Reaching Men and Boys with Messages of Hope
Facilitator’s Guide for Training Faith Leaders in Malawi
JUNE 2020 (REVISED AUGUST 2021)

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Acknowledgments

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The May 2020 curriculum was updated in August 2021 to reflect advancements in the Government of Malawi’s guidelines on community-based HIV prevention and testing services (Introduction and Annex A).
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ARVs</td>
<td>antiretroviral drugs</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HP+</td>
<td>Health Policy Plus</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Commission</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>U.S. President’s Plan for Emergency AIDS Relief</td>
</tr>
<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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</tbody>
</table>
Introduction

About this Guide

This facilitator’s guide is designed to train faith leaders to effectively communicate with men and boys about HIV using “messages of hope.” These positive messages provide men and boys with accurate information about HIV and help them understand that they can live long, healthy lives regardless of their HIV status. Reaching men and boys with messages of hope can encourage them to seek HIV testing and, if HIV positive, to start and stay on treatment.

Data from the Malawi Population-Based HIV Impact Assessment (MPHIA), 2015–2016 (MOH, 2018) indicate that men living with HIV in Malawi are less likely to be aware of their HIV status, on treatment, or virally suppressed than women. Among HIV-positive adults ages 15-64 years, around twice as many men (12.7 percent) as women (6.4 percent) reported never having been tested for HIV or never receiving their HIV test results. Only 63 percent of men living with HIV older than 15 years of age are on antiretroviral therapy (ART), in contrast to 81 percent of women (PEPFAR, 2020). Men are also more likely to die of AIDS-related causes than women (PEPFAR, 2018). To save lives, and to achieve and maintain epidemic control, it is vital to increase uptake of and retention in HIV services among men and boys. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) prioritized engaging communities of faith as one of the key approaches to reach men and boys with HIV services.

Faith communities can play an impactful role in reaching men and boys with important information about HIV. As trusted influencers within their congregations and communities, faith leaders are in a unique position to reach men and boys with messages of hope. The messages are designed to be incorporated into sermons, counselling sessions, outreach, group discussions, and other interpersonal communication, as well as disseminated through a variety of print and broadcast media.

This facilitator’s guide is designed to support efforts to operationalize messages of hope as part of the PEPFAR Faith and Communities Initiative. The messages of hope developed by PEPFAR were adapted in Malawi, validated by the Government of Malawi, and incorporated into a messaging guide: Messages of Hope: Reaching Boys and Men with HIV and AIDS Information (HP+, 2020). Three versions of the guide are available, in English and

Since 2019, Malawi’s main religious mother bodies—the Evangelical Association of Malawi, Qadria Muslim Association of Malawi/Muslim Association of Malawi, Pentecostal and Charismatic Network of Malawi, Episcopal Conference of Malawi, Seventh Day Adventists/Adventist Development and Relief Agency, and Malawi Council of Churches—have used this curriculum to train religious leaders on HIV with impressive results. Across Malawi, more than 550 religious leaders are making a positive impact in their communities by using the Messages of Hope during sermons; one-on-one counseling; community meetings and events; church and mosque events; support group meetings; trainings; football bonanzas; choir competitions; zikiri competitions; and through WhatsApp, radio, and television. The religious mother bodies have combined these messages with key services: helping men and boys and women and girls access HIV testing services; distributing HIV self-testing kits; providing community-based HIV treatment literacy on adherence; supporting positive living; and helping people restart ART when they have stopped. As of August 2021, more than 146,000 people have been reached with these messages.
Chichewa, for use by different faith communities or for secular use: 1) nondenominational, 2) Christian (includes verses from the Holy Bible), and 3) Islamic (includes verses from the Holy Qur’an).

Who Should Use this Guide?

This guide is intended for use by facilitators from faith communities to train faith leaders and laypeople from their communities on using the Messages of Hope guide to reach men and boys. The intended audience includes trainers from Malawi’s religious mother bodies who have been trained to disseminate these skills within their respective organizations by the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID) and PEPFAR. However, this guide and the accompanying slides can be used by anyone working in HIV messaging or related programming.

Training Format

This training uses participatory and interactive methods to deepen learning as participants explore key topics and acquire new skills. The knowledge gained through this training will allow participants to play a meaningful role in national efforts to reach and maintain epidemic control and to better support their communities, including people living with HIV.

The training uses a modular format. Wherever possible, sessions should be offered in the order used in the guide (see Box 1), as each session is designed to build on the content of previous sessions. The training schedule can be customized to fit the needs of different groups. Ideally, content would be delivered over three days. However, sessions can be spaced out over a longer period, if desired. A sample agenda is included below (see Table 1). Times listed are illustrative, as time needed for activities will vary depending on the size and knowledge level of the group. A maximum group size of 30 participants per workshop is recommended.

<table>
<thead>
<tr>
<th>Session</th>
<th>Time Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>7 hours 15 minutes</td>
</tr>
<tr>
<td>Session 1: Introduction/Opening Activities</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Session 2: HIV Basics</td>
<td>3 hours</td>
</tr>
<tr>
<td>Session 3: HIV Testing, Care, and Treatment</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>Session 4: Stigma and Discrimination</td>
<td>2 hours</td>
</tr>
<tr>
<td>Closing</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Box 1. List of Sessions

- Session 1: Introduction/Opening Activities
- Session 2: HIV Basics
- Session 3: HIV Testing, Care, and Treatment
- Session 4: Stigma and Discrimination
- Session 5: Reaching Men and Boys
- Session 6: Messages of Hope: Communicating with Men and Boys
- Session 7: Reflecting on Content
- Session 8: Disclosure Support
- Session 9: Action Planning for Reaching Men and Boys with Messages of Hope
Activity Plans

Each activity in the facilitator’s guide is presented as an activity plan—a detailed, step-by-step description of how to facilitate the learning exercise, which includes:

- **Objectives:** What participants will know or be able to do by the end of the session
- **Time:** Estimated amount of time needed for the session—Timing will vary according to group size and participants’ levels of knowledge; larger groups will require more time, especially for report backs
- **Methods:** Facilitation approach(es) used in the activity (e.g., discussion, role play, case study, individual reflection, brainstorming)
- **Materials:** Materials needed for the session (e.g., pictures, case studies, copies of role play scenarios)
- **Preparation:** Description of what facilitators need to do or prepare advance of the session (e.g., detailed facilitator notes to study ahead of time, flipcharts that need to be pre-written)
- **Steps:** Step-by-step instructions for carrying out the activity.

Table 2 provides a list of handouts and facilitator’s notes by session and activity.
<table>
<thead>
<tr>
<th>Session</th>
<th>Activity</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2</td>
<td>Activity 1</td>
<td>Handout #1: HIV Glossary</td>
<td>Annex B</td>
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<tr>
<td></td>
<td></td>
<td>Handout #2: HIV and the Benefits of ART</td>
<td>Annex B</td>
</tr>
<tr>
<td></td>
<td>Activity 3</td>
<td>Handout #3: HIV Myths and Facts Worksheet</td>
<td>Annex B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitator’s Notes: Answer Key for HIV Myths and Facts Worksheet</td>
<td>After activity</td>
</tr>
<tr>
<td></td>
<td>Activity 4</td>
<td>Facilitator’s Notes for Session 2, Activity 4: HIV and AIDS (Prevention and Management) Act, 2018</td>
<td>Annex A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitator’s Notes on Scenarios: The HIV and AIDS (Prevention and Management) Act, 2018 in Practice</td>
<td>After activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Handout #4: Scenarios for Session 2, Activity 4: The HIV and AIDS (Prevention and Management) Act, 2018 in Practice</td>
<td>Annex B</td>
</tr>
<tr>
<td>Session 3</td>
<td>Activity 1</td>
<td>Facilitator’s Notes for Session 3, Activity 1: HIV Testing Services</td>
<td>Annex A</td>
</tr>
<tr>
<td></td>
<td>Activity 2</td>
<td>Facilitator’s Notes for Session 3, Activity 2: HIV Treatment and Adherence</td>
<td>Annex A</td>
</tr>
<tr>
<td>Session 4</td>
<td>Activity 1</td>
<td>Facilitator’s Notes for Session 4, Activity 1: Seeing Stigma</td>
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<tr>
<td></td>
<td></td>
<td>Picture Tools for Session 4, Activity 1: Seeing Stigma</td>
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</tr>
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<td></td>
<td></td>
<td>Handout #5: Discussion Questions for “Seeing Stigma” Activity</td>
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<td>Session 6</td>
<td>Activity 2</td>
<td>Handout #6: Discussion Questions for Reflecting on the Process of Behaviour Change (Session 6, Activity 2)</td>
<td>Annex B</td>
</tr>
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<td></td>
<td>Activity 3</td>
<td>Handout #7: Behaviour Change Communication Scenarios (Session 6, Activity 3)</td>
<td>Annex B</td>
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<td></td>
<td>Activity 5</td>
<td>Handout #8: Scenarios for Session 6, Activity 5: Communicating with Adolescent Boys</td>
<td>Annex B</td>
</tr>
<tr>
<td>Session 7</td>
<td>N/A</td>
<td>Handout #9: Reflecting on Content from Days 1 and 2</td>
<td>Annex B</td>
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<tr>
<td>Session 8</td>
<td>Activity 1</td>
<td>Facilitator’s Notes for Session 8, Activity 1: Voluntary and Involuntary Disclosure</td>
<td>Annex A</td>
</tr>
<tr>
<td></td>
<td>Activity 2</td>
<td>Handout #10: Assessing Whether or Not to Disclose—Guiding Questions Worksheet</td>
<td>Annex B</td>
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<tr>
<td></td>
<td>Activity 3</td>
<td>Handout #11: Key Messages—Disclosure</td>
<td>Annex B</td>
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<tr>
<td></td>
<td></td>
<td>Handout #12: Putting Learning into Action—How Can I Use What We’ve Done to Support Others?</td>
<td>Annex B</td>
</tr>
<tr>
<td>Session 9</td>
<td>Activity 2</td>
<td>Handout #13: Messages of Hope Action Planning Worksheet</td>
<td>Annex B</td>
</tr>
<tr>
<td>Resources</td>
<td>N/A</td>
<td>Creative Group Splitters (resource for any session that includes group work)</td>
<td>Annex D</td>
</tr>
</tbody>
</table>
Session 1: Introduction/Opening Activities


Objectives
By the end of this session, participants should:

- Understand the purpose and objectives of the training
- Have begun to connect and familiarize themselves with other participants and their backgrounds
- Have established group norms for the day

Facilitator Note: By the end of the session, facilitators should have begun to connect and familiarize themselves with participants.

Time
30 minutes

Activity 1: Welcome and Opening Prayer

Objectives
- Introduce facilitators
- Underscore the central role of faith in the training

Time
10 minutes

Methods
Silent reflection, group discussion

Materials
Name tags or name tents for each participant and facilitator

Steps
1. Introduce yourselves as the training organizers and facilitators, welcome participants, and thank them for attending the training.

2. Begin the workshop with a prayer to emphasize the central role that faith plays in this training and to encourage participants to center themselves, becoming fully present in the moment.

3. Ask participants to take a few moments to reflect on the matter that has brought us together—improving the health and wellbeing of men and boys, and Malawi as a whole, by using our position as faith leaders to share messages of hope and inspire positive change in individuals and in our faith communities.
4. After the reflection, briefly invite participants to share as they are moved to do so.

Activity 2: Participant Introductions

Objectives
By the end of this activity, participants should:

- Have begun to connect with other participants and become familiar with their backgrounds

Time
20 minutes

Methods
Paired interviews

Materials
- “Faith word” index cards (see below)
- Pre-prepared flipcharts:
  - With “5-minute Interview” questions (see below)
  - Labelled “Workshop Expectations”
  - Labelled “HIV-related Challenges Facing Men and Boys”
- Markers

Preparation
- Write “5-minute interview” questions on a flipchart (see Activity 1 below)
- Prepare and post two blank flipcharts—one labelled “Workshop Expectations” and one labelled “HIV-Related Challenges Facing Men and Boys”
- Prepare “faith word” cards (enough for each participant to have one half-card):
  - On index cards or large pieces of paper, write words that evoke shared values among people of faith, such as truth, compassion, peace, love, endurance, gentleness, goodness, and faith (one word per card)
  - Cut the word cards in half, making sure there are enough half-cards for each participant to have one

Steps
1. Introduce the activity by reviewing the “5-minute interview” questions on the pre-prepared flipchart.

5-minute Interview Questions:
- Name (the name they prefer to be called during the workshop)
- Religious affiliation
- Why are you committed to addressing HIV among men and boys?
• What is the most important challenge related to HIV facing men and boys in your community?
• One expectation of the workshop

2. Hand out the “faith word” cards to participants, giving each participant one half-card.
3. Explain that participants will need to locate the person who has the other half of their card. When participants have found their “other half,” they will take turns interviewing their partner using the questions listed on the flipchart. Each participant will have five minutes to interview their partner.
4. After five minutes, prompt participants to switch roles (if they have not already done so).
5. After 10 minutes, invite partners to introduce each other to the group, beginning by sharing the word that binds them, followed by their partner’s name, affiliation, one expectation they have for the workshop, and what they see as the most important HIV-related challenge facing men and boys.
6. Record the expectations and challenges identified by participants on the appropriate flipcharts.
7. If time allows, after everyone has been introduced, initiate a brief discussion of how the words on the cards may relate to what has brought the group together for this training—reaching men and boys with messages of hope.

Activity 3: Workshop Agenda

Objectives
By the end of this activity, participants should:
• Understand the purpose and objectives of the workshop

Time
5 minutes

Methods
Presentation, discussion

Materials
• Pre-prepared flipchart with workshop objectives and agenda
• Markers

Preparation
• Post workshop objectives and Day 1 agenda on a flipchart

Steps
1. Review the workshop objective(s) and agenda, displaying the pre-prepared flipchart.
2. Review participant expectations identified during Activity 1. Clarify any contradictions between participants’ expectations and the workshop’s objectives and content.
3. Ask participants if they have any questions about the workshop objectives or agenda.
Session 2: HIV Basics

Objectives
By the end of this session, participants should be able to:

- Define the terms “HIV” and “AIDS”
- Distinguish myths and facts about HIV and dispel some commonly held myths about HIV
- Describe the new approaches to HIV testing, treatment, and prevention that inform the messages of hope (i.e., new testing approaches, “test and start,” new ART regimens, new options for receiving ART more easily, and new prevention approaches)
- Describe the meaning of “95-95-95 by 2030”
- Understand key components of the HIV and AIDS (Prevention and Management) Act, 2018 and the role of faith leaders in implementing this policy

Time
3 hours

Activity 1: Introduction to HIV

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

- Define the terms “HIV” and “AIDS”
- List three ways HIV CANNOT be transmitted
- Explain three methods of preventing HIV transmission

Time
30 minutes

Methods
Group brainstorm, large group discussion

Materials
- Handouts (one copy for each participant) (Annex B):
  - Handout #1: HIV Glossary
  - Handout #2: HIV and the Benefits of ART
- Five pre-prepared flipcharts with the following headings:
  - HIV
  - AIDS
  - Transmission
Reaching Men and Boys with Messages of Hope: Facilitator’s Guide

- How You **CANNOT** Get HIV
- Prevention

- Laptop, projector, screen, and speakers
- Markers

**Preparation**

- Make your flipcharts (see above)
- Before the session, review the handouts and familiarize yourself with the content. Make sure you are familiar with the flipchart topics and prepared to discuss these with participants.
- If you are using the video, do a “test run” ahead of time—play the video using the audio-visual equipment at the training venue to avoid problems and delays on the day of the training.

**Steps**

1. Invite participants to write words or phrases on each flipchart that show what they think the heading means. Instruct participants not to repeat what is already written.
2. When everyone has written their words/phrases, ask volunteers to read what has been written.
3. Review what participants have written. Expand on or correct what has been written, giving facts about what each heading means or involves. This will begin dispelling HIV myths and reinforcing HIV facts.
5. Use the questions listed below to check participants’ understanding and generate discussion. Ask the questions one at a time, taking answers from volunteers after each question. Discuss each question as needed before moving on to the next question.
   - What do CD4 cells do when a person gets infected with HIV?
   - What does HIV do to CD4 cells?
   - What happens if lots of HIV particles are in the body?
6. Ask if there are any questions.
7. Distribute the handouts and tell participants that they should refer to these throughout the training.

**Facilitator Note:**

The video *HIV: What’s Going on Inside Your Body* is only available in English and Spanish. If you believe that participants will have difficulty with the language, you can skip the video and facilitate a discussion using the questions and flipcharts as needed.

If you choose to use the video, it is available for download here: [https://www.helpstopthevirus.com/hiv-education](https://www.helpstopthevirus.com/hiv-education)

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

- Describe the new approaches to HIV testing, treatment, and prevention that inform the messages of hope
- Describe the meaning of “95-95-95 by 2030”

Time
1 hour

Methods
PowerPoint presentation

Materials
- PowerPoint: PEPFAR Engaging Faith Communities to Find Men and Children: New Choices, New Treatment, New Timing, New Hope (to obtain the presentation, contact: policyinfo@thepalladiumgroup.com)
- Laptop, projector, screen
- Pre-prepared flipchart labelled “Parking Lot”

Preparation
- Prior to the training, study the facilitator’s notes in Annex A. You should be very familiar with this content prior to the training. Have a printout of these notes on hand in case you need to refer to them during your training.
- Hang the pre-prepared flipchart on the wall

Steps
2. Encourage participants to ask any questions they have during the presentation. Explain that there will also be time at the end of the presentation to ask questions and have a discussion.
3. After the presentation, answer participants’ questions and discuss any areas of concern or interest. As later sessions of the training will go into more detail on all these topics, you may want to place some participant questions in a “Parking Lot”—in other words, writing questions on the “Parking Lot” flipchart to come back to at a more appropriate point in the training.
Activity 3: Myths and Facts about HIV

Objectives
By the end of this activity, participants should be able to:

- Distinguish myths and facts about HIV
- Dispel some commonly held myths about HIV

Time
45 minutes

Methods
Small group discussion

Materials
- Flipchart paper and markers
- Handout #3: HIV Myths and Facts Worksheet (Annex B) (one copy for each participant)
- Answer key for facilitators: HIV Myths and Facts worksheet (see below) (one copy for each facilitator)

Steps
1. Introduce the exercise by explaining that participants will work together to discuss some common myths about HIV. Divide participants into groups of four.

