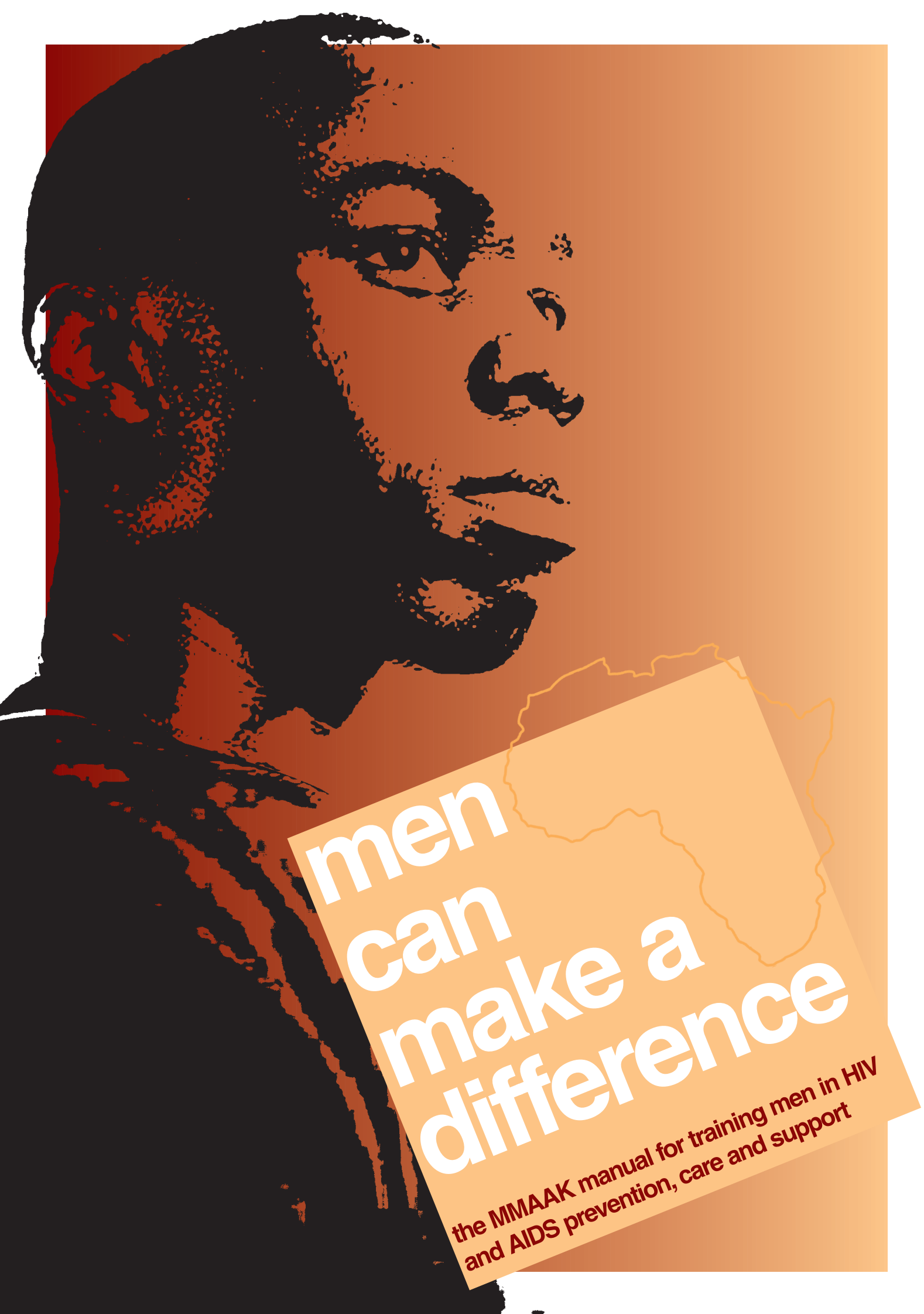

men can make a difference

the MMAAK manual for training men in HIV and AIDS prevention, care and support

contents

men can make a difference
THE MMAAK MANUAL for TRAINING MEN in HIV and AIDS
PREVENTION, CARE and SUPPORT

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Michael Onyango and Zebedee Mkala are members of MMAAK. As National Coordinator and Programme Officer respectively, Michael and Zebedee have worked to make their vision of MMAAK a reality since 2001. This manual is the product of their numerous workshops and meetings with men's groups and evidence of their commitment and dedication to transforming the experiences and contributions of men living with HIV and AIDS in and beyond Kenya.

