequate micronutrient intake. Meals, including milk-only feeds, other foods and combination of milk feeds and other foods, should be provided four or five times per day.
  - All children need complementary foods from six months of age.

### 5 Conditions needed to safely formula feed

Mothers known to be HIV-infected should only give commercial infant formula milk as a replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status, when all the following conditions are met:

- safe water and sanitation are assured at the household level and in the community.
- the mother or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant.
- the mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition.
- the mother or caregiver can, in the first six months, exclusively give infant formula milk.
- the family is supportive of this practice.
- the mother or caregiver can access health care that offers comprehensive child health services.

These descriptions are intended to give simpler and more explicit meaning to the concepts represented by AFASS (acceptable, feasible, affordable, sustainable and safe).

### 6 When the infant is HIV-infected

If infants and young children are known to be HIV-infected, mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, which is up to two years or beyond.
Building skills and strategies to support the prevention of parent-to-child transmission (PPTCT)

Activity 14 The *Umbrella* story

Why do this activity?

Clarify that using condoms can be consistent with applying Christian principles and teachings around loving others and caring responsibly for your own health and the health of others.

Summary

A story called Umbrellas is told, about a chief with three sons and their issues with using umbrellas. Umbrella is a metaphor for condoms and the story explores attitudes and moral issues that Christians and others face around using condoms. The story has four parts, with notes and discussion questions after each section.

Time

45–60 minutes

Materials

An umbrella to illustrate the story as you tell it (optional).

How to prepare

Read the story yourself. Think about whether you will read out the story, or whether you will tell it in your own words. Could you adapt elements of the story to make it more relevant to your audience? (eg use local names for the three sons). Would it be better to translate it into another language for your audience?

If used at a church meeting, ask the pastor or a church leader if they are willing to read the story and facilitate this activity.

How to run this activity

Step 1 Introduce the activity

Welcome everyone. Invite participants to relax and listen to a story called *Umbrellas*. Explain that the story is in four parts, with a break between each part for discussion. Do not tell participants that the story is about condom use.
Step 2  Read Part 1 of the story Umbrellas

Either read out Part 1 of the story Umbrellas or tell it in your own way using the language that your participants are most comfortable with.

There was once a village chief, who lived with his wife and three sons, Juma, Yoma and Kwesi. They lived on top of a small hill overlooking the village and the river. The rainy season had just started and it was raining hard every day.

The chief was a good, righteous man, committed to the welfare and good morals of his family and the people in his village. One of the traditional moral teachings he taught was that people should stay at home if it rains and should not go outside.

Many people followed this teaching, but others did not and often went out in the rain. Some did this simply because they enjoyed the sensations and experience of walking in the rain, while others went out in the rain because they wanted to carry on their business and earn some money. Some young people did it because their friends pressured them and said it was “cool” to go out in the rain. Sometimes those who got wet and cold in the rain became infected with influenza and developed fevers. Some died as a result.

A traveller entered the village one day, selling umbrellas. The villagers had never seen an umbrella before and some of them were suspicious, including the chief.

“Umbrellas are not natural,” he declared at the next village meeting. “They are not part of our culture and beliefs. Our beliefs and traditional teachings say that it is immoral to go out in the rain. People should just stay at home if it is raining, so umbrellas should not be necessary and no-one should use them.”

“What if our house leaks?” asked a young married couple. “Can we not use umbrellas within our own house to stop us both getting wet?”

“I suppose that would be OK,” acknowledged the chief, “provided you use them only for the two of you together.”

Despite what the chief said, the traveller went to the far end of the village and talked to those who were interested in umbrellas. He demonstrated how to use an umbrella properly, without breaking it, so that it would protect them from the rain. Several of the villagers, both men and women, bought umbrellas and often used them when they went out in the rain, to avoid getting wet and cold and catching a fever. Some couples also bought umbrellas and used them to prevent the fever spreading within their homes, because the roofs of their houses leaked.

The chief’s sons Juma and Yoma also bought umbrellas, but did not tell their parents because they knew their parents would disapprove.

Step 3  Questions and discussion about Part 1

Facilitate brief discussion about the meaning of the story, using the following questions to prompt discussion:

Ask:

- What do you think of this story so far?
- If we think of this story as a sort of parable, what might the following represent?
– The Chief? (answer: the church / church leaders).
– Going out in the rain? (answer: having sex outside marriage).
– Using an umbrella? (answer: using a condom).
– Using an umbrella in the rain? (answer: having sex with a condom outside marriage.
  The fact that it is outside marriage makes this unlawful sex in terms of God’s law, but
  at least it is safe and responsible and protects you and others from HIV, other sexually-
  transmitted diseases and unintended pregnancy).
– In the rain without an umbrella? (answer: having unprotected, unsafe sex outside
  marriage, which puts yourself and others at risk of HIV infection or unwanted pregnancy).
– Using an umbrella within your own house in case the roof leaks? (answer: using a condom
  with your husband or wife, eg lawful sex which also protects against the risk of HIV
  infection or re-infection if one or both of you are living with HIV, or you do not both
  know for sure that you are both HIV-negative. It can also be for family planning).

If participants have not yet worked out what the story might mean, do not tell them, but say
that it will become clearer after they hear part 2.

Step 4  Read Part 2 of the story Umbrellas

Read part 2 of the story Umbrellas or tell it in your own words.

The rain continued, day after day, and the river rose.

The chief’s three sons soon became bored by sitting at their home on top of the hill, waiting for
the rain to stop.

“Let’s go out and enjoy ourselves with our friends in the village,” said Juma the oldest brother.

“But father says we must stay in while it is raining” replied Yoma, the middle brother.

“Then we will take our umbrellas,” said Juma.

“But father says we must not use umbrellas. If we did that, we would be doing two things wrong,
go out in the rain and using umbrellas,” said Yoma.

“OK, let’s stick to doing just one thing wrong and go out without the umbrellas,” said Juma.

“I’m not going to risk it. I’m staying at home,” said Kwesi, the youngest brother.

“You wimp, you sissy,” said Juma. “We are off, and we are leaving the umbrellas here. Umbrellas
are just for wimps like you anyway. I am too cool and tough for that.”