2. Group work: Myth or Fact? Ask each group to work together to fill out the handout, discussing any differences of opinion. Each participant should record their own responses on a handout. After about five minutes, come back into plenary and go through the statements on the handout one by one. For each statement, ask participants to vote “myth” or “fact.” Whenever there is disagreement, facilitate a brief discussion to clarify the issue and bring everyone to a common and correct understanding. Use the facilitator’s answer key on the next page as a resource as needed.
## Answer Key for Facilitators: HIV Myths and Facts Worksheet

<table>
<thead>
<tr>
<th>Statement</th>
<th>Myth or Fact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Men and boys get infected because they have sex with many partners.</td>
<td><strong>Myth:</strong> While having sex with many partners does increase risk of HIV, not everyone who is HIV positive has sex with many partners.</td>
</tr>
<tr>
<td>2. Undetectable viral load reduces the risk of sexual transmission.</td>
<td><strong>True:</strong> An undetectable viral load reduces the risk of transmitting HIV to a partner during sex.</td>
</tr>
<tr>
<td>3. Mosquitoes can spread HIV.</td>
<td><strong>Myth:</strong> Mosquitoes cannot spread HIV.</td>
</tr>
<tr>
<td>4. People of all ages can become infected with HIV.</td>
<td><strong>True:</strong> People of all ages must practice good prevention.</td>
</tr>
<tr>
<td>5. If you have sex with a person with albinism or who has a disability,</td>
<td><strong>Myth:</strong> There is no cure for HIV.</td>
</tr>
<tr>
<td>you will be cured of HIV.</td>
<td></td>
</tr>
<tr>
<td>6. You can get HIV by sharing food with a person who is HIV positive.</td>
<td><strong>Myth:</strong> You cannot get HIV by sharing food or utensils with a person who is HIV positive.</td>
</tr>
<tr>
<td>7. Prayer can cure people who are HIV positive.</td>
<td><strong>Myth:</strong> There is no cure for HIV. Prayer can help people who are HIV positive to be happier and healthier because it supports their spiritual health. However, prayer cannot cure HIV. People living with HIV must continue to take their ARVs for the rest of their lives.</td>
</tr>
<tr>
<td>8. People living with HIV cannot get loans from a bank.</td>
<td><strong>Myth:</strong> It is illegal for a bank to discriminate against a person living with HIV. People living with HIV have the same rights as everyone else in the community.</td>
</tr>
<tr>
<td>9. Being diagnosed with HIV is a death sentence.</td>
<td><strong>Myth:</strong> People living with HIV can live long and healthy lives if they stay on treatment and take their ART as directed by healthcare providers (ART adherence).</td>
</tr>
<tr>
<td>10. During the window period, someone who has HIV can still test negative.</td>
<td><strong>True:</strong> During the window period, someone with HIV can test negative. The person should test again after three months.</td>
</tr>
<tr>
<td>11. You can tell whether a person has HIV by looking at them.</td>
<td><strong>Myth:</strong> It is impossible to tell whether someone has HIV by looking at them.</td>
</tr>
<tr>
<td>12. Individuals can start ART (antiretroviral therapy) the same day that</td>
<td><strong>True:</strong> If a person is confirmed HIV positive, they can begin ART the same day, if they are ready and consent. It is best to begin treatment as early as possible to keep the body healthy.</td>
</tr>
<tr>
<td>they receive a confirmed HIV diagnosis.</td>
<td></td>
</tr>
<tr>
<td>13. ART is a treatment for HIV, not a cure.</td>
<td><strong>True:</strong> There is no cure for HIV. People who are living with HIV must continue to take ART for the rest of their lives.</td>
</tr>
<tr>
<td>14. People living with HIV should never have children.</td>
<td><strong>Myth:</strong> People living with HIV have the right to decide whether to have children. If they want to have children, they should ask their healthcare provider about how to prevent mother-to-child HIV transmission.</td>
</tr>
<tr>
<td>15. All children born to women with HIV will be infected with HIV.</td>
<td><strong>Myth:</strong> Prevention of mother-to-child transmission (PMTCT) programmes offer services for women living with, or at risk of, HIV to maintain their health and stop their infants from acquiring HIV.</td>
</tr>
<tr>
<td>Statement</td>
<td>Myth or Fact?</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16. Feeling better after starting ART means that an HIV-positive person has been cured and doesn’t need to keep taking ART medication.</td>
<td><strong>Myth:</strong> There is no cure for HIV. People who are HIV positive must stay on treatment and continue taking their ART medications for the rest of their lives.</td>
</tr>
<tr>
<td>17. You can get HIV by shaking hands with someone, hugging them, sitting in the same chair, or using a toilet that they have used.</td>
<td><strong>Myth:</strong> You cannot get HIV by shaking hands, hugging, sharing a chair or toilet seat with a person who is living with HIV.</td>
</tr>
<tr>
<td>18. ART is safe for children to take.</td>
<td><strong>True:</strong> ART is safe for children, although ART for children is often different from ART for adults. A health service provider determines the appropriate ART for a child, based on the child’s weight. It is important never to share ARVs with other people.</td>
</tr>
<tr>
<td>19. HIV makes you less of a man.</td>
<td><strong>Myth:</strong> HIV does not make anyone less of a man. Finding out your HIV status and starting and staying on treatment if you are HIV positive is the “manly” thing to do.</td>
</tr>
<tr>
<td>20. Anyone with tuberculosis (TB) or pneumonia has HIV.</td>
<td><strong>Myth:</strong> People who are HIV negative can contract TB or pneumonia.</td>
</tr>
<tr>
<td>21. Traditional healers can cure HIV.</td>
<td><strong>Myth:</strong> There is no cure for HIV. ART is a treatment, not a cure.</td>
</tr>
<tr>
<td>22. A faithful couple does not need to use condoms if both partners are living with HIV.</td>
<td><strong>Myth:</strong> Couples who both are HIV positive must still use condoms. Condom use is important to prevent transmission of STIs and unplanned pregnancy.</td>
</tr>
<tr>
<td>23. ART is only for people who look very sick.</td>
<td><strong>Myth:</strong> Everyone who is HIV positive must continue taking ART for life, to prevent the virus from replicating so they can live a long and healthy life.</td>
</tr>
</tbody>
</table>

**Activity 4: Overview of the HIV and AIDS Act**

**Objectives**

By the end of this activity, participants should be able to:

- Identify key components of the *HIV and AIDS (Prevention and Management) Act, 2018*, specifically:
  - Prohibition of harmful practices, discrimination, and the publication of false information
  - Human rights of people living with HIV, including their right to privacy and confidentiality, to make choices about their sexual and reproductive health (including pregnancy), and to receive non-discriminatory healthcare services

**Time**

45 minutes

**Methods**

PowerPoint presentation
Materials

- PowerPoint: *The HIV and AIDS Act*
- Laptop, projector, screen
- Flipchart paper
- Markers
- Facilitator’s notes for Session 2, Activity 4: HIV and AIDS (Prevention and Management) Act, 2018 (Annex A) (one copy per facilitator)
- Facilitator’s notes on session 2, activity 4 scenarios (see below)
- Handout #4: Scenarios: The HIV and AIDS (Prevention and Management) Act, 2018 in Practice (one copy for each participant)

Preparation

Before your training, study the background information on the *HIV and AIDS (Prevention and Management) Act, 2018* in Annex A so you are very familiar with the content. During the training, you should have a printed copy of Annex A available to refer to as needed. Following these steps is a copy of the scenarios for activity 4 with additional notes for facilitators.

Steps

1. Tell participants that, during this activity, they will learn about and discuss the *HIV and AIDS (Prevention and Management) Act of 2018*—known as the “HIV and AIDS Act.” For their work, it is important for faith leaders to understand what is legal and illegal in Malawi in relation to HIV. Faith leaders must always follow the law and be able to inform others about the law.

2. Tell participants that the HIV and AIDS Act was ratified by Parliament in November 2017. The Act went into force in February 2018, when it was approved by the President and published in the Gazette.

3. The purpose of the Act is to strengthen institutional structures to address HIV and AIDS and to protect the human rights of people living with HIV and people affected by HIV.

4. Tell participants that, in this activity, they will not be going through the entire Act. Instead, the activity will focus on the sections that are most relevant for faith leaders engaged in HIV communication and programming. If they wish, participants can read the entire Act on their own.

5. Give the PowerPoint presentation: *The HIV and AIDS Act*.

6. Answer questions and comments (recording notes on flipcharts if desired)

7. Allow participants to reflect and discuss.

8. Tell participants that next they are going to discuss a few different scenarios to help them understand what the Act means in practice.

9. Divide participants into four groups.

10. Pass out the handout and assign each group one of the scenarios. Tell participants they will have about 15 minutes to discuss their scenario as a group before reporting on their discussion.
11. After about 15 minutes, call the groups back into plenary (all participants). Ask groups to report out (share key points from their discussion) one by one. After each group presents, ask the other groups to provide comments and feedback.

12. As groups report out, provide feedback as needed on the group’s discussions.
Facilitator’s Notes on Activity 4 Scenarios: The HIV and AIDS (Prevention and Management) Act, 2018 in Practice

In addition to the scenarios, this section provides guidance you can give to groups after they report out on their discussions about the scenarios. It is important that all participants leave the session with accurate knowledge about the HIV and AIDS Act.

Group 1

**Scenario:** An organization developed posters targeting boys with messages from the Messages of Hope guide. They took these posters to the community and pretested them. After incorporating the changes, they printed the posters and hung them in clinics and places of worship. Was this the correct procedure according to the HIV and AIDS Act? Please explain why or why not.

**Facilitator feedback:** This was not the correct procedure according to the HIV and AIDS Act. The organization cannot hang the posters until they have been accredited by the National AIDS Commission (NAC). The organization should have contacted NAC and asked them to review and approve the posters before hanging them. This part of the Act is important to ensure that nobody is spreading false, inaccurate, or misleading information about HIV to the public.

Group 2

**Scenario:** A man named F____ has gone to his faith leader for advice. F_____ told his faith leader that he recently went for HIV testing and was found to be HIV positive. F____, who is married, believes he has HIV because he had a few girlfriends in the past. He does not want to disclose his HIV status to his wife because he fears how she will react. The faith leader is concerned for the health of F____’s wife. He wants to tell F____’s wife about her husband’s HIV-positive status so she can get tested. What should the faith leader do? Please explain why.

**Facilitator feedback:** The faith leader cannot disclose the man’s HIV status to anyone, including his wife. Disclosing another person’s HIV status is illegal under the HIV and AIDS Act and is punishable by a fine of MWK 5,000,000. The faith leader should spend time counselling the man on how to discuss his HIV status with his wife. The leader can also offer to be present when the man discloses, to provide support, if the man would like it.

We will learn more about disclosure, and how to support people to disclose their HIV status to their partners and families, later in this training.

Group 3

**Scenario:** A faith leader has been preaching to congregants that people who are living with HIV can stop taking their antiretroviral drugs (ARVs) if they come to him and have him pray for them. The faith leader has said that those people will be cured of HIV after he has prayed for them. Is this legal according to the HIV and AIDS Act? Why or why not?

**Facilitator feedback:** What the faith leader has been doing is not legal. As we know, there is currently no cure for HIV. If a person stops taking their ARVs, their viral load\(^1\) will go up,

\(^1\) The amount of HIV in the blood, measured by number of viral copies per milliliter (copies/ml) of blood; the best measure for the level of progression of HIV infection.
and eventually their infection could progress to AIDS. Under the HIV and AIDS Act, spreading false, misleading, or inaccurate information about HIV—such as saying there is a cure—is illegal. If convicted, the faith leader could be imprisoned for five years and have to pay a fine of MWK 5,000,000.

Faith leaders have a lot of trust and influence in their communities. Given this position of influence, it is vital that the information faith leaders share is accurate. After completing this messages of hope training, as faith leaders who are knowledgeable about HIV, you will have an important role to play in educating other faith leaders about HIV.

**Group 4**

**Scenario:** A boy wants to join a youth football team organized in the community. Some of the other children know that he is HIV positive. They make fun of him, calling him names and saying they do not want him to be on their team. The team’s coach decides that it would be too disruptive for this boy to play football with the other children and tells the boy that he cannot be on the team. As a faith leader who has participated in this messages of hope training, you hear about this situation. What should you do and why?

**Facilitator notes:** The boy has been discriminated against by the other children and by the coach. Under the HIV Act, the human rights of people living with HIV, including their right to participate in social life (e.g., activities such as football) cannot be denied because they are HIV positive. The Act states that people living with HIV must have the same rights as any other community member and prohibits discrimination related to HIV or AIDS. A person convicted of such discrimination could be imprisoned for five years and fined MWK 5,000,000.

As a faith leader, you could talk to the football coach, help the coach understand that keeping the boy from playing on the team is discrimination, and explain how this discrimination is harmful to the boy who is being excluded. You could hold a session with the other children to educate them about HIV, rights, and the harmfulness of discrimination. You could also provide counselling to the boy, who has been hurt by this discrimination.

We will discuss discrimination in greater detail later in this training.
Session 3: HIV Testing, Care, and Treatment

Objectives
By the end of this session, participants should be able to:

- Describe HIV testing approaches and how faith leaders can promote testing and support individuals who have received their test results
- Define ART and state when to start ART
- Define ART adherence and viral load monitoring
- Understand what ART does in the body and the importance of ART adherence
- Understand how ART leads to viral suppression and undetectable viral load
- Differentiate between spiritual support and “faith healing”

Time
1 hour 30 minutes

Activity 1: HIV Testing Services

Objectives
By the end of this activity, participants should be able to:

- Describe HIV testing approaches and how faith leaders can promote testing

Time
30 minutes

Methods
PowerPoint presentation

Materials
- Laptop, projector, screen
- PowerPoint presentation: *HIV Testing*
- Flipchart paper
- Markers
- Facilitator’s notes for Session 3, Activity 1: HIV Testing Services (Annex A) (one copy per facilitator)

Preparation
Study the facilitator notes in Annex A prior to the training. You should be very familiar with these notes before the training. During the training, you should have a printed copy of Annex A available to refer to as needed.
Steps
1. Give the PowerPoint presentation: *HIV Testing*.
2. Answer questions and comments (recording notes on flipcharts if desired).
3. Allow participants to reflect and discuss on any topics related to testing.

Activity 2: HIV Treatment and Adherence

Objectives
By the end of this activity, participants should be able to:

- Define ART
- State when to start ART
- Understand what ART adherence means and why it is critically important
- Explain what viral load is and what it means when an individual’s viral load is said to be “virally suppressed” or “undetectable”

Time
1 hour

Methods
PowerPoint presentation

Materials

- Laptop, projector, screen
- PowerPoint presentation: *Treatment and Adherence*
- Flipchart paper
- Markers
- Facilitator’s notes for Session 3, Activity 2: HIV Treatment and Adherence (Annex A)

Preparation
Study the facilitator notes in Annex A before the training so you are very familiar with the content. During the training, you should have a printed copy of Annex A available to refer to as needed.

Steps
1. Give the PowerPoint presentation: *Treatment and Adherence*.
2. Answer questions and comments (recording notes on flipcharts if desired).
3. Allow participants to reflect and discuss on topics related to treatment and adherence.
Session 4: Stigma and Discrimination

Session Overview

This session is designed to help participants better understand HIV-related stigma and discrimination. The session accomplishes this by leading participants through an experiential learning process, enabling them to:

**Name the problem**—See that stigma exists and that it is harmful. Stigma takes many forms (rejecting, isolating, shaming, blaming, judging, etc.). This discussion will focus on how stigma harms men and boys specifically. Stigma discourages men and boys from seeking HIV testing and treatment, makes it harder for HIV-positive men and boys to receive the support they need to live healthy lives by accessing and staying on treatment. Stigma keeps men and boys from accepting themselves and feeling fully accepted and supported by their loved ones and communities.

**Own the problem**—See that stigma is present in faith communities and understand that everyone plays a role in producing stigma, often without realizing it.

**Start talking about solutions**—Begin discussing how faith leaders can help combat stigma in their communities, building on the deeper understanding of stigma gained through the first two steps. Once you are able to see the problem, understand its harmful effects, and recognize that we all play a role in producing stigma, you will be in a powerful position. If everyone is part of creating the problem of stigma, that means that everyone has the power to be part of the solution. Faith leaders, in particular, are in a powerful position to tackle stigma in their communities. The *Messages of Hope* guide offers a tool that faith leaders can use to reduce stigma in their faith communities.

**Objectives:**

By the end of this session, participants should be able to:

- Describe some of the key forms of stigma (e.g., rejecting, isolating, shaming, blaming, judging, etc.)
- Recognize that stigma exists in their faith communities and discuss examples, particularly examples of stigma experienced by boys and men
- Understand some of the harmful effects of stigma
- Discuss actions they can take to reduce HIV-related stigma in their faith communities

**Time**

2 hours

**Activity 1: Seeing Stigma**

**Objectives**

By the end of this activity, participants should be able to:

- Identify different forms of stigma in different contexts
- Understand some of the effects of stigma, particularly how stigma affects boys and men
• Discuss examples of stigma from their own communities, particularly examples of stigma in the context of faith communities and stigma experienced by boys and men

**Time**
1 hour

**Methods**
Discussion in pairs, reviewing pictures of stigma in different contexts, plenary discussion

**Materials**
- Facilitator’s notes for Session 4, Activity 1: Seeing Stigma (Annex A) (one copy per facilitator)
- Large copies of pictures for posting (selected from ANNEX C. Picture Tools for Session 4, Activity 1: Seeing Stigma)
- Tape for posting pictures
- Pre-prepared flipchart with discussion questions (see step 1)
- **Handout #5: Discussion Questions for “Seeing Stigma” Activity** (Annex B) (one for each pair) (see step 1)
- Flipchart paper
- Markers

**Preparation**
- Before your training, study the background information on stigma in Annex A until you are very familiar with the content. During the training, you should have a printed copy of Annex A available to refer to as needed.
- Select pictures from Annex C and print large copies of each for posting
- Post pictures around the room before Session 4
- Decide how you will divide participants into pairs (see ANNEX D. Creative Group Splitters for ideas)
- Write discussion questions on a flipchart (see step 1)
- Make copies of picture questions (enough to give one copy to each pair)

**Steps**
1. Divide participants into pairs and ask each pair to walk around together and look at as many of the pictures posted on the wall as possible.
2. Once participants have had a chance to walk around and look at the pictures, ask each pair to select one picture to discuss. Each pair should use a different picture. To facilitate this, ask participants to remove their chosen picture from the wall.
3. Ask each pair to use the picture they have chosen to discuss the questions below:
   - What do you think is happening in the picture related to stigma?
   - Why do you think this stigma is happening?
• Does this happen in your community? In your congregation? If so, discuss some examples.