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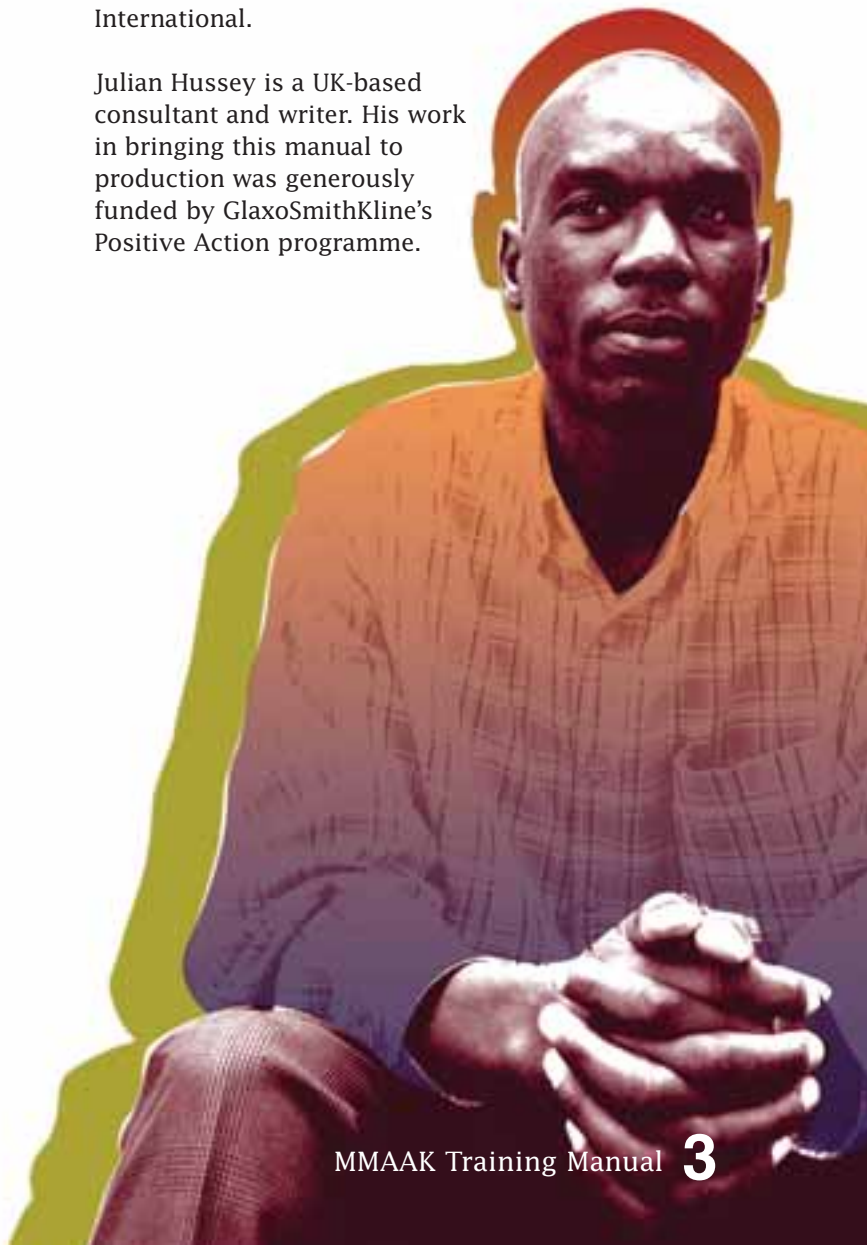


foreword

"Men can make a difference" in HIV and AIDS prevention, care and support

Every human being needs affirmation, love, care and support in order to feel wanted and a sense of belonging. This is even more so when one is ill disposed.

HIV and AIDS are complex and challenging conditions affecting human beings of all ages, of both sexes and across all socio-economic divide. AIDS has become the single most devastating disease affecting and devastating individual, family, community and national welfare. It affects one's sense of self-worth, confidence, dignity and capacity. It undermines one's independence. It depletes economic resources at family and national levels. Victimization and stigmatization due to HIV and AIDS are as devastating as the illness itself.