That evening it was cold and the rain was an intense as ever. Juma and Yoma struggled to climb
the small hill back up to their house. They arrived, tired and shivering. Juma developed a fever
that night, from which he seemed to recover, but it never fully left him.

Later that year Juma married a beautiful young woman called Patience.

Patience suggested to Juma that they should check the roof of their new house for leaks before
sleeping there. He refused. Patience then suggested putting a large umbrella over their bed until
they had tested the roof emphasising that as the chief had said, there is nothing wrong with using an umbrella within your own house.

But Juma responded angrily, saying, “trust me, the roof will not leak. I will not use an umbrella in my own house.”

When a storm broke that night, water poured through the roof onto Patience as she lay in bed, and she also contracted the same fever that Juma had, though she did not realise it.

Juma’s wife soon became pregnant and when she gave birth to a son, there was great celebration in the village. However, the celebration was short-lived, as the baby boy soon became sick with the same fever and died. Juma’s health also became worse and after a few months fighting the fever, he also died, leaving Patience also sick with the fever. The chief and his two younger brothers, Yoma and Kwesi, were all stricken with grief.

When going through Juma’s possessions, the chief found in the bottom of a drawer an umbrella covered with dust. When they shook the dust off and opened it, the umbrella looked brand new. It had clearly never been used. The chief asked Yoma: “what was Juma doing with this? If he had an umbrella, why did he not use it when he went out in the rain?”

“Father, you banned us from using umbrellas, so we did not take them when we went out in the rain,” replied Yoma.

The chief felt even sadder. “What have I done?” he cried. “I banned my sons from using the one thing that could have prevented Juma’s death and through him the death of my only grandchild. If only I had allowed and encouraged him to use an umbrella.”

Step 5 Questions and discussion about Part 2

Facilitate discussion about the meaning of the story, using the following questions to prompt discussion.

Ask:
- What do you think of the behaviour of the three sons, Juma, Yoma and Kwesi?
- What do you think about what the chief said and did?

Step 6 Read Part 3 of the story Umbrellas

Read part 3 of the story Umbrellas or tell it in your own words.

The following day the chief set off early to travel to the capital. This was unusual and there was much discussion in the village as to why he had travelled there.

When the chief returned a few days later, he summoned a meeting of the whole village. He stood up and addressed the people:

“I am going to talk to you today about living long and healthy lives. I want you to stay healthy and fulfil your dreams in life.

It is your choice what you do in your life. I can only make recommendations. The choice is yours.
When it rains, the best thing you can do is to stay within your own home. That is the best way according to our beliefs and for those who follow this way there are blessings in this life and beyond.

If your roof has leaked or you have not tested to check that your roof is watertight, you may need to use an umbrella within your own house.

I know that many of you from time to time choose not to follow this righteous way and you are tempted out into the rain. I also know that, whatever I say as your chief, some people will continue to go out and play in the rain, whether or not they have umbrellas.

Indeed, in my own youth I sometimes chose to go and play in the rain, even though my parents told me not to.”

There was a slight gasp at this confession from their chief, but also a sense of admiration for his honesty. The chief took a large, colourful umbrella from his bag. There was another big gasp.

The chief continued:

“To those who even occasionally go out in the rain, I say this: If you go outside when there is a possibility of rain, you must take an umbrella with you and use it if you need to, to protect yourself and others. You must also know how to use it properly.”

“Chief!” interrupted an old woman, “you must not encourage our young people to use these things – it is promoting immorality.”

“I am telling you about umbrellas,” he said, “not because I like umbrellas, not because I believe they are necessarily the best way or because I want to promote them, but because I love you my children and the people of my village and I want you to live healthy and long lives.

Furthermore, there are some cases where a married couple has a leaking roof and the fever is already within their house; in that case, using an umbrella is very important for them when they are inside their own house. I want you to avoid the fate of my eldest son and my only grandson. If Juma had used umbrellas, they would still be alive.”

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**Step 7 Questions and discussion about Part 3**

Facilitate discussion about the meaning of part 3 of the story, using the following questions to prompt discussion:

Ask:
- What do you think of the actions of the chief in part 3?
- What messages does the chief give his people?
- What do these messages mean in terms of condom use?

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**Step 8 Read Part 4 of the story Umbrellas**

Read part 4 of the story Umbrellas or tell it in your own words.

After the chief had spoken, the mutterings in the crowd died down.
“I have noticed” said a young man “that whenever the umbrellas are up, it is raining. Since the umbrellas arrived in our village, we have had a lot of rain. Therefore these umbrellas must be causing the rain.”

Some people laughed at this idea, and the chief explained gently:

“Umbrellas do not actually cause rain, nor do they make people go out in the rain. The desire to go out in the rain comes from within the person, not from the umbrella. However, umbrellas can protect people from the rain.”

A young woman indicated she would like to speak:

“I have a friend who actually prefers going out into the rain without an umbrella, so that she can feel the natural sensation of the rain hitting her face, caressing her skin and trickling down her neck.”

People nodded knowingly. The woman blushed. Everyone guessed that the friend she was talking about was herself.

The chief responded: “Surely your ‘friend’ knows the dangers of infection, illness and even death if you get wet – as has happened to my son and others in our village. If your friend uses an umbrella, she can relax and enjoy being in the rain anyway.”

“But umbrellas don’t always work,” she pressed. “They sometime rip, break, or turn inside out, so that you get wet anyway. And it is tricky to put them up properly when it is dark.”

“Yes, that is true, they are not quite 100 per cent safe. However, umbrellas are very effective if you use them properly every time, and use one that is in good condition and not too old. And to use umbrellas properly, you must know how.”

To everyone’s surprise, the chief then started to demonstrate how to use the umbrella, taking it out of its cover and putting it up. “During my visit to town, I met the traveller who introduced us to umbrellas, and I have learnt all about them myself,” he explained. “I will now share this knowledge with you. This is knowledge that anyone might need at some point in their lives, whether you go out in the rain or stay at home, as some houses have leaky roofs that we may not know about.”

The chief demonstrated to everyone how to use an umbrella. He handed round umbrellas to everyone, so that they could all practise until they were skilled and confident in using them properly.

“Finally,” the chief concluded, “whether you go out in the rain or stay at home, you and your family members may on occasions need to use an umbrella to ensure you stay safe and healthy. The choice is yours.”