4. After about five minutes, ask each pair to briefly report out by explaining what they think is happening in the picture and why. Ask pairs to hold up their picture while they present, so everyone can see the picture they are discussing. Record key points on a flipchart.

5. After all the pairs have presented, use the processing questions listed below to facilitate a large group discussion. Refer to the facilitator’s handout for this exercise to raise any aspects of stigma happening in the pictures that participants have not mentioned. Try to do this by posing questions. This will give participants a chance to reach conclusions for themselves, which will deepen their learning and help participants retain what they have learned.

**Processing questions:**

• Does anyone have anything to add about what is happening in these pictures?
• What are the major forms of stigma that we have seen in the pictures?
• Do these types of stigma happen in your community? Can you share some examples?
• Why do people stigmatize those who are known or suspected to be HIV positive?
• What are some of the effects, particularly for men and boys?

6. Close by recapping some key points from the discussion.


**Activity 2: How Stigma Feels**


**Facilitator’s Note:** This is an important exercise because it draws on personal experiences to bring out feelings of being stigmatized. The exercise asks participants to think about a time in their lives when they felt stigmatized and use this experience to help them empathize with stigmatized groups.

The exercise looks at stigma in general, not stigma toward people living with HIV or key populations. For this reason, participants are instructed to, “Think of a time in your life when you felt isolated or rejected for being seen as different from other people.”

Emphasize that the sharing is voluntary—no one is forced to share their personal experiences. Underscore the importance of confidentiality; remind participants that whatever is shared should stay in the room. Encourage group members to listen carefully to each other’s stories.
Objectives
By the end of this activity, participants should be able to:

- Describe some of their own personal experiences concerning stigma
- Identify some of the feelings associated with being stigmatized

Time
30 minutes

Methods
Individual reflection, sharing in pairs, plenary discussion

Materials
- Facilitator’s notes for Session 4, Activity 1: Seeing Stigma (Annex A) (one copy per facilitator)
- Flipchart
- Markers

Steps
1. Ask participants to sit on their own. Then say, “Think about a time in your life when you felt lonely or rejected for being seen as different from others.” Explain that this does not need to be an example of stigma toward people living with HIV or other marginalized groups; it could be any form of stigmatization for being seen as different. “What happened? How did it feel? What impact did this experience have on you?” Tell participants, “These reflections can be kept private and do not need to be shared with anyone else.” They can also choose to reflect on the experience of a family member or close friend experienced stigma and how it affected them.

2. Say, “Share your experience with someone with whom you feel comfortable. If you prefer not to share with a partner, that is okay too. There is no pressure to share.” Give the pairs a few minutes to share their stories with each other if they choose.

3. Invite participants to sit in a circle. This is voluntary; no one should be forced to share their story. They can reflect on the process of the exercise and how it made them feel, if they do not feel comfortable sharing specific stories.

4. Ask the following questions to help participants process their reflections:
   - What did you learn from the exercise about stigma?
   - What feelings are associated with stigma?

Activity 3: Reducing Stigma in Our Community

Objectives
By the end of this activity, participants should be able to:

- Discuss actions they can take to reduce HIV-related stigma in their faith communities
**Time**

30 minutes

**Methods**

Discussion

**Materials**

- Facilitator’s notes for Session 4, Activity 1: Seeing Stigma (Annex A) (one copy per facilitator)
- Flipchart
- Markers

**Steps**

1. Ask participants to reflect on the feelings and thoughts they experienced during the previous exercise.
2. Ask participants, “How do you think people living in your community feel?”
3. Take a few responses and note these on the flip chart.
4. Next ask, “What can we as faith leaders do to reduce stigma in our communities?”
5. Facilitate a discussion on this topic and write the responses on a flipchart.
6. As needed, you can use the following prompts to keep the discussion moving forward:
   - Are there words we should or should not use when talking about people living with HIV?
   - Who should we engage to reduce stigma in our faith communities?
   - What specific actions can we as individuals take to reduce stigma in our communities?
   - What would you say if you observed someone saying or doing something stigmatizing?
7. At the end of the discussion, summarize the key points and thank participants for their contributions.
Session 5: Reaching Men and Boys

**Objectives**

By the end of this session, participants should be able to:

- Understand why it is critical to focus on reaching men and boys
- Describe common barriers that prevent men and boys from accessing HIV services and identify solutions

**Time**

1 hour and 30 minutes

**Methods**

Small group work, discussion

**Materials**

- Flipchart paper
- Markers

**Steps**

1. Ask participants the following questions, recording their responses on a flipchart:
   - What does it mean to be a man in Malawi?
   - Have the expectations of what it means to be a man in Malawi changed over time?
   - Are there things that were common in your parents’ or grandparents’ time that are different now?
   - Are there new or changing expectations for young men and boys in Malawi?

2. Explain that the group will now spend some time thinking about challenges related to HIV that are faced by men and boys. Share the following points about HIV in Malawi:
   - HIV prevalence is higher among women than men. However, only around two-thirds (65.6 percent) of men have been tested for HIV, compared to more than three-quarters (81.6 percent) of women (MOH, 2018).
   - Looking at adolescent boys in Malawi, less than half of males ages 15–24 years had ever tested for HIV and received their results (MOH, 2018).
   - We need to reach more men and boys with testing services. To do that, we need to understand why men and boys do not go for testing.

3. Divide participants into groups of three to four. Assign half of the groups to focus on men and the other half to focus on boys. Ask participants to discuss the following questions in their small groups and write their responses on a flipchart.

   **Groups Focusing on Men:**
   - How do you think men in your community feel about getting HIV?
   - How do you think men in your community feel about getting tested for HIV?
Groups Focusing on Boys:

- How do you think boys in your community feel about getting HIV?
- How do you think boys in your community feel about getting tested for HIV?

4. Ask each small group to share some of their responses with the whole group (plenary), then discuss these responses. Possible responses include:

- Being HIV-positive is emasculating: “It means I am weak; I am not a strong man.”
- Men are in denial; they feel they are not at risk.
- They feel they could not cope with a positive HIV test, so they avoid being tested.
- They are not aware that HIV is a manageable condition and still equate it with certain death.
- Testing HIV positive can feel like life is over; they are worried they won’t be able to live a normal life.
- Men fear losing relationships (romantic, family, etc.) and losing status in their community.
- Men do not feel able to talk openly to healthcare providers.
- Men worry that their HIV status will not be kept confidential.
- Men fear losing their autonomy, losing control over their lives.
- Men do not like to go to the clinic because it is inconvenient or unpleasant.
- Men are supposed to be strong and not need health services.
- Boys fear they will not be able to go to school or have a good job.
- Boys fear they will not be able to marry and have children.
- Boys do not want their parents (or other adults) to know they have had sex.
- Boys do not feel comfortable talking to adults about HIV.

5. Explain that, in Malawi, HIV-positive men are less likely to be on treatment, and less likely to be virally suppressed, than HIV-positive women. The 2015–2016 Malawi Population-Based HIV Impact Assessment (MPHIA), a nationally representative population-based survey of households across Malawi, found 61 percent of males and 73 percent of females over the age of 15 were virally suppressed (MOH, 2018). According to 2019 estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS), in Malawi, only 61 percent of males over the age of 15 years are virally suppressed, compared to 79 percent of women in the same age group (UNAIDS, 2019). These statistics show that Malawi’s HIV response has made better progress in supporting women than men. Remind participants that, to be virally suppressed, people living with HIV need to adhere to their treatment regimens. There is an urgent need to find ways to encourage and help men to start and stay on treatment.

6. Next, share that data for adolescent boys and young men ages 15–24 years show that Malawi is having a very hard time reaching this age group. Only 37 percent of HIV-positive males in this age group were virally suppressed (MOH, 2018).

7. In the same small groups, ask participants to discuss the questions listed below. Again, half of the groups should discuss men, and the other half should discuss boys.
Groups Focusing on Men:

- Why do you think men often do not start and/or adhere to treatment? (By “adhere,” we mean going to the clinic and taking antiretroviral drugs [ARVs] regularly.)

- What do you think we can do to help men adhere to treatment? Are there things we are already doing that are effective?

- How can the qualities and expectations of Malawian men that we listed earlier help us find solutions to these challenges?

Groups Focusing on Boys:

- Why do you think boys often do not start and adhere to treatment? (By “adhere,” we mean going to the clinic and taking ARVs regularly.)

- What do you think we can do to help boys adhere to treatment? Are there things we are already doing that are effective?

- Knowing that boys grow into men, how can the qualities and expectations of Malawian men that we listed earlier help us find solutions to these challenges?

8. In plenary, ask each small group to share some of their responses, then discuss these responses. Keep the flipcharts from each group so these can be displayed and referred to during later sessions.
Session 6: Messages of Hope: Reaching Men and Boys with HIV and AIDS Information

Session Overview

The Messages of Hope guides were created to help faith leaders engage men and boys on HIV issues by giving them information on key HIV topics. The Christian and Islamic versions of the guide pair HIV messages for men and boys with supporting verses from the Holy Bible and the Holy Qur'an, respectively. In this session, participants will be introduced to the messages in the Messages of Hope guides and learn some principles of effective communication for behaviour change. They will build communication skills to help them successfully reach men and boys with HIV messages. Facilitators will encourage participants to connect this session’s content with what they have learned about stigma and discrimination. Doing this will help them understand the importance of using non-judgmental and non-stigmatizing language when delivering messages of hope to men and boys.

Objectives

By the end of this session, participants should be able to:

- Understand some principles of effective communication for behaviour change
- Understand the importance of using positive messages
- Discuss the specific communication needs of adolescents
- Practice applying the messages in the Messages of Hope guide
- Demonstrate effective communication techniques

Time

3 hours

Activity 1: Introducing the Messages of Hope Guide

Objectives

By the end of this activity, participants should be able to:

- Be familiar with the messaging guide Messages of Hope: Reaching Boys and Men with HIV and AIDS Information—how and why the guide was developed and its overall structure and purpose
- Understand the purpose of the messages and the evidence they are based on
- Discuss which excerpts from holy texts should be used with the messages of hope

Time

1 hour

Methods

Presentation
Materials

- *Messages of Hope: Reaching Boys and Men with HIV and AIDS Information* (enough for every participant to have a copy)
- PowerPoint presentation: *PEPFAR Engaging Faith Communities to Find Men and Children: Messages of Hope for Men and Children Tool* (to obtain the presentation, contact: policyinfo@thepalladiumgroup.com)
- Laptop, projector, and screen

Steps

1. Give the PowerPoint presentation: *Engaging Faith Communities to Find Men and Children: Messages of Hope for Men and Children Tool*.
2. As you go through the presentation, take time to answer participants’ questions and discuss any concerns that arise.
3. After the presentation, call participants’ attention to the concept of “hope.” Ask whether they can think of examples about hope from the scriptures (i.e., the Holy Bible and the Holy Qur’an).
4. Ask:
   - Why is hope important?
   - Why is hope important for people living with HIV?
   - Why is hope important for people who do not know their HIV status?
5. Spend some time discussing the importance of hope in our lives, especially in relation to HIV.
6. Spend 5–10 minutes introducing the *Messages of Hope* guide and the messages it contains, including:
   - Why the guide is needed (refer to Session 5: Reaching Men and Boys)
   - How the messages were developed and validated (i.e., by faith leaders in an interfaith effort to address challenges facing men and boys in the context of HIV)
   - The role of faith leaders (use content from page 6 of the guide):
     - Faith leaders influence their communities through both their words and their actions
     - The Messages of Hope guide is not only about the messages themselves, but also how faith leaders deliver the messages: Faith leaders should not only deliver the messages, they should strive to embody what the messages represent and lead by example (i.e., getting tested for HIV to show others they do not need to be afraid of testing; breaking the silence about HIV; using supportive, non-stigmatizing, non-judgmental language and fostering a supportive environment in their faith communities)
     - Faith leaders are being asked to (refer to page 7 of the guide):
       - Lead by example—go for HIV testing
       - Encourage men and boys to seek HIV testing
Help men and boys understand the benefits of HIV testing and treatment

Take a stand against stigma and discrimination—one of the biggest barriers to testing and treatment

The guide’s structure—an introduction followed by three main sections: (1) HIV testing, (2) starting treatment (ART), and (3) ART adherence, which each include:

- Background information on the topic
- Guidance and messages—The guide includes HIV messages for men and boys, as well as messages encouraging faith leaders to take action. Messages are paired with supporting verses from the Holy Bible (Christian version) or Holy Qur’an (Islamic version). These verses were identified and validated by faith leaders and were carefully chosen to emphasize supportive messages and non-stigmatizing, non-judgmental language. Faith leaders using the nondenominational version should select appropriate verses from their community’s religious texts.
- How to use the guide (session 7 will go into this topic in greater detail)

7. Tell participants that next they will be discussing the verses from the Holy Bible and Holy Qur’an that are included in the Messages of Hope guides. Choose a message from the guide; ask a volunteer to read the message and its associated verses.

8. Ask participants, “Does this verse promote hope, as we discussed earlier?” Take some responses.

9. Working in pairs with the person next to them, ask participants to pick one HIV message and accompanying verse from each section of the guide,—(1) HIV testing, (2) starting treatment (ART), and (3) ART adherence—and discuss how the verse relates to the message and to the idea of hope.

10. Give the pairs about 10 minutes to work, then ask each pair to share what they have discussed.

When delivering the messages of hope, emphasize that it is essential for faith leaders to avoid using verses that can be interpreted as shaming or stigmatizing. Shame prevents people from accessing important HIV testing and treatment services. In contrast, love and hope are effective ways to support people—making them powerful tools in the HIV response.

11. Leave several minutes for general questions.

Activity 2: Building Behaviour Change Communication Skills

Sources: Adapted from:


Background

Good communication skills are vital to reach men and boys with HIV messages in ways that encourage them to change their attitudes or behaviours—for example, to get tested for HIV and, if HIV positive, to start and stay on treatment (ART). Communication is an important part of faith leaders’ role in their communities. This session is designed to strengthen participants’ existing behaviour change communication skills to enable them to better reach men and boys with HIV messages in ways that encourage them to change their attitudes or behaviours.

Objectives

By the end of this activity, participants should be able to:

- Understand some principles of effective communication for behaviour change

Time

1 hour

Methods

Role play, pairs discussion, plenary discussion

Materials

- Flipcharts
- Pens and paper
- Handout #6: Discussion Questions for Reflecting on the Process of Behaviour Change (Annex B)
- Pre-prepared flipchart with discussion questions for reflecting on behaviour change (see part 1, step 5 below)
- Four pre-prepared flipcharts, each labelled with one of the titles below:
  - Open, Not Closed
  - Encourage, Don’t Push
  - Support, Don’t Judge
  - Listen More, Speak Less

Steps

Part 1: The process of behaviour change

1. Introduce the session by explaining that:

   - Reaching men and boys with messages of hope requires good behaviour change communication skills
Many of the messages encourage men and boys to change their behaviour—for example, to seek HIV testing, start or to stay on treatment (ART), or continue taking their ART medications as instructed by medical professionals.

2. Ask participants to share examples of how they have changed people’s behaviour through their work as faith leaders. Take responses from a few volunteers. Responses may include preaching, counselling, or other interactions with congregants and community members.

3. Next, ask participants how they would define “behaviour” and what “behaviour change” means to them. Take a few responses, then continue with the session by explaining:
   - Behaviour is the way people act, react, and perform in different situations and conditions. Different people act differently under the same conditions.
   - Behaviour change is a gradual process of shifting from one behaviour to another. This process does not happen all at once, and it takes work to sustain the change.

4. Ask participants to think of a habit or behaviour in their own lives that they wanted, or tried, to change. Start the conversation by sharing an example from your own life, such as eating healthier, quitting smoking, or spending more time with your family.

5. Keeping this habit in mind, ask participants to think about the questions below, taking notes so they can share their reflections with a partner:
   - What made you decide to change this behaviour? OR Why did you want to change? Did you get new information that prompted the decision?
   - Were there good things you thought would happen if you changed? If so, what were they?
   - Were you able to change this behaviour? If yes, how long did it take to make the change? What were some of the steps in the change process?
   - Did you ever go back to the old behaviour? If so, why?

6. Give participants a few minutes to reflect on the questions, then ask them to form pairs and share with a partner. Tell participants they will have about 10 minutes to share in pairs and write down some key points to share with the group. Emphasize that sharing is voluntary. If they do not feel comfortable sharing their example with a partner, participants can keep their responses general.

7. After 10 minutes, debrief by going through each question in plenary and inviting participants to share responses as they are comfortable. Emphasize the following points:
   - People often become aware of the need to change their behaviour after receiving new information. However, information alone is usually not enough to cause a change in behaviour.
   - Often, people begin to change as a result of a personal experience or crisis that motivates them to try to change their behaviour or lifestyle.
   - When trying to change a behaviour, almost everyone stumbles along the way because of their own personal obstacles or obstacles in their environment.
   - To successfully change their behaviour, most people need some form of support, either from within themselves or from their peers, family, or others who are important to them.
• It can be helpful to think about behaviour change as a five-step process (see Box 2). Viewing behaviour change this way helps us see that individuals do not change their behaviour all at once. Rather, changing behaviour takes time. During the process, people may “backslide,” returning to an earlier step, especially when the time comes to put the change into practice. To sustain behaviour change, new behaviours must be practiced every day, which can be difficult. Humans beings are imperfect; the important thing is to keep trying.

• Trusted influencers, such as yourselves, can help people move smoothly through the behaviour change process. Keep these steps in mind as you think about how you can help community members adopt healthy behaviours related to HIV.

**Box 2. Behaviour Change: A Five-Step Process**

**Step 1: Knowledge**—The person recalls the message and understands that there is a need to change their behaviour (e.g., to go for HIV testing or start ART).

**Step 2: Approval**—The person responds favourably to the message, and thinks their friends, family, and community will approve of what the message is encouraging them to do.

**Step 3: Intention**—The person recognizes that the desired change meets a personal need and intends to practice the new behaviour.

**Step 4: Practice**—The person practices the new behaviour.

**Step 5: Promotion**—The person acknowledges the benefits of the new behaviour and calls upon others to change their behaviour.

**Source:** Adapted from Phyllis Tilson Piotrow, D. Lawrence Kincaid, Jose G. Rimon II and Ward Rinehart, Health Communication, Lessons from Family Planning and Reproductive Health, Praeger: 1997

**Part 2: Behaviour change communication**

1. Reflecting on the points above and their experience changing a behaviour in their own lives, ask participants, “What can communication do to change behaviours?”

2. Record key points on a flipchart, and share the points below:

   • In public health, communication is a tool that leaders, such as health workers or faith leaders, can use to help community members better understand their health situation and make choices that will support their health. Sharing health-related information can result in changes or improvements in health practices.

   • Communication can help change knowledge, attitudes, and behaviours (the way people act).

3. Transition to the next step in the exercise by asking participants to reflect on the following question:

   • Does the way we communicate influence how effective our communication is in changing behaviour?

4. Tell participants that you are going to transition into an exercise that focuses on how to communicate effectively to support behaviour change.
Part 3: Characteristics of effective interpersonal communication

1. Introduce the exercise by explaining, “When we share messages from the Messages of Hope guide, we will be supporting men and boys by encouraging them to change their behaviour. Support providers have the power to help others feel accepted for who they are, regardless of what situation they are experiencing. Supporting others in this way is harder than it seems and requires specific communication skills. In this exercise, we will practice some of those skills.”

2. Hang the four pre-prepared flipcharts labelled with the interpersonal communication skills that participants will be practicing during this exercise. Tell participants that you will briefly explain each skill; then they will have an opportunity to practice the skills.

3. Using the content below, explain the four communication skills, briefly demonstrating each as needed:

   **Skill #1: Open, not closed**
   Mind your body language. By uncrossing your arms, looking at the other person, and leaning forward, you show that you are interested in communicating.

   **Skill #2: Encourage, don’t push**
   Give people time to think. By making small comments such as “tell me more about that” and “what was that like for you?”, or by just nodding your head, you can help people feel safe and open up.

   **Skill #3: Support, don’t judge**
   Simply reminding people we are there to support them, without judging, can help them feel accepted—reducing their feelings of stigma and shame.

   **Skill #4: Listen more, speak less**
   Giving people the opportunity to speak can make them feel heard and important.

4. Ask two of your fellow facilitators to come up and demonstrate these four skills by performing the two-person role play described below:

   **Two-person role play instructions:**
   One facilitator is playing the role of “persuader,” trying to persuade their partner to do something they are reluctant to do.

   **DO NOT TELL PARTICIPANTS THIS**, but instead of modelling “good” communication skills, these facilitators are going to show participants what NOT to do, by performing the role play as “badly” as possible—doing the opposite of the skills described above, in an exaggerated way. For example:

   - **Closed, not open**: The persuader will use “closed” body language such as crossing their arms over their chest, turning away from their partner, or being distracted (looking at their phone instead of their partner).

   - **Pushing, not encouraging**: Instead of encouraging their partner, the persuader will “push” them. For example, the persuader may make dismissive sounds instead of encouraging, empathetic sounds; say something that dismisses what their partner has said; interrupt their partner; or tell their
partner what to do. The persuader may say something like, “Oh yes, I know what you mean. But I think it would be best for you to go to the clinic today.”

- **Judging, not supporting:** Instead of saying something supportive, the persuader will say something judgmental. For example: “Well, I don’t know why you would do something like that,” or “Well, you wouldn’t be in this position if you had done the right thing in the first place.”

- **Speak more, listen less:** The persuading partner interrupts or talks over their partner instead of listening to them.

5. Let your cofacilitators perform their role play until it becomes clear that they are doing it “wrong” (about one minute). Then stop them by saying, “Wait a minute! Time out!”

6. Ask participants, “How were they doing? Were they using the skills we talked about?” Hopefully, participants will say no. If they do not, ask questions to prompt them to think about the specific skills used. For example, you could ask, “How open was his body language when he was trying to persuade his partner?”

7. Ask for a volunteer to help your cofacilitators. Have the volunteer take the place of the persuader, then perform the role play again, doing their best to correctly demonstrate one of the four communication skills.

8. Debrief by asking:
   - How did the way persuaders were communicating change how the other person responded?
   - What have we learned about behaviour change communication through this exercise?

9. Close the activity by emphasizing that the way we communicate is central to successful behaviour change. When you are encouraging someone to change their behaviour, you need to think about how you are communicating to make sure they feel supported in the change process.

**Activity 3: Behaviour Change Communication Role Play**

**Objectives**

By the end of this activity, participants should be able to:

- Practice using good communication skills to deliver HIV messages from the *Messages of Hope* guide to men and boys

**Time**

30 minutes

**Methods**

Role play

**Materials**

- Handout #7: Behaviour Change Communication Scenarios (Annex B)
Steps

1. Divide participants into groups of three.

2. Distribute the handout (Behaviour Change Communication Scenarios).

3. Explain that participants will be acting out role play scenarios in their groups. For each scenario, one group member will be the faith leader, another the community member, and the third the observer. The faith leader will use one of the messages from the Messages of Hope guide to talk with the community member while the observer pays attention to the skills used by the faith leader.

4. Explain that groups will work through these role plays and rotations simultaneously, while you keep time and tell them when to start and stop, when to switch role players, and when to share feedback.

5. Ask whether there are any questions. Address any questions that arise, then begin the exercise.

6. Guide participants through the exercise using the process below:
   - Announce, “Start the first role play.”
   - After 2 minutes, say “Time’s up!” ask observers to briefly give role players feedback about their use of the four communication skills learned in the previous activity. Tell participants they will have 2 minutes to do this.
   - If time allows, ask the participants to change roles and do the next role play.

7. At the end of the exercise, gather participants in a large circle and debrief the exercise by asking participants:
   - How did it feel to be the person providing support? What was easy? What was hard?
   - How did it feel to be the person who was trying to change someone else’s behaviour? What was easy? What was difficult?

8. Summarize the exercise, focusing on the points below:
   - These communication skills take practice, but with practice they will start to come naturally.
   - In this session, participants practiced supporting people in three different behaviour change situations.
   - As we continue, keep the skills you used in mind, and continue reflecting on what sorts of communication will be effective when delivering messages from the Messages of Hope guide to encourage men and boys to change their behaviour.

Scenario 1
A man comes to speak to you. He has never had an HIV test, but his wife thinks they should both get tested because this was recommended to her during a women’s group meeting. The man feels healthy, so does not think he could have HIV. He does not understand why he should get tested and is upset with his wife.

Scenario 2
M____, who you have known for many years, comes to speak to you after your sermon. He has recently tested positive for HIV. He is scared about what this means for his life and for
his family. He has not started ART yet because he feels healthy, and he is afraid that if he begins to take medication all his family members and neighbours will learn that he is HIV positive.

Scenario 3

L______, a member of your youth congregation, comes to your office one day. He is HIV positive and has been taking ART for about six months. He does not want to go to the clinic anymore because when does he has to miss school. He says he has been praying that he will be healed. He has heard there is a group saying that this is possible and that he does not need to take any medication. He asks whether you can pray for him, so he can stop taking ART medication.

Activity 4: Are We Speaking the Same Language?
Communicating with Adolescent Boys


Objectives
By the end of this activity, participants should be able to:

- Understand unique considerations for communication with adolescent boys
- Understand strategies and tips for communication with adolescent boys

Time
30 minutes

Methods
Presentation, discussion

Materials
None

Steps
1. Present the following content to the group:
   
   - Adolescence is a unique phase of life, and adolescents are going through dramatic biological and emotional changes. Seeking healthcare may seem challenging to young people because the normal changes of adolescence affect their self-confidence, relationships, social skills, and general thinking.
   
   - Adolescents may feel fearful, embarrassed, or uncomfortable around authority figures such as faith leaders. They may be reluctant to disclose personal information because they fear being scolded or mocked, especially if a caregiver is present.
   
   - Most adolescents have concerns about confidentiality, which will impact their willingness to discuss personal issues.
   
   - When meeting face-to-face with a faith leader, healthcare worker, or other adult, adolescents may feel:
• Shy about discussing personal matters
• Embarrassed that they are seeking assistance on a taboo topic (HIV, sex, sexuality, wanting to have sex, wanting to have a baby, etc.)
• Worried that someone will see them and tell their parents or other people
• Unable to adequately describe their concerns and ill-informed about HIV in general
• Anxious that they have a serious condition that will have significant consequences
• Afraid that they might die
• Intimidated by healthcare workers, faith leaders, and other adult authority figures
• Defensive about being the subject of discussion or because they were referred against their will
• Resistant to receiving help or engaging in care and treatment because of rebelliousness, fear of the unknown, or some other reason
• Unsure about how to ask for help related to living with HIV
• Loyal to a healthcare worker or faith leader with whom they have a long-established relationship
• Hopeful that clinic staff can provide them with care that will make them more comfortable and able to live a normal life

• The following are tips for building rapport with adolescents:
  o Treat them equally and with respect.
  o Be genuinely open to adolescents’ questions or need for information.
  o Do not use judgmental words or body language. Do not talk down to adolescents by scolding, shouting, blaming, or getting angry.
  o Validate their feelings instead of telling them not to feel a certain way.
  o Use words and language that adolescents can understand and that are appropriate to their age and developmental stage. Use educational materials—like flipcharts or pictures—to explain complicated information.
  o Do not be critical of adolescents’ appearance, concerns, or behaviour.
  o If sensitive issues are being discussed, make sure that conversations are not seen or overheard by others, even if you have to politely interrupt them or move to a private space.
  o Reassure adolescents that anything they say will be kept confidential.
  o Do not threaten to break adolescents' confidentiality “for their own good.”
  o Adolescents may be reluctant to disclose personal information if their parents or caregivers are present. You should stress that whatever they tell you will not be shared—even with caregivers—unless the adolescent gives their permission.
  o Allow enough time for adolescents to become comfortable enough during the visit to ask questions and express concerns.
o Show an understanding of and empathize with the adolescent’s situation and concerns. Try to put yourself “in their shoes.”

o Understand that adolescents might be uncomfortable; be reassuring when responding to them. Explain that you are here to help.

o Reassure adolescents that their feelings and experiences are normal.

o Be honest and admit when you do not know the answer to a question.

2. In the large group (plenary), discuss the following questions one at a time:
   • What might be challenging about talking to boys about HIV?
   • How might you overcome these challenges?

Activity 5: Communicating with Adolescent Boys: Practice with Scenarios

Objectives

By the end of this activity, participants should be able to:

• Discuss specific communication skills and messages for talking with boys about their HIV-related questions and challenges

Time

30 minutes (1 hour if the optional role play is included)

Methods

Group work with scenarios, role play (optional)

Role play option: If you have enough time, instead of having each group present their responses, you can ask them to act these out as a role play in front of the other groups (see Step 5). Participants usually enjoy role plays, and these can be a particularly effective learning method.

If you choose to do role plays, this activity will take around 1 hour.

Materials

• Handout #8: Scenarios for Session 6, Activity 5: Communicating with Adolescent Boys (Annex B)

• Flipchart paper (enough for each three-person group to have two pieces)

• Pre-prepared flipchart with the discussion questions (see step 3 below)

• Markers

Steps

1. Divide participants into groups of three and give each group flipchart paper and markers.

2. Distribute the handout and assign each group one of the scenarios.

3. Tell participants they will be working in groups to consider a scenario in which a boy has a question or challenge related to HIV that he wants to discuss. Ask participants to work
together in their groups to respond to the discussion questions below; write their responses on flipchart paper.

**Discussion Questions:**

- What specific communication skills would you use when talking to this boy?
- How would you communicate effectively with him?
- Discuss and write down the specific messages or supporting information you would give to this boy.

4. In plenary, ask each group to read their scenario to the group and present their responses.

5. To debrief, in plenary, invite participants to share a few of the most important things they learned during this activity, and ask them:

6. Was there anything challenging about your scenario? “What special considerations did you take in talking with the young person in your scenario?” “Is there anything else you’d like to share about your discussion?”

**Scenario 1**

M_____ is an 18-year-old boy in a youth group that you lead. There is an upcoming football match where HIV tests will be provided. In the youth group, you have been discussing the importance of HIV testing. M_____ is scared because he has had sex with a few girlfriends. He is worried that if he tests positive his current girlfriend will leave him, he will never get married, and he will never get a job.

**Scenario 2**

P___ is a 15-year-old boy who was born with HIV. His mother died when he was five years old, and he has been living with his grandmother ever since. His grandmother does not like to talk about P___’s HIV status and none of P___’s friends know he has HIV. P___ wants to stop taking ART because he is worried his classmates will find out he is HIV positive.

**Scenario 3**

G___ is a 16-year-old boy who tested HIV positive four weeks ago. When you see him today, he appears upset. He tells you he has not told anyone about his HIV-positive status, that he isn’t doing well in school, and that he feels angry most of the time. G___’s girlfriend is threatening to break up with him because of his moodiness. When you ask him questions, he gives you short responses in an angry voice.
Session 7: Reflecting on Content from Days 1 and 2

Objectives
By the end of this session, participants should be able to:

- Demonstrate deeper understanding of content covered in Days 1 and 2
- Practice using their new skills
- Identify topics or skills for which they need additional support

Time
2 hours

Methods
Small group work, study clinics with facilitators, independent study

Materials
- Flipchart paper
- Markers
- Pre-prepared flipchart with reflection questions (see below)
- Handout #9: Reflecting on Content from Days 1 and 2 (Annex B)
- Flipcharts posted around the room labelled with topics for “study clinics”

Steps
1. Explain that in this session participants will have the opportunity to work in small groups to reflect on what they have learned in the first two days of training. Next, they will have a chance to choose among several “study clinics” offered by facilitators to get additional support on key topics. Finally, they will be breaking into pairs for additional practice (“homework” assignments).

2. Divide participants into groups of three to four. In these groups, ask each participant to spend a few minutes on their own considering the reflection questions below, taking notes on their handout:
   - What have you learned during the first two days of this training?
   - What has been new and/or surprising?
   - What have you learned that you think will be most helpful as you prepare to reach men and boys with “messages of hope”?
   - What topics or skills do you have questions about or want more practice in? Hint: You can use this list to choose which “study clinic” you would like to attend.

3. After about five minutes, ask participants to discuss their responses in their small groups.

4. After about 10 minutes, debrief by asking participants to share some key points from the first three reflection questions with the whole group.
5. Transition to the study clinic part of the activity by asking participants to share their responses to question four (which skills or topics they have questions about or want more practice in). As they answer, a co-facilitator should make a list of topics on a flipchart. Continue until you have a good list of topics, then ask participants to vote for the topic that is most important for them. Ask each participant to vote only once. The top 1–3 topics will be the topics for the “study clinics.” The number of topics for the clinics will depend on the number of facilitators. Each study clinic should be led by at least one facilitator.

6. Write each of the topics chosen on one of the flipcharts around the room. Have facilitators choose a study clinic. Tell participants that there will be two study clinic periods, so each participant will have a chance to attend clinics on two different topics. Ask participants to go to their clinic of choice—you may need to shift participants around if the group is too unevenly divided.

7. Once participants are divided in study clinics, start the first round of study clinics. Each clinic will last about 30 minutes, depending on how long it has taken to divide the group. Each clinic facilitator should give participants a chance to ask questions, or explain what they are finding confusing, providing clarification and answering questions until the time is finished. Facilitators should encourage other participants in the clinic to help each other with their questions. The facilitator can share additional clarification or correction as needed. If any questions come up that the facilitator is not sure of, the facilitator should write these down and tell participants that they will discuss these with their fellow facilitators and get back to participants with answers during Day 3.

8. After 30 minutes, thank participants and ask them to move to their second topic. Repeat the clinic process as described above.

9. After the second clinic is concluded, debrief by taking a few comments or points from participants. Thank everyone for their hard work, cover any logistics about the evening ahead, or about Day 3, then close the day’s session.
Session 8: Disclosure Support

Objectives

By the end of this session, participants should be able to:

- Define “disclosure”
- Define voluntary and involuntary disclosure
- Understand that disclosing someone’s HIV status without their consent is unethical and illegal
- Discuss some of the factors involved in a person’s decision of whether to disclose their HIV status
- Discuss some of the factors involved in the disclosure process
- List some tips on how to support disclosure in different contexts

Time

2 hours

Activity 1: Voluntary and Involuntary Disclosure

Objectives

By the end of this activity, participants should be able to:

- Explain what disclosure means
- Define the disclosure process
- Define voluntary and involuntary disclosure
- Understand that sharing someone’s HIV status without their permission (involuntary disclosure) is illegal and unethical
- Discuss the factors involved in voluntary and involuntary disclosure

Time

45 minutes

Materials

- Three pre-prepared flipcharts with the information below—Do not show these to participants until you reach the appropriate step in the activity:

  **Flipchart #1:**

  Voluntary Disclosure

  When someone shares sensitive information about the by choice, without coercion or pressure.

  **Flipchart #2:**
Involuntary or Inadvertent Disclosure

When sensitive information about someone is shared without their permission or inadvertently

**Flipchart #3**

*CONTROL versus NO CONTROL*

**Preparation**

Study the facilitator notes in Annex A before the training so you are very familiar with the content. During the training, you should have a printed copy of Annex A available to refer to as needed.

**Steps**

1. Ask, “When you hear the word ‘disclosure,’ what are the first things that come to mind?” Write responses on a flipchart.

2. Review the responses by reading them aloud.

3. Ask, “How would you define disclosure?” or “What is disclosure?”

4. Take responses from a few volunteers, then share the formal, dictionary definition of disclosure:

   **Disclosure:** The action of making new or private information known.

5. Explain that disclosure is normally thought of as something you say to someone, then ask, “What if someone says something about you? Would you also consider that to be disclosure?”

6. Take a few responses.

7. Ask the questions below, taking a few responses after each:
   - What is disclosure?
   - What is voluntary disclosure?

8. Show participants the prepared flipchart with the definition of voluntary disclosure (flipchart #1) and ask a volunteer to read the definition aloud to the group.

   **Voluntary Disclosure:**

   When someone shares sensitive information about themselves by choice, without coercion or pressure.

9. Ask, “How do you feel about this definition of voluntary disclosure?”

10. Take a few responses, then ask, “Are there any key words that stand out to you? If so, what are they?” Underline words as they are mentioned by participants.

11. Ask, “What is involuntary disclosure?” and listen to the group’s responses.

12. Show the prepared flipchart with the definition of involuntary or inadvertent disclosure (flipchart #2); ask a participant to read the definition aloud to the group.
Involuntary or Inadvertent Disclosure:
When sensitive information about someone is shared without their permission or inadvertently

13. Show the prepared flipchart with “Control vs. No Control” (flipchart #3), then ask, “Would you say that the difference between voluntary and involuntary disclosure is based on how much control a person feels about who, when, where, what, and why they disclose?”