**Step 9 Questions and discussion about Part 4**

Facilitate discussion about the meaning of part 4 of the story, using the following questions to prompt discussion:

Ask:

- What do you think about the comment from the young man that umbrellas make people go out in the rain? How does this relate to sex and condom use?
What do you think about the comment from the young woman about preferring to go out in the rain without an umbrella? How does this relate to sex and condom use?

What messages does the chief give his people?

What do these messages mean in terms of condom use?

Facilitate the discussion and add in the following key messages if participants do not come up with these messages themselves:

Say:

- Condoms themselves do not cause promiscuity, any more than umbrellas cause rain. To alter the words of one of the chief’s statements: “Condoms (umbrellas) do not actually cause people to have sex outside marriage (go out in the rain). The desire to have sex comes from within the person, not from the condom. However, condoms can protect people when they have sex.”

- Using a condom can be part of being loving and responsible for your own health and for the health of your wife and your future children.

- There are many reasons why people use condoms within their marriage, for example:
  - To delay or prevent having their next child.
  - If one partner is HIV-positive and the other is HIV-negative (a discordant couple) they can use condoms to avoid infecting each other. There are many cases of discordant couples who have had regular sex using condoms for 15 years and more, and the HIV-negative person has remained HIV-negative.
  - If both are living with HIV, they should also use a condom to avoid re-infecting each other with more HIV.
  - If, for any reason, they are not certain that they are both HIV-negative, they can use condoms until they have gone together for an HIV test.

Step 10  Mutuality in sexual relations

Reflect upon St Paul’s instructions to married couples in 1 Corinthians 7:1-5. In sexual relations, who does Paul say has more power (authority) than the other? Who says ‘yes’ and who says ‘no’? Do not underestimate how revolutionary this was – and is!

Also read Ephesians 5. This is often quoted as proof that the woman submits to her husband. Some Bibles even use this as the heading, but this is not correct. In Ephesians 5: 21 we read ‘Be subject to one another out of reverence for Christ.’ Who is subject to whom?

Step 11  Close with a prayer

Close by praying for:

- married people in the group and the shaping of their relationships into godly ones of mutual love and respect
- people to understand that condom use is responsible, safe and righteous for couples who are faithful to each other, if one or both of them are living with HIV or they do not both know their HIV status.
How to run this activity

Step 1  Introduce this activity and explain its importance

Explain: The previous activity used a story to teach us the importance of using a condom (which was referred to metaphorically through the word umbrella). This activity will build skills and confidence to use a male condom should you ever need to.

The condom was originally introduced as a child-spacing method for couples. When HIV was discovered, research established that proper use of condoms is also highly effective at preventing transmission of HIV from one partner to another. Using a condom may safeguard the lives of your partner and your unborn child.

Even if somebody has no plans to use a condom now, it is good for both men and women to know exactly how to use one. Then you can use one properly and safely if you ever need to – for example, if you find that you or your partner is living with HIV.

Step 2  Types of condom

Show participants a sample of the male condom. Let them pass it round so that everybody feels it. As they pass them round give the following information:
Say:

- A condom acts as a tough skin that sperm, HIV and sexually transmitted diseases (STDs) cannot get through. If used properly every time you have sex, condoms are very effective at stopping HIV infection. They also stop other STDs and prevent unwanted pregnancies.
- The male condom is a thin rubber tube that fits over the hard penis and catches the man’s semen so that it cannot enter the vagina, anus or mouth.
- Male condoms are widely available in nearly all countries. They come in different sizes, shapes and colours and some are studded, ribbed or flavoured to make sex more pleasurable.

Ask if anyone has seen or knows about female condoms.

Explain:

Most female condoms are made out of a type of plastic called polyurethane. The female condom is inserted into the vagina before having sex. Female condoms are not available in many places in Africa and are more expensive, so this session will focus just on male condoms.

Step 3 Where can you get condoms?

Ask:

- Where can you get condoms in this community?
- What different types are available? How much do they cost?
- What difficulties might people face in getting hold of a condom?

Step 4 Demonstrate use of the male condom

Take a male condom packet and demonstrate how to check the expiry date and remove the condom from the packet, ensuring that it is not damaged.

OPTIONAL: hide the penis model when you start the demonstration, and ask for a male volunteer. Look at him as though you want to demonstrate using his penis. Then say that actually you can provide your own model and get out the penis model. This can cause some amusement and good humour and put participants at ease.

Demonstrate putting the condom on the penis model and guide participants through the process of using a male condom, making use of the notes in Handout 6: How to use a male condom.

Step 5 Practise using male condoms

People normally feel embarrassed doing this, so put men and women into separate groups with people they will feel comfortable with. If there are older and younger people in the group, you could also split them up.

Give out the male condoms to each group (if possible, two to each person). Give to the groups the penis model and some bananas or similar for them to practise on.

Say:

Watch others in your group putting condoms on the models, and help each other so that everyone learns to do it right.

OPTIONAL: once participants are confident about putting the male condom on the model, challenge them to try it again with their eyes closed or blindfolded, so that they can even put it on in the dark.
Step 6  Demonstrate use of the female condom

**NOTE:** if female condoms are not locally available, then leave out Steps 6 and 7 and focus just on male condoms.

To help guide participants through the process of using a female condom use **Handout 7: How to use a female condom.**

Take a female condom packet and demonstrate the following:

- Check and remove a female condom from the packet, ensuring that it is not damaged.
- Insert the condom. Hold the thumb and index finger of one hand together, so that the gap between them becomes a ‘dummy vagina’. With the other hand, demonstrate squeezing the inner ring of the female condom and inserting it into this dummy vagina (**Fig a**), then pushing the inner ring all the way into the cervix (**Fig b**) so that the outer ring sits neatly over the vagina (**Fig c**). To make insertion easy, the woman can crouch down, lie on her back or put one foot on a chair.
- Guide the erect penis into the condom (**Fig d**), making sure it does not enter around the side (**Fig e**).
- Twist the outer ring and remove the condom from the dummy vagina (**Fig f**).
- Distribute copies of **Handout 7: How to use a female condom.**

Step 7  Practice using the female condom

Get participants into small groups, give out at least one female condom each, and get people to practice by using their hands as in the demonstration here. Encourage people to watch others and to help each other so that everyone learns to do it right.
How to use a male condom

1. Get your condoms from a shop or clinic that supplies many condoms and where they are stored in covered packages in a cool place, out of the sun. Check the expiry date written on the condom packet. Check the condom package to make sure that there are no cracks, holes or open sides. If the colour of the condom is uneven or it is dry, brittle, torn or unusually sticky, throw it away because it will probably burst. Open the package carefully. Do not unroll the condom before putting it on.