14. Ask the group to provide one example of voluntary HIV disclosure and one of involuntary HIV disclosure.

15. Listen to the responses and discuss as a group.

16. Remind participants that, during the first session, they learned about the HIV and AIDS Act, which states: “A person living with HIV has the right to privacy and confidentiality with regard to information concerning his status.” Under the Act, disclosure of someone’s HIV status is a crime, and is punishable by a fine of MWK 5,000,000 and five years of imprisonment.

17. As you wrap up the discussion, share the following takeaway messages:

- People living with HIV may be at varying levels of disclosure: nondisclosure, partial disclosure, or full disclosure. Disclosure simply a matter of either non-disclosure or full disclosure—many people will be somewhere in between (i.e., partial disclosure).
- Deciding whether and how to disclose differs based on a variety of factors, including those related to age, gender, and societal norms. For example, disclosure decisions may be affected by gendered power relations within families and communities that may put people, especially women, at risk for violence; traditional gender norms around masculinity; emotional maturity levels of children and adolescents; and other complex social factors.
- Reasons for disclosure are context-specific, involving the benefits and risks of disclosing to certain people at a certain time and place.
- The role of someone supporting a person living with HIV who is deciding whether to disclose their status is to help them weigh the risks and benefits of disclosure.
- People living with HIV have a right to privacy and confidentiality. In Malawi, sharing another person’s HIV status without their permission is illegal.
- When counselling someone who is deciding whether to disclose their HIV status, our role is not to tell them they must—or must not—disclose but to support them to come to the best decision possible assessing the risks and benefits of their particular situation.

Activity 2: Supporting People to Assess Whether to Disclose

Objectives
By the end of this activity, participants should be able to:

- Discuss the issues involved in disclosing HIV status
- Describe how they can support people to disclose voluntarily


**Time**

30 minutes

**Materials**

- **Handout #10: Assessing Whether or Not to Disclose—Guiding Questions Worksheet** (Annex B)
- Flipchart paper—enough for each small group to have at least one piece
- Markers

**Steps**

1. Explain that, during this activity, the group will explore the different factors that should be considered when deciding whether to disclose HIV status.

2. Divide participants into small groups and distribute the handout: Assessing Whether or Not to Disclose: Guiding Questions Worksheet to each group.

3. Introduce the small group exercise with the following instructions:
   - In your group, please ask one person to share an experience with deciding whether to disclose something private to someone else (or in a particular setting such as a training or a prayer group). This can be any type of secret or personal information.
   - Sharing an experience is completely voluntary! Only share if you are comfortable doing so.
   - After the person shares their experience, work together as a group to respond to the questions on the handout: Assessing Whether or Not to Disclose: Guiding Questions Worksheet.
   - Write your responses on a flipchart for sharing with the whole group.

4. After 20 minutes, bring the larger group back together.

5. Ask one person from each small group (it does not have to be the person who shared their experience of disclosure) to present the scenario that was shared.

6. Facilitate a discussion by asking the following questions:
   - What strikes you about these responses? Did anything surprise or concern you?
   - What patterns do you see?
   - Are there considerations specific to different groups of people living with HIV that need to be taken into consideration when deciding whether to disclose? What are these considerations?
   - Are there considerations specific to disclosure decisions in particular settings such as a church or a mosque, a health clinic, or when interacting with law enforcement?
   - If involuntary disclosure happens, what should you do? What actions can you take?
   - Do you have any other ideas to add?

7. Tell participants that, if someone inadvertently discloses another person’s HIV-positive status, they need to go back to the person they told, explain that they should not have shared this private information, and ask them to go to anyone they told and do the same.
Faith leaders should also have a strategy in place to support the HIV-positive person whose status has been shared.

8. Ask: “Based on what we have discussed, what would you say are the three to five key issues, questions, or concerns that people living with HIV need to be aware of as they assess whether to disclose?”

9. Write responses on a flipchart.

10. Thank everyone for their hard work. Wrap up the activity by asking participants for any final reflections or questions. Encourage them to continue thinking about what they see as most important when making decisions about disclosure.

Activity 3: Key Messages, How to Put This Module into Action

Objectives

By the end of this activity, participants should be able to:

- Develop a plan of action for how they will use what they have learned in their work as faith leaders
- Agree that using the messages of hope should not include pushing people to disclose if they are not ready to do so

Time

45 minutes

Materials

- Handouts (Annex B):
  - Handout #11: Key Messages—Disclosure
  - Handout #12: Putting Learning into Action—How Can I Use What We’ve Done to Support Others?
- Flipchart paper
- Markers

Steps

1. Explain that the group has finished the Disclosure Support session.
2. Invite participants to share comments or reflections.
3. Explain that the group will conclude this module by reflecting on key takeaway messages.
4. Ask participants to take three minutes to discuss with a partner, “What are your key lessons about disclosure?” Ask participants to note their responses so they can share with the rest of the group.
5. After three minutes, ask participants to share some responses. Record these on a flipchart.
6. Distribute the handout Key Messages: How Can I Use What We’ve Done? Disclosure. Ask a participant to read the messages out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and responding to any questions. Invite participants to include their own, additional responses on the Key Messages—Disclosure handout for future reference.


9. Ask participants to complete the handout individually.

10. Ask a few volunteers to share what they wrote.
Session 9: Action Planning for Reaching Men and Boys with Messages of Hope

Objectives
By the end of this activity, participants should be able to:

- Develop concrete action plans for using the Messages of Hope to communicate with men and boys about HIV
- Develop a plan to monitor and evaluate implementation of the action plan

Time
1 hour 45 minutes

Activity 1: Identifying Main Communication Channels for Reaching Men and Boys with Messages of Hope

Objectives
By the end of this activity, participants should be able to:

- Identify main communication channels that can be used to reach men and boys with messages of hope

Time
15 minutes

Methods
Large group brainstorm

Materials
- Flipchart
- Markers

Steps
1. As a large group, ask participants to brainstorm communication channels that can be used to reach men and boys with messages of hope. Write their responses on a flipchart.
2. Once the activity is finished, post the sheet of flip chart paper somewhere easily visible, so the brainstorm can guide participants in the next activity.

Activity 2: Action Planning

Facilitator Note: If the format of your workshop allows, after participants have developed their action plans, it can be helpful to take a break for lunch or tea before coming back together to share their plans. The break allows participants to recharge their energy before giving constructive feedback to others.
Objectives
By the end of this activity, participants should be able to:

- Create a concrete, actionable, and measurable plan for reaching men and boys with messages of hope, based on the Messages of Hope guide.

Time
1 hour 30 minutes

Methods
Small group work

Materials
- Handout #13: Messages of Hope Action Planning Worksheet (Annex B)—one copy per participant
- Pens

Steps
1. Divide participants into small groups (two to five people).
2. Hand out the action planning worksheet, making sure each participant gets a copy.
3. Explain that participants will be using the worksheet to plan how they will integrate select messages from the Messages of Hope guide into their work. This includes:
   a. Choosing which messages they will use—up to six messages, at least one from each section of the guide
   b. Deciding what channels they will use to deliver these messages (sermons, men’s groups, youth groups, family groups, printed materials, etc.)
   c. Determining the timing and frequency with which they will be delivering the messages
   d. Outlining how they will monitor and report their progress
4. Participants should discuss the content of the worksheet as a group, but each participant should fill out their own worksheet.
5. After about 30 minutes, ask participants to return to the large group.
6. Invite participants to present their action plans to the group one at a time. After each presentation, prompt the rest of the group to ask questions and provide suggestions about how to make the plan more effective. Facilitators should also offer suggestions and ask questions that encourage participants to think critically about whether the plans will be effective and realistic.
References


UNAIDS. 2019. "AIDSinfo." Available at: https://aidsinfo.unaids.org/


ANNEX A.
Facilitator Notes

The following should be studied before conducting the training.

Key Facts About HIV

- HIV attacks the body’s defence system, called CD4 cells, which defend the body against illness. As the virus invades a person’s cells it makes copies of itself and goes on to infect more cells. Without treatment, HIV can eventually weaken the immune system to such an extent that the body can no longer fight off other diseases and infections.
- A person who is HIV-infected might be very healthy and may not have any signs of illness for a long time, but they can still pass the virus to others.
- You can only tell if you are HIV-infected by getting a test.
- ART stops the HIV virus from reproducing and prevents a body’s CD4 cells from being destroyed by the virus.
- People on ART (who take their medicines the right way every day) are less likely to pass on HIV to their sexual partner or unborn child.

HIV Transmission

HIV lives in semen, vaginal and birthing fluids, blood, and breast milk. It can be transmitted in several ways:

1. **Unprotected sexual intercourse**
   - Direct contact with the body fluid of an infected person
   - HIV transmission is more likely if
     - One or both people have advanced HIV infection or AIDS
     - One or both people have just recently been infected with HIV
     - One or both people are not taking ART or have poor adherence to ART

2. **Mother-to-child transmission (MTCT)**
   - During pregnancy
   - During labour and delivery
   - During breastfeeding

3. **Blood-to-blood transmission:**
   - Transfusion with infected blood

4. **Use of unsafe sharp objects:**
   - Injecting drugs, sharing needles, piercing and cutting with unclean knives or objects.

Saliva, tears, sweat, vomit, feces, and urine do not transmit HIV. HIV cannot be transmitted by kissing. HIV cannot survive outside the human body and cannot pass through the skin on the outside of your body unless you have an open cut. HIV is not spread through casual
contact like holding hands, hugging, sharing drinks or food, or sitting on toilet seats. If a person is on antiretroviral treatment and is noted as undetectable by medical staff, the person cannot transmit the virus through sexual intercourse. We will learn more about what “undetectable” means later in this training.

What is AIDS?

Acquired immunodeficiency syndrome (AIDS) is the most advanced stage of HIV, when the body’s immune system has become very weak. HIV has destroyed the body’s ability to fight off infection and disease. The person becomes seriously sick and vulnerable to a group of diseases, or opportunistic infections, that a person who is not immuno-compromised would probably not contract. Clinicians have two ways to determine whether a person has advanced to an AIDS diagnosis:

1. From other infections:
   If a person's immune system is so weakened by HIV that they get one or more opportunistic infections. A person with a healthy immune system (e.g. who is undetectable) is highly unlikely to acquire these infections; for example, tuberculosis or pneumocystis pneumonia (also known as PCP). Both are infections in the lungs.

2. From certain blood tests:
   When blood tests show that the number of CD4 cells in an HIV-positive person’s body has dropped to a certain low point.

   The key to slowing or stopping the progression of HIV to AIDS is early HIV testing, care, and treatment. Today, effective medicines can help people with HIV stay healthy for many years, even a lifetime.

HIV Prevention

1. Behaviour change communication (BCC)
   BCC can help people to reduce behaviours that increase the risk of HIV and adopt behaviours that prevent HIV. BCC should be linked to other prevention approaches, such as condom distribution, pre-exposure prophylaxis, testing services, or other approaches listed below. Some effective approaches to BBC are covered in Session 6.

2. Post-exposure prophylaxis (PEP)
   PEP means giving ART to a person who has been potentially exposed to HIV. PEP is used in case of emergency and must be started within 72 hours of exposure to HIV. PEP is a common component of post-rape care.

3. Pre-exposure prophylaxis (PrEP)
   PrEP is ART taken by someone who is HIV negative before they are exposed to HIV. PrEP is usually taken daily and is effective in preventing the person from becoming infected.

   Communities have an important role to play in educating people about PrEP and helping eligible people access PrEP. This can include engaging:

   • HIV testing providers who screen clients at substantial risk of HIV and for PrEP eligibility as well as test for HIV before PrEP initiation
• *Expert clients* who screen for PrEP eligibility, especially in sero-discordant couples
• *Community health workers* who educate people about PrEP as well as screen clients at risk of HIV
• *Peer educators* who screen potential clients, especially youth at risk of HIV

4. **HIV counselling and testing**

HIV counselling and testing for prevention has two focuses:

- Identifying those that have HIV so they can be put on treatment as early as possible to keep them healthy and reduce their probability of transmitting HIV
- Helping those who test HIV negative to stay negative

5. **Treatment as prevention**

ART for all HIV positive people is the most effective prevention method available: Successful ART leads to very low levels of virus in the blood and in body fluids (viral suppression). Successful ART means that the person is taking ART every day as prescribed, is being monitored by health providers, and their body is responding well to the medication. This leads to viral suppression, which can be measured through viral load monitoring. Viral suppression greatly reduces the risk of sexual or mother-to-child transmission.

6. **Voluntary male medical circumcision (VMMC)**

VMMC can reduce a man’s chance of acquiring HIV from a female partner by about 60%. It provides a man with lifelong, partial protection against HIV and other STIs.

7. **Use of male and female condoms**

Condoms are the most reliable and cost-effective means of preventing HIV. Condoms also prevent STIs and unplanned pregnancy.
Session 2, Activity 4: HIV and AIDS (Prevention and Management) Act, 2018

Do not read these notes during your training. Please study these notes in advance and refer to them as needed.

This section does not include all content from the *HIV and AIDS (Prevention and Management) Act* of 2018. Rather, it includes key information that is important for faith leaders in Malawi.

**Short title**: *HIV and AIDS (Prevention and Management) Act, 2018*

**Key Definitions**

- **Living with HIV**: the presence of HIV in a human body as documented by the presence of HIV or HIV antibodies in the human sample being tested.

- **HIV testing**: any validated, medically recognized, and viral sensitive test for determining the presence or absence of HIV in a person or in the blood, tissue, or other bodily products of a person.

- **Compulsory HIV testing**: HIV testing imposed upon a person without their informed and voluntary consent.

- **Discrimination**: any distinction, exclusion, or restriction made on the basis of a person’s actual or perceived HIV status which impairs that person’s rights or equality with the other members of the community.

- **Harmful practice**: any social, religious, or cultural practice that (a) puts a person at risk of HIV infection or re-infection, or (b) may catalyse the progression of HIV infection to AIDS.

**HIV Testing Services**

Every person has the right to access HIV testing and counselling services. A child who is at least thirteen years of age may access HIV testing and counselling services without parental (or guardian) consent. Any child younger than 13 years of age can only access HIV testing and counselling services with the consent of their parent or guardian.

A health service provider who carries out an HIV test must provide free pre-test and post-test counselling to a person. However, pre- and post-test counselling is not required for people donating blood.

A person who offers to donate body tissue is required to undergo HIV testing immediately before the donation. The recipient of donated blood or tissue, or their immediate family member, can request further HIV testing on the donated blood or tissue.

It is illegal to ask a person to undergo HIV testing as a condition for entry into an education or training institution or as a condition for any form of employment.

**Consent to HIV Testing**

A person shall not test another person for HIV infection except—

a) with voluntary informed consent of the person to be tested;
b) where the person to be tested is below the age of thirteen years, with the voluntary informed consent of a parent or legal guardian of that person; or

c) where the person to be tested has a disability which in the opinion of the person providing the pre-test information, renders the person incapable of understanding the meaning and consequences of HIV testing, with the voluntary informed consent of one of the following persons, said consent to be sought from these persons in the order in which they are listed—

   (i) his partner or spouse

   (ii) his legal guardian

   (iii) an immediate family member; or

d) where a person is required to undergo HIV testing under the provisions of this Act or any other written law.

Prohibition of Compulsory Testing

Compulsory testing for HIV infection is prohibited.

However, compulsory testing for HIV infection shall be permissible under an order of the court, for a person who is convicted of a sexual offence.

A person who forces another person to take an HIV test commits an offence which is punishable.

Disclosure

A person living with HIV has the right to privacy and confidentiality with regard to information concerning their status. Every health service provider has a duty to strictly observe confidentiality in handling all medical information concerning a person living with HIV.

A person who discloses the HIV status of another person otherwise than as provided for under this Act commits an offence.

A health service provider can reveal information about the HIV status of a person only under very specific circumstances. These include:

- there is a written consent of the person with HIV, their guardian, parent or partner;

- required to do so by a court order; and

- the knowledge of the HIV status of the person is necessary or relevant to making clinical decisions in the best interest of the person.

Rights of People Affected and Infected with HIV and AIDS

In addition to all other human rights, a person who is living with HIV or is vulnerable to HIV has the right to:

- Dignity, physical integrity, life and health;

- Practice a profession of choice;
• Compensation associated with the restriction of their enjoyment of their rights.
• Free medication, at a state medical institution, necessary for antiretroviral therapy (ART) or treatment of an HIV-related disease.

A person living with HIV has a duty to take ART and comply with precautions and safety measures prescribed by a health service provider.

A person who is related to or associated with someone living with or vulnerable to HIV has the right to dignity of their person, physical integrity, life and health; and compensation associated with the restriction of the enjoyment of their rights.

A person living with HIV has the right to privacy and confidentiality with regard to information concerning their status.

**Access to HIV and AIDS Information**

A person has the right to access information in connection with HIV and AIDS held by the State or any organ of the State, if the information is necessary for the exercise of their rights.

The National AIDS Commission (NAC) must accredit all HIV or AIDS information before it is shared with the public.

A person who gives or publishes false or inaccurate information concerning HIV and AIDS to another person or the public commits an offence which is punishable by a fine.

**Prohibitions by the Act**

**Prohibition of harmful practices.** A person who conducts a harmful practice commits an offence punishable by a fine of MWK 5,000,000 and imprisonment for five years. A person who subjects, permits or encourages another person to indulge in a harmful practice commits an offence and shall be liable, upon conviction to a fine of MWK 5,000,000 and imprisonment for five years.

**Prohibition of discrimination.** Discrimination on the basis of the actual or perceived HIV status of a person is an offence punishable by a fine of MWK 5,000,000 and imprisonment for five years.

**Prohibitions of publication of false information.** A person who gives or publishes false or inaccurate information concerning HIV and AIDS to another person or the public commits an offence punishable by a fine of MWK 5,000,000 and imprisonment for five years. If the offender is a legal person (an organization or company), the fine is MWK 10,000,000.
Session 3, Activity 1: HIV Testing Services

Do not read these notes during your training. Please study these notes in advance and refer to them as needed.