2. Make sure that the condom is the right way up with the tip upwards, like a mexican hat. Pinch the tip of the condom and put it over the end of the erect penis. (This leaves room for the semen so that the condom does not burst on ejaculation).

3. Roll the condom down over the penis, still holding the tip as you do so.

4. Unroll the condom all the way to the base of the erect penis. Always put on the condom before entering a partner. The vagina needs to be wet to ensure the condom does not break, and to make sex more comfortable. A woman becomes wet with vaginal fluid when she is ready for sex. A good lover will take time to be romantic and caress her so that she is wet before entering her. Never use vaseline, vegetable oil, mineral oil, hand lotion or anything made with oil to make a condom wet. Oil makes a male condom burst. However, it is fine to use saliva or water-based lubricants such as KY jelly.

5. After ejaculating, hold the base of the condom and withdraw from your partner.

6. Hold a tissue round the base of the penis and slide the condom off the penis without spilling the semen. Wrap it in the tissue or knot it and dispose of it by throwing it in a waste bin. Do not use it again. Always use a new condom every time you have sex.
How to use a FC2 female condom

These notes focus on one of the most widely available and tested brands of female condom called FC2. This is just one brand that is available in Sub-Saharan Africa and Tearfund does not endorse or promote the use of any one brand over another.

These instructions show step by step how to insert the FC2 female condom in the vagina. FC2 can be inserted either a few hours or just before sex. When FC2 is used for the first time, people might need to practise insertion. FC2 can be inserted by women themselves and their partner can also do it for them.

1. Before opening your FC2 female condom:
   - Check the expiry date which is stamped on the front or on the side of the female condom packet.
   - Spread the lubrication inside around by rubbing the packet with your hands.

2. To open the packet, tear straight down from the arrow at the top and remove the condom. Do not use scissors, a knife or your teeth to open the packet.

3. Hold the inner ring between your thumb and forefinger. Then squeeze the sides of the inner ring together to form a point.

4. You can insert FC2 in lots of different ways. Find a position that is comfortable. This may be standing, sitting, squatting or lying down.

5. Feel for the outer lips of your vagina and spread them.
6 Use the squeezed inner ring to push FC2 into your vagina. Slide your index finger or middle finger inside the condom and push it in your vagina as far as possible, using the inner ring. Make sure the condom is not twisted and lies smoothly against your vaginal wall.

7 A small part of the condom, including the outer ring, stays outside your body and lies over the lips of your vagina, partially protecting your external sex organs and covering the base of your partner’s penis.

8 FC2 lines the inside of your vagina and covers your cervix. The opening of your cervix is so small that it is impossible for FC2 to pass through this space.

9 Hold the outer ring in place as your partner guides his penis inside the condom. Once his penis is inside the condom, you do not have to continue holding the outer ring. For extra pleasure you may want to add more lubricant either on the inside or outside of FC2 or directly onto your partner’s penis once the condom is inserted.

10 Please notice! Your partner needs to immediately withdraw his penis if:

- His penis enters between the condom and the vagina wall. In this case you should put the outer ring back in position before he slides his penis back inside the condom.
- The outer ring has been pushed into your vagina. In this case you should use a new FC2.

11 To take FC2 out, hold the outer ring and twist it to keep the semen inside. It’s best to do this before standing up. Gently pull the condom out, wrap it in a tissue or the empty packet, and throw it in a rubbish bin.

This handout has been derived from SUPPORT’s How to use FC2 Female Condom card. www.femalecondom.org
Activity

16 Dramas to address other relationship issues

Why do this activity?

To equip participants with skills and strategies to deal with relationship issues which may relate to the prevention of parent-to-child transmission.

Summary

This activity addresses different relationship issues using the same approach as for Activity 11: Pregnant and positive drama. The facilitator chooses a particular relationship issue. Participants prepare and act a short play in which the key character says and does things which clearly show they do not have the skills and strategies to address the issue. The actors perform their play once through to the end. When it is performed a second time, the audience can interrupt the play and make suggestions for what the key character could do or say differently. The play then continues, using these suggestions, to achieve a better ending.

Time

20–40 minutes for each drama. However, the forum theatre technique can be used many times to address different situations.

How to prepare

Use the table on the following page to decide which objective and drama you will use. First be clear about your objective – what skills and strategies do you want your participants to develop? Then find and brief your actors (either co-facilitators or participants) to perform a short play in which the key character demonstrates that he or she definitely does not have these skills and strategies. Most plays for this type of drama need only two actors and only one scene, which lasts 1–5 minutes.

If this is your last session with a group of participants, give out the evaluation questions in Appendix 4.

How to run this activity

Step 1 Perform the play the first time

Introduce the drama and allow the actors to perform it for the first time straight through to its end. The person playing the key character must say and do things which are very clearly wrong or inappropriate, and lead to a bad or sad ending. For example, for Drama E, the behaviour of the ‘friend’ (key character) should really upset the person who discloses their HIV-positive status.

When it is finished, encourage the audience to applaud.

Ask:

- What may happen next?
- What did you think of the way the key character behaved? (clarify which actor is the key character)
- What should the key character say or do differently?
<table>
<thead>
<tr>
<th>Objective</th>
<th>Suggested drama</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>To develop skills and strategies for discussing and getting agreement with your partner to go together for HIV testing and counselling. A husband (the key character) says to his wife: ‘I don’t know what you get up to while I am out all day, so I am going to take you for an HIV test.’</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>To build skills and strategies for disclosing HIV-positive status. A man who has just been for voluntary counselling and testing and tested HIV-positive, says to his wife: ‘I’ve got HIV and I’m going to die, and I think it was you who gave it to me.’</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>For men and women to develop skills and strategies to negotiate use of condoms. When her husband arrives home, his wife (the key character) says to him: ‘I’ve decided that it is too soon for us to have another baby, and when you arrive late I don’t know who you have been with, so you’ve got to use condoms from now on, right?’ The husband gets very annoyed and refuses.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>For a woman living with HIV to build skills and strategies to stick to exclusive breastfeeding when relatives, friends or colleagues are pressuring her to give the baby other foods as well. A woman (key character) living with HIV, is following the advice she has been given and is exclusively breastfeeding her four-month-old baby. A relative insists that she should start introducing some solids. The mother tries to refuse, but then gives in to the pressure, as she does not want to offend them. She starts giving the baby some solids and then, as soon as the relative leaves goes back to breastfeeding.</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>To build skills and strategies to support someone who we know is living with HIV. A woman who recently had HIV testing and counselling tells a friend (the key character) that she is HIV-positive, but the friend rejects her and rudely breaks off their friendship.</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>For boys and young men to develop skills and strategies to resist peer pressure to have sex. A young man (key character) is being teased by friends because he is a virgin and wants to avoid sexual intercourse and the risk of HIV infection. They pressurize him to have sexual intercourse to ‘prove that you are a real man’. He gives in and agrees to it.</td>
</tr>
<tr>
<td><strong>G</strong></td>
<td>For parents to develop skills and strategies for talking to their children about sex and relationship issues. A child (either a girl or boy) asks their mother or father (key character) a question to do with sex. The parent lacks the skills or confidence to talk about sexual issues and either avoids the question, changes the subject, or answers in a vague and indirect way – leaving the child confused with the wrong information.</td>
</tr>
</tbody>
</table>
**Step 2**  Act the play again, with audience involvement to change the outcome

**Explain:**  *The play will run again, starting off exactly the same, but you (the audience) must change what the key character does and says in order to improve the ending. As soon as the key character does or says something that you think is wrong, put your hand up and say “stop” to stop the play.*

Stop the play as soon as a participant lifts a hand or says stop. Ask those who stopped the play why they have done so, and what the key character should do or say differently. Invite one of the participants to come and take over the role of the key character and demonstrate what they think the key character should say and do. To help them get into role, they may put on a hat, coat or other garment worn by the key character.

Direct the original actor and the new actor playing the key character to rewind the scene and run it again. Once again, invite the participants to put a hand up and say “stop” to stop the play if the new key character does or says something they think is not helpful and could be improved.

This can continue, with several participants taking a turn as the key character, trying out different ideas and changing the play until it has a better, but still realistic, ending.

If members of the audience are reluctant to take the place of the key character, get the original actors to act the scene again, with the key character changing what he/she does and says in response to suggestions from the audience.

**Step 3**  Identify what strategies are working well

**Ask:**
- What have we learnt from this activity?
- What are the strategies that worked well in this situation?

**Step 4**  Practise in pairs/small groups

Split participants into pairs.

**Explain:**  *This is your chance to try out and practise some of the ideas you have developed. Follow these steps:*

- Act the play you saw again, with one person taking the role of the key character, and others playing the other character. The person playing the key character must do their best to address the issue in a good way, while the other actors make it difficult for him.

- When you have finished the play, give feedback to the person who just played the key character, including what they did well and any suggestions for how they could improve what they do or say.

- Swap roles and repeat the previous two steps.
Step 5  Conclude

Re-assemble the group.

Ask:
- What else did you learn from practising in pairs?
- What are the other key things you have learnt throughout this programme?
- How will you each apply what you have learnt?

Step 6  Evaluate

If this is your last session with a group, give each participant a copy of the evaluation questions in Appendix 4. Lend a pen or pencil to those who do not have one.

Explain: To help us evaluate the Guardians of our children’s health training programme, please complete all questions on this questionnaire sheet and hand it in before you go. Do not write your name on the paper – your answers are confidential and nobody will know who gave which answers.

Collect all completed questionnaires before participants leave the session.
APPENDIX 1  Icebreakers and energisers

Use icebreakers and energisers when appropriate with a new group, at the beginning of a session and to help participants to relax and feel comfortable with you and each other. Use an energiser when participants start to look tired, or when you want to liven up the mood of the group. Below are a few examples of energisers and icebreakers. The first one (*My name is ... and I love to ...*) is best used as an icebreaker. All the others can be used as either icebreakers or energisers.

**My name is ... and I love to ...**

This is a fun way of getting people to introduce themselves and build relationships within the group. Everyone stands up in a circle. Ask everyone to think of something they love doing, and an action that goes with it (eg playing football, cooking, dancing etc). One person steps forward and says *'My name is ... and I love to ...'* (with an action), then steps back. Everyone else then steps forward together and repeats exactly what the person just did and said, with exactly the same words, tone and actions. Each person (including facilitators) takes their turn at introducing themselves in this way.

**Knotty problem**

Ask participants to form groups of five to twelve people standing in a circle.

**Say:** Put out your arms in front of you, close your eyes and slowly walk forwards, until each of your hands finds another person’s hand. Find one hand with your right hand and another belonging to someone else with your left hand. Keep your eyes closed.

Make sure no-one is holding more than one other hand in each of their hands. If you see three or more hands joined together, take one of these hands and connect it to a free hand.

**Say:** Keep holding on to the hands you have found and open your eyes. You are in a tangled-up human knot. Try to untangle the knot without letting go of your hands.

When the group has untangled as much as possible, there should be one or more circles of people. This may be better done in single sex groups.

**Change your behaviour!**

Point your finger at the person next to you and tell them to “Change your behaviour!”

**Say:** Point out that, when they have one finger pointing at someone else, their other three fingers are pointing back at themselves.

**Emphasise:** Effective change is only possible when that change starts with you!
Foot in mouth

Instruct your participants as follows and demonstrate the actions as you explain:

Say: All stand up. Put both your hands on your head and imagine that you can unscrew your head and take it off your shoulders. Lift your head gently off your shoulders, bring it down carefully and put it so that you are holding your head under your left arm. Now lift up your right foot.

Stretch down with your right hand, take hold of your right foot and unscrew it so that it comes off your leg. Lift up your foot and put it in your mouth.

Watch as most participants move their right hand up to their mouth. Then demonstrate that, as their head is now under their left arm that is where they should really put their foot!