All HIV testing must be confidential, voluntary, free of stigma, and without causing risk of violence. It is important to use a mix of testing services to reach people who do not know their HIV status. The HIV testing services (HTS) in Malawi follows the following approaches:

1. **Facility-Based Testing**
   - *Provider-initiated testing and counselling (health worker-initiated testing)*—HIV testing is routinely offered to all clients accessing health services in the facility:
     - Healthcare worker offers testing to the client—who may refuse testing
     - Focuses on informing the client about the testing process
   - *Voluntary counselling and testing*—HIV testing is provided at clients’ request.
     - Decision to seek testing is made by clients on their own, voluntarily
     - Clients must request testing
     - Focuses on giving information about HIV
     - Prepares and encourages the client to test (pre-test counselling)
     - Focuses on behaviour change

2. **Community-Based Testing**

   Community-based testing approaches include campaigns, home-based testing, door-to-door testing, workplace testing, mobile testing, distribution of HIV self-test kits, outreach, school/educational institution-based testing, moonlight testing, and church/mosque-based testing. In community-based approaches, testing is conducted in the natural setting of communities through a variety of models including:
   - Mobile outreach vans or tents
   - Home-based services
   - Formal workplace settings (including within public and private organizations and institutions)
   - Informal private and public workplaces such as marketplaces, taxi ranks, and fisher-folk workspaces
   - Social gathering locations and events including bars, clubs, and sporting events
   - Places of worship
   - Institutions of higher learning
   - Social networks and community gatherings, such as football bonanza, choir festival, and *zikiri* competition
   - HIV-specific or multi-disease campaigns

*Community mobilization*—Two methods are used to mobilize people to access HIV testing services:

- **Mass/group mobilization**: This involves communication about HIV testing through local radio, television, print media, and/or theatrical performances at events such as social gatherings. The approach may utilize individuals with knowledge and
skills in community mobilization (e.g., HIV diagnostic assistants, health surveillance assistants, community health workers, expert clients, peer navigators, peer educators, and traditional and faith-based leaders) to facilitate testing campaigns. Engaging these key individuals may reduce stigma and further motivate people to get tested.

- **Network-based approaches:** This approach utilizes peers as “HIV testing ambassadors” to provide information and encourage others to get tested. This has proved to be a successful strategy, especially among specific populations, such as adolescents and key populations. Through this strategy, the HIV testing ambassadors identify other potential clients among their social networks and support peers to provide HIV messages to encourage testing. This approach may utilize individuals who are considered trusted community mobilizers. These individuals could be HIV diagnostic assistants, health surveillance assistants, expert clients, peer navigators, peer educators, or trained lay mobilizers.

*Community linkages*—Community linkage can be passive (through the use of a referral form) or active (physical escort to a health facility). These methods should be applied both for linkage to confirmatory testing, treatment, and care as well as linkage to prevention and other related services.

3. **Index Testing**

People who have tested HIV positive are asked to voluntarily share the contact information of their sexual partners, household members, and family members, including children and adolescents, so those people can also be tested.

- Index testing can be offered in health facilities or in the community.
- Because index testing involves an HIV-positive person disclosing their status to partners and family, it poses a risk to clients of intimate partner violence or gender-based violence. Criminalized populations, such as men who have sex with men and sex workers, also face a high risk of stigma, violence, or other harm through this disclosure.
- Due to concerns about confidentiality, consent, and potential risks to clients, all PEPFAR partners must verify that every index testing site is implementing testing in line with the World Health Organization’s (WHO) Index Testing and Partner Notification Guidelines (WHO, 2016).
- PEPFAR is developing minimum standards and processes for index testing sites, as well as country-level monitoring mechanisms.

4. **Mandatory (Compulsory) Testing**

Compulsory testing is prohibited in Malawi and may only be ordered by a court of law. Clients must be informed that their results will be shared with court officials. Anyone receiving HIV tests in this circumstance should be informed of the testing, and all guiding principles for HTS must be adhered to.

All clients donating tissue must have an HIV test immediately before donation. According to the *HIV and AIDS (Prevention and Management) Act of 2018*, all clients offering to donate tissue or blood are considered to have given their consent for HIV testing.

All donated blood and blood products are screened for HIV and other bloodborne infections.
5. HIV Self-Testing

Key facts:

- HIV self-testing is the process whereby a person who wants to know their HIV status collects an oral swab specimen, performs a rapid test, and interprets the tests result themselves, in private.

- Self-testing does not constitute a confirmed HIV diagnosis; rather, it is a screening test. Clients whose self-testing results are positive should be instructed to go to an HIV testing facility for a confirmatory test and linkage to care if the confirmation test is positive.

- People who have already tested HIV positive or are on antiretroviral therapy (ART) or PrEP should be discouraged from self-testing.

- HIV self-test kits can be distributed through primary or secondary distribution strategies:
  - Primary distribution—Healthcare workers and other trained personnel directly distribute HIV self-test kits to the user. In assisted self-testing, the user receives support from a trained provider before or after testing themselves for HIV. This may include a demonstration of how to use the test, pre-test information, post-test counselling, or referral to confirmatory testing and additional services.
  - Secondary distribution—Healthcare workers and other trained personnel distribute HIV self-test kits to an individual who is instructed to deliver the kit to the user for unassisted self-testing. Indirect support such as leaflets, telephone calls or hotlines, referral information, support groups, and information on HIV treatment, care, and prevention services may be provided.

Who should get tested? Anyone who has not been tested or had an HIV negative result in the past three months

What does a positive self-test result mean? An HIV self-test result is not a confirmed diagnosis. A certified testing provider must confirm self-test results in accordance with Malawi’s national HIV testing guidance.

When should a person get tested again? People who test HIV negative with self-testing can perform another self-test after three months.

In general, the WHO recommends retesting after 12 months for sexually active individuals. Sometimes, retesting should be more frequent based on a client’s HIV risk or as part of a broader HIV prevention intervention. For example, people on pre-exposure prophylaxis (PrEP) require more frequent testing. Individuals with recent HIV risk, with a sexually transmitted infection (STI), or with confirmed or presumptive tuberculosis (TB) should be retested. Pregnant women should also be retested in high HIV burden settings. Healthcare workers will determine during counselling whether a person needs to be retested. If a person received a negative test result and there is no risk of HIV, there is no need for that individual to retest.
Why is counselling important? Counselling is important to provide information to the client on:

- HIV risks and risk reduction (prevention)
- The meaning of an HIV-positive or HIV-negative diagnosis
- The personal health benefits of early ART initiation
- Disclosure processes

Linkage to other relevant services, including HIV treatment, care and support, and/or HIV prevention, is an essential part of post-test counselling.

Counselling must be conducted by trained individuals who have the appropriate information, can answer any questions the client may have, and can provide emotional support. Taking an HIV test can be scary, and its essential to provide clients with the various types of support they need.

6. Recency Testing

What is recency testing? Recency testing shows whether someone who is HIV positive acquired HIV within the past 12 months. Recency testing is being rolled out across Malawi for all people who test newly positive for HIV.

Why is recency testing needed? Recency testing is important for public health because it can help us understand whether there are a lot of people acquiring HIV in a certain geographic area or among certain population groups. This information can be used to improve HIV programs. For example, if recency testing reveals an area with many new HIV infections, this can show that there is a need to increase testing and prevention services in that area.

Who will receive recency testing in Malawi? People ages 13 years and above who have a positive HIV test or positive HIV self-test result and give voluntary, verbal informed consent to test for recent infection.

Will clients receive the results of their recency tests? Under the current process, people will not receive the results of their recency test.

Special Considerations for Men for Offering HIV Testing Services

Men are significantly less likely to access HIV testing services compared to women. There are therefore more undiagnosed men living with HIV who are not benefitting from ART and may transmit the virus to others. Some strategies to encourage and facilitate men to access HTS can include:

- Extended and weekend clinic hours to accommodate men who cannot access services during normal clinic hours (e.g., male wellness clinics)
- Outreach services to sporting venues, workplaces, and places of entertainment and recreation that men frequent
- Distribution of HIV self-test kits in community settings men frequent as well as businesses and workplaces
- Sending family referral slips or HIV self-test kits home with women who test positive at antenatal care or have a partner of unknown status
Session 3, Activity 2: HIV Treatment and Adherence

Do not read these notes during your training. Please study these notes in advance and refer to them as needed.

Management of HIV includes the use of multiple antiretroviral drugs (ARVs). Antiretroviral therapy (ART) is the combination of ARVs that an HIV-positive person takes to prevent HIV from replicating (making copies of itself). ARVs do this by preventing HIV from attaching to the host cell (CD4), interrupting the HIV life cycle in its earliest stages. This reduces the amount of HIV in the body (also called viral load) and prevents the destruction of CD4 cells (infection-fighting blood cells that protect our bodies from disease). If ARVs are taken correctly, they help a person live a longer, healthier life and prevent onward transmission.

ART is a treatment for HIV—not a cure; when people start ART, they must continue taking it for the rest of their lives. If people stop taking the treatment, HIV will replicate (multiply) in their bodies and they will become sick again, risk developing resistance to the combination of ARVs that they are taking, and increase their risk of infecting others.

What are ARVs?

- ARVs are drugs that help prevent HIV from destroying the immune system.
- Before ART initiation, HIV infection is confirmed at a clinic by conducting an HIV confirmatory test.
- ART requires combining three ARVs that act differently to avoid development of drug-resistant HIV. Today, these ARVs are combined in one pill, so ART is easy to take.
- ART does not eliminate or cure HIV, but it can decrease the amount of HIV in the body to undetectable levels.
- ART allows the body’s defence system to recover, enabling someone living with HIV to live a healthy life.
- Once started, ART must be taken every day for life.
- The amount of virus will increase when ART is interrupted or stopped.
- The type of ART a person is taking may no longer work for them (this is called resistance).
- Unless they have an undetectable viral load, patients on ART can still pass on HIV to others and must use condoms.

When should someone who is HIV positive start ART?

All clients are eligible to start ART as soon as they are confirmed to be HIV positive and are ready for treatment—the same day!

People living with HIV should start ART as soon as possible after getting infected with HIV so they can rapidly gain the benefits of treatment.

Post-test counselling is important to help those who test positive understand the importance of adherence, so they are prepared to take their ART daily for the rest of their lives.

How does ART work?

HIV attacks the body’s immune system and CD4 cells. HIV infects a type of white blood cell in the body’s immune system called a CD4 cell. These CD4 cells keep people healthy by
fighting off infections and diseases. HIV takes control of the cell’s DNA, replicates itself inside the cell, then releases more HIV into the blood.

When on ART, one takes a combination of three or more ARVs. A combination of ARVs is needed because each medicine does something different in the body. The different ARVs:

1. Prevent HIV from entering the CD4 cells
2. Prevent HIV from replicating inside the CD4 cells
3. Prevent HIV from leaving the cells to infect other CD4 cells

The new treatment contains all three of these medicines in one pill. So, it is easier than ever to take ART.

When a person takes ART the right way, every day, for life, it helps CD4 cells decrease the amount of HIV in the body to a level that is no longer harmful to the person living with HIV or their partner. This means the person has healthy CD4 cells and decreased viral load (the amount of virus in the body), which can help the body protect itself from infection.

New ARVs

In Malawi, as of January 2019, the first-line ART regimen for all adults, and for children weighing more than 20 kilograms (kg), is based on **Dolutegravir, sometimes called DTG**. DTG is more effective and has fewer side effects than previous ARVs. People can take this new ART regimen without fear of the side effects of earlier drugs. The new regimen is also easier to take—only one pill per day, which contains three different drugs.

Benefits of ART

- Prevents HIV from reproducing in CD4 cells
- Prevents HIV from leaving one cell and infecting other cells
- Decreases viral load, leading to viral load suppression and undetectable viral load
- Keeps the person healthy by increasing the number of healthy CD4 cells, which keeps the immune system strong so the body can prevent and fight infections
- Prevents transmission of HIV from a mother to her baby
- Prevents sexual transmission of HIV (if viral load is undetectable)
- Makes the person feel healthier and able to work, take care of self and family, and be an active member in the community

Viral load

Viral load is defined as the concentration or amount of HIV in the blood, usually expressed as copies per millilitre (copies/ml).

Viral suppression is when an individual has a viral load of typically < 1000 copies/ml, depending on national guidance.

Undetectable viral load is when the amount of virus in the body is typically < 20 copies/ml or < 50 copies/mL, depending on machine used to measure viral load.

People who are HIV positive receive *viral load tests*, which determine the amount of virus in the body. Viral load testing is very important because viral load is the best measure for the progression of HIV infection.
Higher levels of HIV in the body leads to faster destruction of CD4 cells, so it is important to keep viral load as low as possible. Successful ART leads to such low levels of HIV in the blood that HIV can no longer be detected with viral load testing. This is the aim of ART.

If a person’s viral load is undetectable, that person’s immune system will be much stronger and able to protect the body from other illnesses. In Malawi, this is called “T=T” (*tizirombo tochepa = thanzi*), or “suppressed viral load= good health.”

To become undetectable, a person must adhere to their treatment exactly as directed by their healthcare provider.

**ART adherence**

Adherence to treatment includes:

- Taking (or giving) ARVs the right way, as prescribed, each day for the person’s whole life, even if the person feels healthy (“every pill, every day”)
- Taking (or giving) other medicines, as prescribed
- Not taking any “treatment breaks”

In other words, the ability to take:

- The right drugs
- The right dosage
- At the right time
- In the right way

**Nonadherence to ART includes:**

- Missing one or many appointments at the hospital or health centre, lab, or pharmacy
- Not following the care plan
- Missing a dose or doses of medicine
- Sharing medicines with other people
- Stopping medicine for a day or many days or taking a “treatment break” or “holiday”
- Taking medicines at the wrong times

**New methods of ART delivery**

There are now more options for people living with HIV, who have been on ART for more than six months and are virally suppressed, to receive their ARVs. This is called “differentiated care” and can reduce the number of clinic visits, which means less time spent waiting and less time off work. This can help people adhere to treatment. In Malawi, differentiated care services include:

- Receiving multi-month distribution of ART—enough pills to last three or six months—which means fewer visits to the clinic
- Receiving ARVs at teen clubs or drop-in centres linked to the district health office
- Obtaining ARVs through mobile clinics like ART-provider managed community ART groups, meaning people can get their ARVs in their communities, without going to a clinic
- Picking up ARVs through pharmacy fast-track refills, without going to a clinic
Session 4, Activity 1: Seeing Stigma

Discussion Questions

- What do you think is happening in the picture related to stigma?
- Why do you think this stigma is happening?
- Does this happen in your community? In your congregation? If so, discuss some examples.

Sample Responses

Note: The responses below are only examples of what participants might say about the photos. Participants may have different interpretations of the pictures. There are no “right” answers. The purpose of this exercise is to encourage participants to think about how stigma shows up in day-to-day situations.

Picture 1—Woman sitting on a stool, surrounded by people who are turning their backs.

- The woman looks sad. The people around her are turning their backs on her. They could be family members, or community members who are turning their backs because they have learned that she is HIV positive. They believe that this is a punishment from God, that it is shameful, that to have this disease she must be a bad person—she must have done something sinful. She looks isolated and alone, maybe ashamed.

Picture 2—People pointing their fingers at you

- People are pointing their fingers at me—as I stand looking at the picture. They are yelling, or scolding. The people are all ages, men and women—representing the whole community.
- We seem to be standing in the place of a person living with HIV who is being judged and shamed by community or family members for being HIV positive because they believe that having HIV is something to be ashamed of—maybe even a punishment from God.

Picture 3—A man standing at the center of a group of people who are pointing their fingers

- People are pointing their fingers at the man. They look like they are yelling, or scolding. The man is being judged and shamed by community or family members for being HIV positive because they believe that having HIV is something to be ashamed of.

Picture 4—Man sitting on a stool, reading his HIV test results; two other men sitting nearby, talking about him

- One man is sitting on a stool, reading a piece of paper that says, “HIV test results.” He looks worried. Two other men are sitting nearby and seem to be talking about the man—gossiping about him. It seems like he has gotten a positive HIV test result and he is being gossiped about. He might be feeling scared, worried that he will lose his status in the community, that he will get sick and won’t be able to take care of his family.
• The man is just reading his test results, yet already people are talking about him. This could mean that someone—maybe a health worker—has broken his confidentiality by talking about his HIV-positive status without his permission.

Picture 5—Man pointing his finger at a young man who is just coming in the door, holding his shoes

• This looks like a father scolding his son, who is sneaking into the house. It is nighttime. We do not know why the man is scolding his son—it could be because he is coming home late. But we noticed that there is a packet of something in the boy’s pocket. This might be pills—perhaps he is sneaking out to get his HIV medication (his ARVs) because he is afraid to tell his parents that he is HIV positive.

Picture 6—Man sitting alone on a bus

• The man looks very isolated. Other passengers seem to be talking about him and making fun of him.

Picture 7—Man sitting alone on a bed

• This man has been isolated—put in a room on his own and forced to stay there alone. He has no visitors. No one is there to comfort him. He looks abandoned.

• The man looks very alone and sad, like he has cut himself off from other people. Maybe this man is has learned that he has HIV and he feels ashamed. He is self-isolating because the thinks that having HIV means that he is a bad person. He also doesn’t want anyone to find out that he has HIV. He doesn’t know how to tell his friends or his family.

Picture 8—Woman and man sitting on stools

• A man and woman are talking. Maybe they are girlfriend and boyfriend, or husband and wife. The woman looks ashamed and worried. The man looks shocked. Maybe she has just told him that she is HIV positive. We do not know exactly what is happening, but he might get angry and think that her test results mean that she has been unfaithful. She looks worried—maybe she is afraid that he will leave her because she is HIV positive.

Picture 9—Man and woman taking a child to see a traditional healer

• A man and woman are walking into a house with their son. The woman is looking over her shoulder and there is a clinic in the background. They look worried that someone will see them. Maybe they have found out that their son has HIV and they think that he can be healed by a traditional healer. Maybe they are ashamed and don’t want anyone to find out their son has HIV because they are worried that the community will treat the whole family badly because they think HIV is something to be ashamed of and to hide.

Picture 10—Man walking out of a counselling room, asking “What am I going to do now?”

• The man has just learned that he is HIV positive. He is asking, “What am I going to do now?” He looks like maybe he is a young man. Maybe he is worried that he will be kicked out of school if anyone finds out that he has HIV. Or maybe he thinks that having HIV means that he will get sick and die. He is feeling afraid and alone. Maybe
he would not be feeling so afraid and alone if HIV was not stigmatised—then he could reach out and ask for support without feeling ashamed.

Picture 11—A man sitting on a stool with “HIV positive” test results

- This man has just found out that he is living with HIV. He is alone and has been drinking—there are beer cans beside him. Maybe he is feeling afraid and ashamed. Maybe he is alone because he does not want to tell anyone about his test results because he is afraid of being judged—or of losing his job, or the respect of others in the community, or maybe even worried that his family will ask him to leave the house, or that his fiancé will leave him.

Picture 12—Man walking up to a woman and girl, holding his HIV test results

- This man has just found out that he is HIV positive. He is coming home to tell his wife his test results. He is feeling ashamed and maybe worried about how she will react—he might be worried that she will leave him, or maybe he is worrying about whether he will be able to keep his job and continue providing for them.