Mime a lie

Prepare in advance a volunteer to the facilitator’s right who will ask them what they are doing. Everyone stands in a circle. The facilitator starts by miming an action. The person on the facilitator’s right asks the facilitator ‘What are you doing?’ The facilitator replies that they are doing something completely different, eg the facilitator mimes swimming and says, ‘I am washing my hair.’ The person to the facilitator’s right then has to mime what the facilitator said they were doing, but when the next person asks ‘What are you doing?’ they must say they are doing something completely different. Go around the circle in this way until everyone has had a turn.

The sinking boat

Ask everybody to imagine they are on a ship, which is sinking fast. To board the lifeboats we must get into groups with a certain number in each group. If there are too few people, you will not be able to row the lifeboat. If there are too many, it will sink. Ask everyone to walk round and then shout: ‘Sinking boat – get into groups of three.’ Repeat several times with different numbers, eg groups of four or groups of seven.

This energiser can also be useful if you want to divide participants into smaller groups.
As and Bs

Everyone should stand up and move (if necessary) to an open space.

Say:  *Each person must choose someone else in the group. Do not tell them. That is your person A.*

Choose another person in the group. That is your person B.

When I say go, get as physically close to your person A as you can and as physically far away from your person B as you can… GO!

After about a minute:

Say:  *Now get as physically close to your person B as you can, and as physically far away from your person A as you can… GO!*

After another minute:

Say:  *Now get as physically close to both your person A and your person B as you can… GO!*

We will make you fishers of men

Get everyone to sit down and sing the song, 'We will make you fishers of men' with the following actions:

**MALE PARTICIPANTS:** stand up on the first word beginning with M (make) then sit down again on the next word beginning with M (men) then stand up again on the next word beginning with M etc.

**FEMALE PARTICIPANTS:** stand up on the first word beginning with F (fishers) then sit down again on the next word beginning with F then stand up again on the next word beginning with F etc.

Move if...

The facilitator (who is initially the caller) stands in the middle – all others are seated in an arc or circle. Remove spare chairs, so no seat is available for the caller.

The facilitator/caller says: 'Move if…' and defines a category which can be anything, eg 'you have children', 'you are wearing something blue', 'you have had an HIV test', 'you like to eat fish' etc.

All those who fit the category must get up and move to a different seat and the caller sits down in an empty seat. The person left without a seat becomes the next caller and says: 'Move if…' using a different category.

Note that this can also be useful for finding out things about the group. Also, everyone ends up sitting in a different place, so it can also be used to mix up the group.
APPENDIX 2: Improving parent and child outcomes (IMPACT)

Introduction – the need for IMPACT within Guardians of our children’s health

HIV and maternal mortality have been called the ‘two intersecting epidemics’ as HIV and complications related to pregnancy and childbearing are the two most important causes of death in women of reproductive age. Every year around eight million young children die of preventable causes and more than 350,000 women die from preventable complications related to pregnancy and childbirth. Maternal health and newborn health are closely linked. More than three million newborn babies die every year and an additional three million babies are stillborn. Compared to western countries, maternal and child mortality is considerably higher in Africa. For example, for a woman in Malawi, there’s a one-in-36 chance of dying in her lifetime during birth or in the late stages of pregnancy, which is 58 times greater odds of death than for a woman in the United States.

The maternal mortality ratio has always been higher in HIV-negative women (in most cases six times higher). HIV infection in pregnancy also increases the risk of miscarriages, anemia, postpartum haemorrhage, puerperal sepsis and post-surgical complications as well as risk of TB and malaria infection. Through these mechanisms, HIV is a key contributor to the indirect causes of maternal deaths accounting for almost 1 in 5 of overall maternal mortalities globally. In addition to the role played by the expectant mother, the importance of the role of the male partner is also being increasingly recognised. Recent studies have shown that when the male partner is involved in the whole antenatal care process HIV transmission and child mortality are significantly reduced (by 40 per cent). Whilst significant improvements are being made to reducing HIV vertical transmission, maternal and child mortality in rural areas of many African countries remains a greatest challenge. Poor women in remote areas are the least likely to receive adequate health care. This is especially true for regions with low numbers of skilled health workers, such as sub-Saharan Africa and South Asia. While levels of antenatal care have increased in many parts of the world during the past decade, only 66 per cent of women in developing countries benefit from skilled care during childbirth. This means that millions of births are not assisted by a qualified midwife, a doctor or a trained nurse. In high-income countries, virtually all women have at least four antenatal care visits, are attended by a skilled health worker during childbirth and receive postpartum care. In low- and middle-income countries, less than half of all pregnant women have a minimum of four antenatal care visits.

IMPACT vision

The vision of IMPACT is to see a generation free from AIDS, where every child is born free of HIV. Where the risk to mothers in childbirth is no greater than those in the West and where children are born to live – not to die in their first years through preventable causes. To contribute to achieving this vision the focus of IMPACT is vulnerable, mainly HIV-positive mothers and their families due to the six-fold increase in risk to maternal mortality of being HIV-positive.
IMPACT – main interventions

The principle aim of IMPACT is to ensure that children are born free of HIV and that the best possible processes are followed to contribute towards a reduction in maternal, paternal and child mortality and ensure both parents and their families stay healthy through the following interventions:

- **Mother Buddies**
  These are often HIV-positive mothers who are trained to provide holistic (practical, emotional, spiritual) support to vulnerable expectant mothers and their families in rural communities. A key challenge in reducing parent-to-child transmission, maternal and child mortality is to enable vulnerable mothers to gain access to evidence based knowledge and good-quality service provision when an antenatal clinic may be 10–30 kilometers away. Mother Buddies provide a full ‘buddy’ service to vulnerable expectant mothers throughout pregnancy and at least six months post birth. In addition to ensuring that all interventions/appointments are kept Mother Buddies also provide very practical support, eg help with transport to clinic, adherence counselling, food support etc. An average of seven visits is planned per expectant mother. The number of Mother Buddies is normally based on the number of vulnerable expectant mothers in a given specific community.

- **MiHope**
  A key challenge in rural communities is communication. MiHope is a mobile phone system using the internet that provides chat (instant messaging) information and data collection. The chat system enables 1,000 chat conversations to be held for the price of a single SMS text. In addition all the phones can be updated with bulk messaging. The current information module provides the complete 104-page Guardians of our children’s health training programme and country-specific HIV information. The phones have also been equipped with IMPACT training reference documents related to safe pregnancy and birth.

- **Data collection**
  Data collection currently includes both outcome data collection from clinics and Mother Buddy activity data which are automatically uploaded into a website through android smart phones. Participating government health clinic staff, Mother Buddies and project coordinators have each been provided and equipped with skills to use MiHope data collection software on HIV and maternal health.

- **Prevention**
  The standard Tearfund Church and Community Mobilisation process and Guardians of our children’s health training programme is being used with IMPACT. Volunteers and Mother Buddies perform a variety of prevention activities within communities, including giving talks.
at community maternal healthcare groups, village health development committees, faith-based and community youth groups and in schools.

- **Family support – livelihoods**
  Certain families of vulnerable expectant mothers are offered livelihoods support through the provision of seeds, chickens and goats. Practical support will also enable families and communities to better use their assets.

**IMPACT – expected results from the Guardians of our children’s health training approach**

- Reduced prevalence of HIV through successful community and church-based prevention initiatives.
- Increased access to HIV testing, counselling and appropriate treatment for pregnant women.
- Increased involvement of male partners in maternal health and being tested and treated for HIV and its related infections.
- Improved maternal and newborn-child outcomes through Mother Buddy intervention (skilled birth care and pre- and post-natal support, with a specific focus on HIV-positive mothers).
- Improved child nutrition and family wellbeing for vulnerable HIV-positive families through livelihood intervention.
- Increased empowerment of women and improved attitudes from the community and church towards people living with HIV and the rights of women to control their sexual and reproductive choices.
- Improved health outcomes through increased capacity of local health providers and churches and other Tearfund partners through training and access to better information via MiHope intervention.

**Key components in achieving these results are:**

- **HIV TESTING AND ANTENATAL CLINIC CARE**: ensuring that all expectant mothers are tested for HIV. Also ensuring that vulnerable pregnant women access antenatal services and achieve a minimum of four antenatal clinic visits as recommended by the World Health Organisation.
- **MALE PARTNER INVOLVEMENT**: partners of vulnerable expectant mothers targeted with ‘father friendly’ approaches to increase male partner testing and ensure appropriate treatment.
- **TREATMENT TO PREVENT VERTICAL HIV TRANSMISSION**: country dependent approach (ART policy) – ensuring that vertical transmission is prevented.
- **ENSURING THE HEALTH OF THE PARENTS**: focusing on the health of both parents to ensure families stay together – includes livelihoods support.
- **SKILLED BIRTH CARE**: ensuring that all vulnerable expectant mothers have access to skilled birth care.
- **NEWBORN CARE**: focus on ensuring necessary processes are followed to ensure good newborn care.
- **CHILD CARE**: following the child for at least six months after birth and ensuring that necessary interventions are completed (eg PCR HIV testing, immunizations etc).
Improving parent and child outcomes (IMPACT) diagram

1 Primary prevention
Programmes of education for young people which aim to reduce unintended pregnancy and transmission of HIV.

2 Prevention of unintended pregnancies
Promotion of use of contraceptives provided at government clinics, including injectable contraceptives and condoms. If government supplies run out – the programme will advocate for resupply.

3 HIV testing and antenatal care
Household testing by community volunteers for all members – with a special focus on pre-marital and pre-conception testing. This is done together with the promotion of adequate antenatal care by the government. If mothers cannot afford money to access government clinics the programme will provide transport support.

4 Increasing male involvement
Intensive programmes of support for male involvement and testing of male partners – using proven effective social mobilization methods (eg. Guardians of our children’s health) and also utilising best practice ideas, eg special father-friendly clinics in Nigeria.

5 ARV Prophylaxis in pregnancy (dependent on country ART policy)
Intensive promotion of CD4 testing/viral load and uptake of locally approved maternal ARV prophylaxis regime. If mother cannot afford money to access government clinics the programme will provide transport support to government clinics where these can be supplied and advocate for closer access.

6 Health of the parents
Intensive support using the tried and tested Mother Buddy system and – where necessary – transport support to ensure regular access to supplies and highly-active antiretroviral therapy for those with low CD4 counts, Directly Observed Therapy (DOT) for TB, Cotrimoxazole for all HIV-positive parents.

7 Skilled birth care
Intensive promotion of ensuring that delivery is attended by professionally trained and skilled birth attendants wherever possible with referral if complications occur, including bleeding and obstructed labour. Supported by communications (mobile phone) and transport.

8 Essential newborn care
Intensive promotion by Mother Buddies and other healthcare professionals to ensure that mothers are supported regarding keeping warm and early recognition of infection (especially birth asphyxia, neonatal sepsis and preterm complications) and also supported with infant feeding (especially using affordable, feasible, accessible, sustainable and safe criteria, known as AFASS).

9 Infant and young child care
Using experienced Mother Buddies and working with health professionals, intensive promotion of testing using polymerase chain reaction for infants of HIV-positive mothers and access to antiretroviral drug treatment (supporting transport of samples and mother/child to clinic where necessary). Also ensuring access to clean water, immunisations, use of insecticide-treated nets, early recognition of and access to treatment of infection (especially malaria, pneumonia and diarrhoea).
APPENDIX 4  Evaluation and certification process

Guardians of our children’s health evaluation form

Facilitators:
- Read out the questions to the participants and fill-in accordingly.
- Run this participatory evaluation at the beginning and end of the training.
- For certification purposes, wherever possible, it is recommended that the master trainer should be informed of the last session so that he/she is present during the last process of completing this evaluation form.
- Send the completed forms to the master trainer’s office that will in turn send them to Tearfund.
- Ask for more copies of the evaluation forms from the master trainer for additional trainings.