Picture 13—Man leaving an office, carrying a paper that says, “Dismissed”

- We think this picture is showing a man living with HIV who has just been fired. He looks very depressed and he is asking himself, “What am I going to do?”

Picture 14—Girl sitting alone in a classroom

- The girl is sitting alone because her classmates have found out that she has HIV—or maybe even just that someone in her family has HIV. They are afraid that they might catch HIV if they sit next to her. Also, they might think that having HIV is something to be ashamed of and they do not want to be seen sitting with her because other people might think that they are bad also.
Session 8, Activity 1: Voluntary and Involuntary Disclosure

*Do not read these notes in your training. Please study them ahead of time.*

Disclosure is when someone tells one or more people about their HIV status and the information is given by the choice of the person, without coercion or pressure.

**Disclosure is important because:**

- It can prevent further spread of HIV because it will encourage the person’s partner to get tested as well and/or to start protecting themselves from infection.
- It can relieve the stress of keeping HIV status private and will enable supportive and trustworthy family and friends to provide support.
- Counsellors are trained to help those who test positive to be able to cope with the results.

People living with HIV need ongoing support and to talk about disclosure with their family, friends, or others, such as a trusted faith leader.

Disclosure is an ongoing process; it is not a one-time event.

**What does it mean to say, “disclosure is an ongoing process?”**

Someone who is HIV positive will probably not tell everyone in their community about their HIV status at once. They may start by telling one or two people, such as their partner or a close friend, or may disclose to a counsellor or faith leader to seek support. Over time, they may (or may not) choose to share their status with more people. Disclosing to each new person may cause anxiety because of the risk of stigma and discrimination.

For children and young adolescents who are HIV positive, caregivers should start the disclosure process early. First, they may want to “partially disclose” to the child, which means just telling them some things about having a sickness and needing to go to the clinic. Over time, caregivers should move to “naming HIV,” sometimes called “full HIV disclosure,” which means the child or adolescent knows that they are living with HIV and knows exactly what this means. Once older children and adolescents know their HIV status, it takes some time for them to fully understand what this means and to come to terms with their status.

For adolescents who know their HIV status, disclosure to others is also a process. At first, young people will likely want to tell only one or a few people they are close with about their HIV status (a trusted family member, sexual partner, close friend, etc.). Over time, and as they feel more comfortable, some adolescents might tell more people about their HIV status.

All these processes require ongoing communication and counselling with men and boys and their caregivers. Faith leaders can play an important role in this ongoing process.

**Advantages of disclosure may include:**

- Avoiding the burden of secrecy and hiding
- Avoiding anxiety about accidental or unwanted disclosure
- Access to emotional and practical support from trusted peers or family members
- The ability to talk about symptoms and concerns
- Easier access to healthcare
• Improved adherence to care and medicines
• The ability to discuss safer sex and family planning choices with one's partner(s)
• The ability to refer one's partner(s) for HIV counselling and testing, and to care and treatment if needed
• For pregnant women, the ability to get support for prevention of mother-to-child transmission (PMTCT) from family members and friends—for example, giving the baby antiretroviral drugs (ARVs) and feeding the baby safely
• The freedom to ask a trusted friend or relative to be a treatment buddy
• Access to positive living HIV support groups and community organizations
• Serving as a disclosure role model for other people

Disadvantages of disclosure may include:
• Blame by partner or family for “bringing HIV into the household”
• Distancing, fear, rejection, or abandonment by partner, family, or friends
• Discrimination at school
• Discrimination in the community, including their place of faith
• Discrimination at work, including the possible loss of one's job
• Others making assumptions about one’s sexuality, promiscuity, or lifestyle choices
• Rejection in the community
• Partner not wanting to have children
• Physical violence
• Self-stigma
• Loss of economic support from family members or partners
ANNEX B.
Handouts
Handout #1: HIV Glossary

95-95-95: Refers to 95% of people living with HIV knowing their HIV status; 95% of people who know their status on treatment; and 95% of people on treatment have suppressed viral loads. Our goal is to achieve 95-95-95 by 2030.

Adherence: Taking medications exactly as instructed by a medical provider. Adherence involves factors such as getting prescriptions filled, understanding the directions and remembering to take medication as directed (e.g., the right amount at the right time).

AIDS: Acquired immune deficiency syndrome; the most advanced stage of HIV infection. To be diagnosed with AIDS, a person with HIV must have an AIDS-defining condition or have a CD4 count (see CD4 below) less than 200 cells/mm³ (regardless of whether the person has an AIDS-defining condition).

Antibody: A substance in the blood formed in response to and counteracting any substance that triggers an immune response (including bacteria, viruses, and foreign substances in the blood).

Antiretroviral drugs (ARVs): Drugs that prevent a specific type of virus, including HIV, from replicating (making copies of itself).

Antiretroviral therapy (ART): The daily use of a combination of antiretroviral drugs (ARVs), also called an HIV treatment regimen, to treat HIV infection.

CD4 cells: Cells that help coordinate the immune response by stimulating other immune cells to fight infection, sometimes also called “helper T cells.” HIV weakens the immune system by destroying CD4 cells.

Confirmatory HIV testing: A test conducted when a person has tested HIV positive on a screening test to confirm their HIV-positive diagnosis and rule out errors before they are enrolled into treatment.

Dolutegravir (DTG): A new HIV drug that is combined with two others and provided in one pill per day. This drug is more effective, has fewer side effects and supports better treatment adherence. DTG is given to all people living with HIV except children who weigh less than 20 kilograms.

Drug resistance: The reduction in effectiveness of a drug such as an ARV or tuberculosis (TB) treatment. Drug resistant HIV strains can be passed from a person living with HIV to their partner or to their child during pregnancy, delivery, or breast feeding.

Early Infant Testing (EID): Testing of infants to determine their HIV status, given that HIV can be acquired in utero (during pregnancy), intra-partum (during delivery), postpartum (through breastfeeding), or via parental exposure.

Epidemic control: The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) defines epidemic control, using standard epidemiologic terminology, as the point at which new HIV infections have decreased and fall below the total number of deaths among HIV positive individuals.
**Gender**: The culturally defined roles, responsibilities, behaviours, and values associated with being a woman or man, as well as the power relations between and among women and men, and boys and girls.

**HIV self-testing**: A process in which an individual who wants to know their HIV status collects a specimen, performs a test, and interprets the result by themselves, often in private.

**HIV status**: A reference to being HIV positive, HIV negative, or HIV inconclusive (their test results do not support a conclusion about whether they have HIV).

**HIV testing services**: The full range of services that are provided together with HIV testing, including counselling; linkage to appropriate HIV prevention, treatment, and care services; and other clinical and support services.

**HIV treatment cascade**: A model (sometimes also called the HIV care continuum) that delineates the sequential steps or stages of clinical care that people living with HIV go through from initial diagnosis through treatment initiation and engagement in care to achieving the goal of viral suppression. The cascade shows the proportion of people living with HIV who are engaged at each step of care.

**HIV**: Human immunodeficiency virus; a disease of the immune system due to infection with HIV. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. HIV is a retrovirus that occurs as two types: HIV-1 and HIV-2.

**Immune system**: The bodily system comprised of a complex network of cells, tissues, and organs that protect the body from foreign substances, including those that cause disease (viruses, bacteria, etc.) by producing the immune response.

**Incidence**: The number of new HIV infections in a population during a certain time period.

**Index testing**: A focused approach to HIV testing in which the household and family members (including children) of people diagnosed with HIV are offered HIV testing services; also referred to as index case HIV testing.

**Key population**: A group that is at higher risk of HIV infection, including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings.

**Opportunistic infection**: An infection that occurs more frequently, or is more severe, in people with weakened immune systems such as people living with HIV or people receiving chemotherapy.

**Post-exposure prophylaxis (PEP)**: Short-term treatment started after exposure to an infectious agent, such as HIV or hepatitis B or C, to reduce the risk of infection in the person who has been exposed.

**Pre-exposure prophylaxis (PrEP)**: A method of HIV prevention for people who are HIV negative and at high risk of HIV exposure that involves taking HIV medication daily.

**Prevalence**: The total number of people in a population who are HIV positive, expressed as a percentage of the population.
**Recency testing:** A test that shows whether someone newly diagnosed as HIV positive acquired HIV within the past 12 months.

**Seroconcordant couple:** A couple in which both partners have the same HIV status.

**Seroconversion:** The time when an individual first produces enough HIV antibodies to be detectable through a HIV serological assay test.

**Serodiscordant couple:** A couple in which one partner is HIV positive and the other is HIV negative.

**TB preventive therapy (TPT):** A combination of drugs given to people living with HIV to prevent them from getting TB.

**Testing algorithm:** The combination and sequence of specific tests used within HIV testing strategies.

**Treatment as prevention:** A term that describes the reduced risk of HIV transmission that occurs when HIV medicines lower a person’s viral load to undetectable levels.

**T=T: Tizirombo tochepa=thanzi (suppressed viral load= good health).** If a person’s viral load is undetectable (as a result of ART), they will be healthier. If ART is discontinued, the person's viral load will likely return to a detectable level.

**Undetectable:** When the amount of HIV in the blood is too low to be detected by a viral load test—at < 20 copies/millilitre (ml) or < 50 copies/ml, depending on the setting/machine.

**Viral load:** The amount of HIV in the blood, measured by the number of viral copies per millilitre (copies/ml) of blood; the best measure for the level of progression of HIV infection.

**Viral suppression:** When treatment reduces a person’s viral load to an undetectable level. Viral suppression is not the same thing as a cure, since HIV remains in the body and will likely return to a detectable level if ART is discontinued.

**Window period:** The period between HIV infection and when HIV can be detected using an HIV test. During this time, someone with HIV could still test HIV negative, depending on the type of test used.
Handout #2: HIV and the Benefits of ART

Defining “HIV” and “AIDS”

**HIV** stands for human immunodeficiency virus:
- **Human** (refers to us)
- **Immunodeficiency** (means the body cannot fight diseases and protect itself from getting sick)
- **Virus** (a type of germ in the body that cannot be cured and causes diseases)

**AIDS** stands for acquired immune deficiency syndrome:
- **Acquired** (to get something)
- **Immune** (the way the body fights disease)
- **Deficiency** (not enough of something—in this case not enough protection from getting sick)
- **Syndrome** (a collection of signs and symptoms of disease)

How is HIV Transmitted?

HIV can be transmitted through semen, vaginal and birthing fluids, blood, and breastmilk. Examples of ways HIV can be transmitted include:

1. Sexual intercourse with a person living with HIV
2. Contact with HIV-infected blood
3. Mother-to-child transmission

HIV cannot be transmitted through saliva, tears, sweat, vomit, feces, or urine. Examples of ways that HIV cannot be transmitted include:

1. Kissing
2. Holding hands or hugging
3. Sharing drinks or food
4. Sitting on toilet seats

How Does HIV Affect the Body?

- A person is infected with HIV and the virus enters the blood stream.
- HIV attacks CD4 cells, part of the immune system that helps your body fight infections.
- In addition to destroying CD4 cells, HIV uses these cells to make copies of itself, so over time there is more and more HIV and fewer CD4 cells in the blood stream.
- Over time, there are not enough CD4 cells to fight off infections, and the person can be attacked by opportunistic infections, which can kill them. This stage is AIDS.
- Taking treatment (ARVs) the right way, every day, can prevent HIV from becoming stronger and making the person sick.
**What is ART?**

ART (antiretroviral therapy) is the combination of antiretroviral drugs (ARVs) that are used in the treatment of HIV. These drugs prevent HIV from destroying CD4 cells and using these cells to make copies of itself. This is called “viral suppression” and it reduces the viral load.

**When Does a Person Start ART?**

It is important to start ART as soon as a person is confirmed HIV positive, ideally on the same day, with appropriate counselling.

**What Are the Benefits of ART?**

- Suppress the virus so it cannot replicate (make copies) of itself
- Restore the immune system so it can defend the body from infections
- Decrease the chance of transmitting the virus to another person.

**Why is ART Adherence Important?**

Adherence means taking the right drugs, at the right dosage, at the right time, and in the right way. Benefits of ART adherence include:

- Reduced viral load
- Reduced risk of becoming ill from infections
- Reduced risk of passing HIV on to someone else, including partners and children
- Reduced risk of HIV becoming resistant to the ARVs
- Ability to live a long, healthy life!

Remember ART is a treatment, **not a cure**. People living with HIV must take their medications for the rest of their lives, as prescribed by their healthcare provider.

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**Viral Load**

- The amount of HIV in the body.
- The best measure of the progression of HIV infection.
- Measured by the number of viral copies/ml of blood

*“Undetectable” viral load* is when the viral load in the body is so low, it cannot be detected by standard tests.

**Viral Load Before ART and with Proper Adherence to ART**

# Handout #3: HIV Myths and Facts Worksheet

**Instructions:** For each statement in the table below, please mark whether it is a myth or fact.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Myth or Fact?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Men and boys get infected because they have sex with many partners.</td>
<td></td>
</tr>
<tr>
<td>2. Undetectable viral load reduces the risk of sexual transmission.</td>
<td></td>
</tr>
<tr>
<td>3. Mosquitoes can spread HIV.</td>
<td></td>
</tr>
<tr>
<td>4. People of all ages can become infected with HIV.</td>
<td></td>
</tr>
<tr>
<td>5. If you have sex with a person with albinism or who has a disability, you will be cured of HIV.</td>
<td></td>
</tr>
<tr>
<td>6. You can get HIV by sharing food with a person who is HIV positive.</td>
<td></td>
</tr>
<tr>
<td>7. Prayer can cure people who are HIV positive.</td>
<td></td>
</tr>
<tr>
<td>8. People living with HIV cannot get loans from a bank.</td>
<td></td>
</tr>
<tr>
<td>9. Being diagnosed with HIV is a death sentence.</td>
<td></td>
</tr>
<tr>
<td>10. During the window period, someone who has HIV can still test negative.</td>
<td></td>
</tr>
<tr>
<td>11. You can tell whether a person has HIV by looking at them.</td>
<td></td>
</tr>
<tr>
<td>12. Individuals can start ART (antiretroviral therapy) the same day that they receive a confirmed HIV diagnosis.</td>
<td></td>
</tr>
<tr>
<td>13. ART is a treatment for HIV, not a cure.</td>
<td></td>
</tr>
<tr>
<td>14. People living with HIV should never have children.</td>
<td></td>
</tr>
<tr>
<td>15. All children born to women with HIV will be infected with HIV</td>
<td></td>
</tr>
<tr>
<td>16. Feeling better after starting ART means that an HIV-positive person has been cured and doesn’t need to keep taking ART medication.</td>
<td></td>
</tr>
<tr>
<td>17. You can get HIV by shaking hands with someone, hugging them, sitting in the same chair, or using a toilet that they have used.</td>
<td></td>
</tr>
<tr>
<td>18. ART is safe for children to take.</td>
<td></td>
</tr>
<tr>
<td>19. HIV makes you less of a man.</td>
<td></td>
</tr>
<tr>
<td>20. Anyone with TB or pneumonia has HIV.</td>
<td></td>
</tr>
<tr>
<td>21. Traditional healers can cure HIV.</td>
<td></td>
</tr>
<tr>
<td>22. A faithful couple does not need to use condoms if both partners are living with HIV.</td>
<td></td>
</tr>
<tr>
<td>23. ART is only for people who look very sick.</td>
<td></td>
</tr>
</tbody>
</table>
Handout #4: Scenarios: The HIV and AIDS (Prevention and Management) Act, 2018 in Practice

**Group 1**

*Scenario:* An organization developed posters targeting boys with messages from the *Messages of Hope* guide. They took these posters to the community and pretested them. After incorporating the changes, they printed the posters and hung them in clinics and places of worship. Was this the correct procedure according to the HIV and AIDS Act? Please explain why or why not.

**Group 2**

*Scenario:* A man named F____ has gone to his faith leader for advice. F______ told his faith leader that he recently went for HIV testing and was found to be HIV positive. F______, who is married, believes he has HIV because he had a few girlfriends in the past. He does not want to disclose his HIV status to his wife because he fears how she will react. The faith leader is concerned for the health of F____’s wife. He wants to tell F____’s wife about her husband’s HIV-positive status so she can get tested. What should the faith leader do? Please explain why.

**Group 3**

*Scenario:* A faith leader has been preaching to congregants that people who are living with HIV can stop taking their antiretroviral drugs (ARVs) if they come to him and have him pray for them. The faith leader has said that those people will be cured of HIV after he has prayed for them. Is this legal according to the HIV and AIDS Act? Why or why not?

**Group 4**

*Scenario:* A boy wants to join a youth football team organized in the community. Some of the other children know that he is HIV positive. They make fun of him, calling him names and saying they do not want him to be on their team. The team football coach decides that it would be too disruptive for this boy to play football with the other children, and tells the boy that he cannot be on the team. As a faith leader who has participated in this *Messages of Hope* training, you hear about this situation. What do you do, and why?
Handout #5: Discussion Questions for “Seeing Stigma” Activity

1. What do you think is happening in the picture related to stigma?

2. Why do you think this is happening?

3. Does this happen in your community? In your congregation? If so, discuss some examples.
Handout #6: Discussion Questions for Reflecting on the Process of Behaviour Change

1. What made you decide to change? OR Why did you want to change? Did you get some new information that prompted the decision?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

2. Were there good things you thought would happen if you changed? If so, what?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

3. Were you able to change? If yes, how long did it take to change? What were some of the steps in the process of change?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

4. Did you ever go back to the old behaviour? If so, why?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Handout #7: Behaviour Change Communication Scenarios

**Scenario 1**
A man comes to speak to you. He has never had an HIV test, but his wife thinks they should both get tested because this was recommended to her during a women’s group meeting. The man feels healthy, so does not think he could have HIV. He does not understand why he should get tested and is upset with his wife.

**Scenario 2**
M___, who you have known for many years, comes to speak to you after your sermon. He has recently tested positive for HIV. He is scared about what this means for his life and for his family. He has not started ART yet because he feels healthy, and he is afraid that if he begins to take medication all his family members and neighbours will learn that he is HIV positive.

**Scenario 3**
L_____, a member of your youth congregation, comes to your office one day. He is HIV positive and has been taking ART for about six months. He does not want to go to the clinic anymore because when does he has to miss school. He says he has been praying that he will be healed. He has heard there is a group saying that this is possible and that he does not need to take any medication. He asks whether you can pray for him, so he can stop taking ART medication.
Handout #8: Scenarios for Session 6, Activity 5: Communicating with Adolescent Boys

Directions

Work together in your small group to respond to your assigned scenario, writing your response on flipchart paper. Your small group will then present your scenario and response to the larger group.

Scenario 1

M_____ is an 18-year-old boy in a youth group that you lead. There is an upcoming football match where HIV tests will be provided. In the youth group, you have been discussing the importance of HIV testing. M_____ is scared because he has had sex with a few girlfriends. He is worried that if he tests positive his current girlfriend will leave him, he will never get married, and he will never get a job.

Scenario 2

P___ is a 15-year-old boy who was born with HIV. His mother died when he was five years old, and he has been living with his grandmother ever since. His grandmother does not like to talk about P___’s HIV status and none of P___’s friends know he has HIV. P___ wants to stop taking ART because he is worried his classmates will find out he is HIV positive.

Scenario 3

G___ is a 16-year-old boy who tested HIV positive four weeks ago. When you see him today, he appears upset. He tells you he has not told anyone about his HIV-positive status, that he isn’t doing well in school, and that he feels angry most of the time. G___’s girlfriend is threatening to break up with him because of his moodiness. When you ask him questions, he gives you short responses in an angry voice.
Handout #9: Reflecting on Content from Days 1 and 2

1. What have you learned during the first two days of this training?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. What has been new and/or surprising?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. What have you learned that you think will be most helpful as you prepare to reach men and boys with “messages of hope”? 

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. What topics or skills do you have questions about or want more practice in? Hint: You can use this to choose which “study clinic” you would like to attend.
Handout #10: Assessing Whether or Not to Disclose—Guiding Questions Worksheet

**Instructions:** Think about a person or group to whom you have disclosed private information and answer the questions below. Please note that you do not have to tell others what private information you disclosed. You can give as many or as few answers as you choose.

1. What were the main factors that you considered when you thought about whether to disclose your private information?

2. Disclosure often involves risks. For each of the issues identified in Question 1, what were some of the things you did to manage and minimise the risk of disclosure?

3. What support did you need to take these actions?
Handout #11: Key Messages—Disclosure

- HIV is still highly stigmatised; for that reason, many people living with HIV have specific challenges around who knows their HIV status.
- Disclosure may be voluntary or involuntary. Sometimes a person can be put into situations of forced disclosure; forced disclosure can be a human rights violation.
- Voluntary disclosure is when a person gives sensitive information about themselves to another person or group. This information is given by choice, without coercion or pressure.
- People are at varying levels of disclosure: nondisclosure, partial disclosure, or full disclosure.
- Not disclosing one’s health status can be held as a traditional value. Traditionally, family members might find it problematic to speak openly about chronic illnesses in the family, especially when the illness has the possibility of bringing shame and disgrace.
- The World Health Organization (WHO) strongly recommends that seropositive children know their HIV status by the time they are of primary school age (ages 6–12 years).
- Disclosing to an intimate partner is important but has complexities of its own. Understanding the importance of disclosure, and how to disclose, is critical.

Advantages of disclosure may include:

- Avoiding the burden of secrecy and hiding
- Avoiding anxiety about accidental or unwanted disclosure
- Access to emotional and practical support from peers or family members
- The ability to talk about symptoms and concerns
- Easier access to healthcare
- Improved adherence to care and medicines
- The ability to discuss safer sex and family planning choices with one’s partner(s)
- The ability to refer one’s partner(s) for HIV counselling and testing, and to care and treatment if needed
- For pregnant women, the ability to get support for prevention of mother-to-child transmission (PMTCT) from family members and friends—for example, giving the baby antiretroviral drugs (ARVs) and feeding the baby safely
- The freedom to ask a friend or relative to be a treatment buddy
- Access to patient support groups and community organizations
- Serving as a disclosure role model for other people
Disadvantages of disclosure may include:

- Blame by partner or family for “bringing HIV into the household”
- Distancing, fear, rejection, or abandonment by partner, family, or friends
- Discrimination at school
- Discrimination in the community, including one’s place of worship
- Discrimination at work, including the possible loss of one’s job
- Others making assumptions about one’s sexuality, promiscuity, or lifestyle choices
- Rejection in the community
- Partner not wanting to have children
- Physical violence
- Self-stigma
- Loss of economic support from family members or partners
Handout #12: Putting Learning into Action—How Can I Use What We’ve Done to Support Others?

How can I use information from this module in my role within the faith community? Please list.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with other faith organizations and community leaders, or ...)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Handout #13: *Messages of Hope* Action Planning Worksheet

Use the template below to develop an action plan for how you will communicate specific messages to men and boys in your community. Be as specific and concrete as possible in your plans.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Audience</th>
<th>Message</th>
<th>Channel</th>
<th>Timing</th>
<th>Who is Responsible</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing</td>
<td>Boys</td>
<td>Savvy guys go for an HIV test! Get tested!</td>
<td>Weekly youth group discussions located at...</td>
<td>Weekly, on Thursdays, beginning on...</td>
<td></td>
<td>Document each time the message is used and the number of boys present using [...] tool.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proverbs 29:18, 2 Timothy 1:7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX C. Picture Tools for Session 4, Activity 1: Seeing Stigma


Print one copy of each image. Each image should be scaled to fit on an A4 sheet in landscape orientation.
Picture 1
Picture 2
Picture 3
Picture 4
Picture 6
Picture 7
Picture 9
Picture 10

Counselling Room

PRIVATE NO ENTRY

What am I going to do now?
Picture 11
Picture 13
For Session 4: Activity 1

Picture 14
ANNEX D. Creative Group Splitters


Many of the exercises in this guide require participants to work in small groups. As a facilitator, you can use the process of splitting into groups to keep energy high, ensure that participants are mixing and talking to each other rather than staying with the same people all the time. You can also keep participants interested by using different ways of breaking into groups. There are so many ways to divide into groups (try not to use “1,2,3 – all the ones together” too much—challenge yourselves to avoid using these more than twice!). Here are some ideas for “group splitters”:

- **Actions:** Write or draw different actions on slips of paper (e.g., feeding a baby, dancing, walking as if you are in a hurry). Or whisper an action in someone’s ear. Ask each participant to take a paper without showing anyone. When you shout, “1, 2, 3,” ask them to start doing the action and find others who are doing the same.

- **Songs:** Write song names on slips of paper (use common songs that everyone will know e.g., Happy Birthday, the national anthem, popular songs of the time), then ask each participant to take a slip and start singing until they find others singing the same song. Whisper a song title in participants’ ears if anyone has a visual impairment or low literacy skills.

- **Animal sounds:** Write the names of, or draw different animals, on slips of paper. Each participant must make the noise of their animal and find others making the same noise.

- **Same clothing:** Before you divide the group, look at the clothes people are wearing and see if you can divide them by colours (e.g., “Everyone who is wearing stripes come together,” “Everyone who is wearing sneakers,” etc.). Facilitators should adapt this to their community. If there are sensitivities about clothing colours due to politics, or if there are women in the group wearing mourning, or if there is a clear difference among participants’ clothing because of religion or tribe or profession, this technique should not be used.

- **Things in common:** This is a bit of a random way but you can use it approximately and then mix people if necessary. Adapt it to your community. Say things like, “Everyone who lives close to the river,” or “Everyone who attended _____ school,” etc.

- **“Fire on the mountain, run run run”:** Make this into a chant—everyone runs around in a circle and then you say, “Be in threes,” or, “Be in pairs” and participants move quickly to those next to them to form a group.

**Birthday line:** Ask participants to stand in a line in the order of their birthdays (e.g., January at one end, December at the other end). To make it more fun, ask participants to do so without talking. Once they are in a line, you can then count them off into groups.
FOR MORE INFORMATION, CONTACT:

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The HIV and AIDS Act

Session 2, Activity 4 of the Reaching Men and Boys with Messages of Hope Training
Policy Overview

Short title:
HIV and AIDS (Prevention and Management) Act

Long title:
An Act to make provision for:

- The prevention and management of HIV and AIDS
- The rights and obligations of people infected and affected by HIV and AIDS
- The establishment, organization, administration, general powers, duties and functions of the National AIDS Commission (NAC)
- Incidental matters
Sections of the HIV and AIDS Act

- Harmful Practices
- Discrimination
- Human Rights
- Rights of Persons Affected by HIV and AIDS
- Disclosure
- Public Health
- Information
- HIV and Employment
- Education
- Establishment of NAC through an Act of Parliament
Harmful Practices

Definition

A harmful practice is defined as any social, religious, or cultural practice that puts a person at risk of HIV infection or reinfection. (Section 2)

Prohibition of Harmful Practices

The Act prohibits any harmful practice listed in the First Schedule.
Definition

Discrimination is defined as any form of distinction, exclusion, or restriction made on the basis of the actual or perceived HIV status of a person with the purpose of impairing his or her enjoyment of human rights and freedoms in political, economic, social, cultural, and civil spheres, among others. *(Section 2)*

Prohibition of Discrimination

Discrimination on the basis of the actual or perceived HIV status of a person is an offence punishable by a fine of:

- MWK 5,000,000 and imprisonment for five years (individuals)
- MWK 10,000,000 (legal persons)

*(Section 6)*
In addition to any other rights conferred by any written law, a person who is living with HIV or vulnerable to contracting HIV, has the right to:

- Dignity of his person, physical integrity, life and health
- Practice a profession of choice
- Compensation associated with the restriction of his or her enjoyment of his or her rights
- Free medication, at a state medical institution, necessary for antiretroviral therapy or treatment of an HIV-related disease

A person living with HIV has a corresponding duty to take the medicine necessary for antiretroviral therapy.
Disclosure

• A person living with HIV has the right to privacy and confidentiality with regard to information concerning his or her status.

• It is an offence for a person to unlawfully disclose the HIV status of another person.

• A health service provider has a duty to strictly observe confidentiality in handling all medical information concerning a person living with HIV.

  (Section 9)

• Unlawful disclosure of the HIV status of a person by an individual is punishable by a fine of MKW 5,000,000 and imprisonment for five years.

  (Section 11)
HIV Information

• NAC “shall accredit any piece of information on HIV and AIDS before it is disseminated to the public.”

• A person who develops information on HIV and AIDS shall submit the information to NAC for screening and verification to ensure its accuracy before dissemination.

• A person who proclaims, utters, publishes misleading, false or inaccurate information concerning HIV and AIDS to another person or the public commits an offence.

• Sanctions:
  a) Fine of MWK 5,000,000 + imprisonment for five years (individual)
  b) Fine of MWK 10,000,000 (legal person)
• An employee shall not be discriminated against or be subjected to unfair treatment on the ground of his or her actual or perceived HIV status. (Section 28)

• An employer shall not require anyone to undergo HIV testing as a precondition for recruitment. (Section 27)

• An employer shall not terminate the employment of an employee on the basis of the employee’s HIV status, real or perceived. However, where the capacity of the employee to discharge his or her duties is affected by reason of poor health, general principles of employment law will apply. (Section 28)
Education

• An education or training institution cannot:
  o Refuse admission into the institution
  o Expel a person
  o Discriminate against a person
  o Refuse the participation of a person in an event or activity
  o Or otherwise deny any benefits or services to a person on account of his or her real or perceived HIV status

• A person who does an act prohibited above commits an offence punishable by a fine of MWK 5,000,000 and imprisonment for five years upon conviction.

• If the offender is a legal person, the fine is MWK 10,000,000.

• Further, a court may revoke the licence or business permit of an individual or training institution, respectively.

(Sections 34 and 35)
HIV Testing

Session 3, Activity 1 of the Reaching Men and Boys with Messages of Hope Training
HIV Testing Services (HTS)

- HIV testing checks whether a person is infected with HIV
- HIV testing must be provided in a confidential manner, and with the individual’s consent
- In Malawi, the goal is for 95% of people living with HIV know their status by 2030
Goals of HIV Testing (HTS)

- Identify people living with HIV
- Link people to treatment as soon as possible
- Promote positive living, care, and prevention among those who test positive
- Promote prevention among those who test negative
HTS Approaches in Malawi

Facility based
- Provider-initiated testing and counselling
- Voluntary counselling and testing

Community based
- (e.g., at a workplace, church or mosque, or mobile outreach)

Other approaches include:
- Index testing
- Self-testing
- Recency testing
Men and boys are less likely to know their HIV status than women and girls. Strategies that faith leaders can take to reach men and boys include:

- Promote testing using *Messages of Hope*
- Improve communication and coordination between facilities and communities of faith
- Provide testing at faith community events
- Promote HIV oral self-testing
Health Policy Plus (HP+) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. The project’s HIV activities are supported by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.

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Treatment and Adherence

Session 3, Activity 2 of the Reaching Men and Boys with Messages of Hope Training
Overview

- What is ART?
- When to start?
- What is viral load?
- What is adherence?
- Why is adherence so important?
- Why is adherence challenging for some?
- How can we support adherence?
Antiretroviral Therapy/Treatment (ART)

- ART refers to the combination of antiretroviral drugs (ARVs) that are used in the treatment of HIV.
- Sometimes the terms ARVs and ART are used interchangeably.
How does ART work?

- Remember what HIV does in the body:
  - HIV attacks the body’s CD4 cells, which defend the body against illness.
  - HIV invades CD4 cells and makes copies of itself, which then attack more CD4 cells.
  - As HIV damages CD4 cells, the immune system becomes weaker and the person can get sick.

- ART stops the virus from multiplying, so CD4 cells can recover and protect the body from illness.

- ART does not cure HIV. It keeps the virus from multiplying so it can not attack as many CD4 cells.
Goals of Antiretroviral Therapy

Decrease the amount of HIV in the blood
(typically until viral load is less than 50 copies)

Preserve the immune system
(so CD4 count increases)

Long and healthy life
(check other systems—liver, kidney function, etc.)
Goals of Antiretroviral Therapy

• Suppress the virus
• Restore the immune system
• Treat the complicating illnesses
• Minimize the risk of resistance and toxicity
• Improve the quality of life and clinical outcome

• TREAT THE WHOLE PERSON, not just the diseases they have
Goals of Antiretroviral Therapy (continued)

- Decrease chance of transmission to another person when someone has an undetectable viral load – treatment as prevention
- Prevent HIV transmission in HIV-negative people who are at high risk of being exposed to HIV (pre-exposure prophylaxis, or PrEP)
- Prevent HIV transmission in HIV-negative people who have been exposed to HIV (post-exposure prophylaxis, or PEP)
When to Start ART?

- This means that ART is offered to every person living with HIV in Malawi as soon as they know their status.
- Studies done across the world have clearly demonstrated that ART is the best treatment for HIV and should be started as early as possible.
- ART reduces HIV-related infections and cancers, deaths, and conditions not traditionally considered to be associated with HIV such as non-HIV related cancers, cardiovascular disease, kidney failure, and liver failure.
Viral Load

• **Viral load** is the number of HIV particles in a millilitre of blood. These viral particles are called "copies." A viral load test provides information about the progression of the virus in the patient’s blood and how well ART is controlling the virus.

• The **goal of ART** is to decrease the viral load down to undetectable levels.

• **Undetectable viral load**: In general, your viral load is declared "undetectable" if it is under 50 copies in a millilitre of blood. When undetectable, the chance of passing the virus on to another person is reduced.
Viral Load Monitoring

• Laboratory monitoring is not a prerequisite for the initiation or continuation of ART.

• Viral load monitoring is the preferred lab test for monitoring the success of ART.

• Viral load should be measured at six months after initiation, then annually.
What is Adherence?

• Sticking to a care and treatment plan.
• Going to all clinic visits.
• Picking up and taking all medications as prescribed:
  1. The right drugs
  2. The right dosage
  3. At the right time
  4. In the right way
Adherence to ARVs and More

Benefits of adherence:

- The goal of ART is to decrease the viral load, ideally to undetectable levels.

Having an undetectable viral load:

- Allows the immune system to recover and become stronger.
- Puts you at very low risk of becoming ill because of HIV.
- Reduces your risk of developing some other serious illnesses.
- The risk of HIV becoming resistant to the anti-HIV drugs you are taking is very small.
- Reduces the risk of passing on HIV to someone else.
Consequences of Nonadherence

- Less suppression of HIV replication (so viral load goes up)
- Destruction of immune system (CD4 goes down)
- Disease progression

- Intermittent treatment for HIV and AIDS does not work.
- Preventing complications and preserving good health is more effective than trying to treat complications when they arise.
- Maintenance and/or restoration of immune defenses requires ongoing monitoring and treatment.
Consequences of Nonadherence (continued)

- Drug resistance
- Risk of transmission of resistant viruses
- Limited future treatment options
- High cost for the individual and country
- Increased risk of transmission
- Worsening health and death
Helping People Adhere to Care and Treatment

- Create a good care setting
- Good communication
- Shared confidentiality
- Patient education and peer support
- Strong outreach and follow up

Adherence support is important—faith leaders can help!
Remember, it is NOT ethical, and it is illegal to disclose a person’s HIV status without their consent!
Examples of Question to Ask about Adherence Challenges:

• “When/why is it most difficult to remember your medications?”

• “It is not easy to take medicine every day. What kinds of problems make it hard to take your pills?”

• “It’s not easy to take medicines every day. What things help you to take your pills?”

• “It’s great that you are feeling better now that you started ART. What things make it hard to remember to take your medicines now that you’re feeling better?”
Possible Solutions to Adherence Challenges

Challenge
1. Dosing frequency (some meds are taken two or three times daily)
2. Side effects
3. Medication access/storage
4. Too many pills

Solutions
1. Try pill boxes, carrying an extra dose at all times, setting the alarm on a watch, etc.
2. Seek help to manage side effects
3. Store securely—most can be kept out of the fridge
4. Speak with your medical provider
Possible Solutions to Challenges

**Challenge**
1. Forgot to take pills in the morning
2. Forgot pills at home
3. Tired of taking pills
4. Ran out of pills

**Solutions**
1. Set alarm on phone, take after brushing teeth, etc.
2. Always have a few in a small pillbox in your bag or at work/school
3. Peer support, counselling, etc.
4. Ask provider about a six-month prescription or community pickup
The adherence motto is:

“EVERY DOSE, EVERY DAY, FOR LIFE!”
Six Basic Rules for ART Success

1. ARVs need to be taken every day.
2. ARVs should be taken at the same time.
3. HIV is a chronic disease and ARVs need to be taken for life.
4. See the doctor or nurse if you have ongoing side effects.
5. Never share ARVs with other people.
6. You can still pass HIV to others—even when on ART, and even if you feel well—so remember to use a condom every time you have sex.