Section A  Evaluation for participants (first and last sessions)

Date: ____________________________________________

Description of group type (eg church youth group, ages 17–25):
___________________________________________________________________________________

Number of participants: Male _______ Female ________ Total ____________

1  Can an HIV-positive mother give birth to an HIV-negative baby?  □  □
2  Can HIV be transmitted through breastfeeding?  □  □
3  If the mother is HIV-positive is it OK to give the baby sometimes breast milk and sometimes other food or drink for the first six months after it is born?  □  □
4  Do you know where you can get tested for HIV?  □  □
5  If a man is HIV-positive can his unborn child become infected with HIV?  □  □
6  If used correctly, are condoms very effective at preventing HIV infection?  □  □
7  Do you feel you can ask your husband/wife/partner to use a condom?  □  □
8  Can a person get HIV without ever having sex?  □  □
9  Have you had an HIV test yourself?  □  □
<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>An HIV-positive person visiting my home will be welcome.</td>
<td></td>
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<tr>
<td>11</td>
<td>A man should also be tested for HIV when his pregnant wife is tested.</td>
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<td>12</td>
<td>HIV is a punishment of God.</td>
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<tr>
<td>13</td>
<td>An HIV-negative husband should continue to live with his HIV-positive wife.</td>
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<tr>
<td>14</td>
<td>Couples should go together to get tested for HIV.</td>
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<tr>
<td>15</td>
<td>Using a condom is a responsible and caring way of avoiding HIV infection.</td>
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<td>16</td>
<td>Using a condom is sinful.</td>
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<td>17</td>
<td>Pregnancy, childbirth and caring for a baby are a woman’s responsibility and the father should not get involved.</td>
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<td>18</td>
<td>I am comfortable discussing issues to do with sex and health with my husband/wife/partner.</td>
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<tr>
<td>19</td>
<td>A husband should accompany his wife to antenatal clinics.</td>
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<tr>
<td>20</td>
<td>Antiretroviral drugs (ARVs) should be taken every day exactly as advised by the doctor or nurse.</td>
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<tr>
<td>21</td>
<td>People living with HIV should be allowed to hold positions of leadership in religious institutions.</td>
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</table>
## Facilitation process evaluation
(to be included in the last evaluation session only)

List of sessions completed (include dates and duration)

<table>
<thead>
<tr>
<th>Date</th>
<th>Duration</th>
<th>Description of group (e.g., church youth)</th>
<th>Number of participants</th>
<th>Activities completed</th>
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When using *Guardians of our children’s health*, what worked well? Be as specific as you can.

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

What did not work well?

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

What challenges/difficulties did you have?

___________________________________________________________________________________
___________________________________________________________________________________

How did you address these?

___________________________________________________________________________________
___________________________________________________________________________________

Describe your most successful session using Guardians of our children’s health. What impact did it have on the knowledge, skills and/or attitudes of participants? What evidence do you have for this (eg verbal or written responses or feedback from participants?)

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

OPTIONAL: include a case study and/or any relevant photographs/images you have. These may be used in the next Guardians of our children’s health newsletter.

Did you introduce any changes or adaptations?

___________________________________________________________________________________
___________________________________________________________________________________

How did these work? ________________________________

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

What ideas and suggestions do you have to improve the Guardians of our children’s health training programme? What should be deleted, changed or added?

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Any other comments or feedback?

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

MASTER TRAINER: any general comments, observations, concerns and recommendations? (Please use further electronic guidelines for master trainers from Tearfund)
Certification process

The certification process is designed to provide well-earned recognition for those who demonstrate their commitment in applying the Guardians of our children’s health tools and techniques to address the HIV and AIDS related issues of different target groups. It also requests feedback to help Tearfund further enhance and refine these techniques and activities.

Criteria for certification

1. Attend and complete a recognised Guardians of our children’s health facilitator’s training workshop.

2. Facilitate (or co-facilitate) a minimum of five separate training sessions which incorporate Guardians of our children’s health activities.
   - If co-facilitating, the session counts for both/all of you, provided you each lead the facilitation of at least one activity during the session.
   - Facilitate several different Guardians of our children’s health activities, not the same one or two each time.
   - If sessions you run last less than 30 minutes, they will count as half sessions, and you may need to do one or two extra sessions to get certified.
   - If you facilitated at least one activity during the Real Life Training Practice session on the last day of the facilitator training workshop you attended, that counts as your first session.

In coordination with the master trainer, complete and submit an evaluation form above to impact.gooch@tearfund.org. Tearfund will also send a copy of your completed form to Bridges of Hope who will jointly award the certificates.

Assessment and certificates

If your report is assessed and approved, you will be sent a smart electronic A4 certificate similar to the one shown here, recognising and appreciating your work to date using the Guardians of our children’s health training programme.

If the report you submit is incomplete or provides insufficient evidence for certification, you will be informed what additional information you need to provide or actions you need to take before re-submitting. Certificates will be awarded in stages starting from elementary certificate, intermediary certificate, and advanced certificate depending on the number of trainings and satisfactory reports submitted.

Acknowledgement on the Bridges of Hope webpage

Newly-certified Guardians of our children’s health users will also be acknowledged in the subsequent Bridges of Hope newsletter and on the website: www.boht.org. Extracts from your report, together with any relevant photographs you submit, may also be included, with your agreement and full acknowledgement.
APPENDIX 4

References and source materials

Materials in this guide include elements that have been adapted from or inspired by the following sources:

- Bridges of Hope Training: www.boht.org including Activity 9: What happens in the body? ©Bridges of Hope Training 2013, also Activity 4: Bushfire, Activity 5: Chewing Gum Challenge, Activity 8: Can you tell, Activity 10: My supporters, Activity 12: PPTCT during pregnancy and birth, Activity 13: Infant feeding options, Activity 14: The Umbrella story, and Activity 16: Dramas to address other relationship issues. If you are interested in using these activities and materials in other programmes, contact Bridges of Hope Training website: www.boht.org Email: peter@boht.org


- Health24 website: www.health24.com


- International HIV/AIDS Alliance (2002) 100 Ways to energise groups: Games to use in workshops


- Labouchere P, Mkandawire J, Mkandawire G, Böse K (2007) Have a healthy baby – A Hope Kit update package of experiential learning activities for preventing mother-to-child transmission of HIV. Published by Johns Hopkins University Center for Communication Programs/Population Communication Services


- Shone R (1992) Creative Visualisation

- World Health Organisation (2010) *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants – Recommendations for a public health approach*
- World Health Organisation nutritional guidelines: www.who.int/nutrition/en/
Guardians of our children’s health
Activities for church groups and communities
to involve men and women in preventing
parent-to-child transmission of HIV