UNAIDS figures indicate that worldwide, there are more men living with HIV and AIDS than women. However, more women are becoming infected at a faster rate than men. This is so because socially and culturally, women are unable to determine "when, where and how sex takes place". UNAIDS reports also reveal that to cultural beliefs and social expectations heighten men's own vulnerability to HIV infection. Within the context of masculinity, men are expected to be physically strong, emotionally robust, daring and virile. This compromises the desire to live positively and manage stigma, denial and discrimination. Some of the resultant clichés from this perspective include "Real men don't cry, real men don't stay at home like women; real men are adventurous and risk takers etc. etc.". Unfortunately, some of these social conditioning and misplaced expectations translate into ways of thinking and behaving that endanger the health and well-being of men and their families including abuse of alcohol, narcotics and other dangerous substances. This can lead to unsafe sexual behaviour that increases vulnerability to HIV infection. Sadly, many men consider their masculinity compromised or slighted by the very behaviour that can limit the spread of HIV and AIDS, namely; having one steady sex partner, taking no excess alcohol or other related substances, using condoms, abstinence, showing love, respect and caring for women and their families.

Many women have been made more vulnerable and infected by HIV positive men simply because of their inferior social statues and men's misplaced and unmanaged expressions of masculinity. Many women have been forced into sexual intercourse through rape or commercial sex. Studies have shown that more than 50% of infected married women contracted HIV from their husbands. Discrimination and social stigma and the fear of losing masculinity continue to prevent many men from accepting and disclosing their positive HIV status.

Michael Onyango
MMAAK National Coordinator

introduction

The Movement of Men Against AIDS in Kenya - the context for this manual

The burden and debilitating nature of HIV and AIDS has reached unacceptable proportions in Kenya and other parts of Africa, and if left unabated, its residual effect will be irreversible at individual, family, community and national levels.

Since 2001, the Movement of Men Against AIDS in Kenya (MMAAK) has concentrated on supporting and equipping men, especially men living with and affected by HIV and AIDS to play a major role. MMAAK's strongest premise for developing this training manual is its belief that "men can make a difference" in HIV and AIDS prevention, care and support at all levels of their existence and interactions, regardless of their social, economic, political or religious affiliations. This belief emanates from MMAAK's experience as an organisation inspired by the lives, strengths and vision of men living with and affected by AIDS: from this we know that men can make a measurable difference if only they are supported in playing an active role.

MMAAK has established men's groups in Nairobi, Mombassa, Karatina, Kericho and Kisumu. By working with VCT centres they have developed approaches that have greatly increased the numbers of men coming forward for testing – as individuals and with their partners – and maintained their interest and participation after testing. MMAAK has also worked with schools to establish young men's groups and with employers to create Positive Workers' Unions.

MMAAK has devised this training manual to help others to start men's HIV and AIDS support groups of their own. It can be used by organisations, training facilitators and men in general to achieve an understanding of and commitment to the changes they can make to our experience of the AIDS epidemic.

The development of this training manual has been participatory, it was done through a number of interactive processes, collecting views and narrative testimonies from men from all walks of life in Kenya.

Some of the attributes that are socially ascribed to men offer an opportunity for them to play a major role in HIV prevention and AIDS and control, including:

- The man as family provider
- A strong, protective source of security for family
- Knowledgeable
- A daring risk-taker
- Enduring
- Loving and caring.

For these potential strengths and attributes to emerge requires facilitation: men need safe and supportive spaces for knowledge and awareness creation, and to develop practical skills and gain the confidence necessary to exercise a supportive role. Of course this also means recognising and dealing with the negative aspects of masculinity that have been long attributed and become ingrained in some communities. This manual will help facilitate that process for individual men and groups of men who are committed to addressing HIV and AIDS

MMAAK - the values and goals behind this manual

This training manual embodies and promotes certain principles which have been critical to the developing work of the Movement of Men Against AIDS in Kenya.

MMAAK values:

- Respect for and securing of the full enjoyment and protection of all human rights
- Commitment and accountability individually and collectively (Individual and collective responsibility)
- Partnership building
- Equality and equity
- Human dignity of each and every individual regardless of their HIV status and situation
- Love and giving hope to individuals and families affected by HIV and AIDS
- Reducing the burden of HIV and AIDS on individuals and families

MMAAK's vision:

To build a society where men infected and affected by HIV and AIDS emerge as participants, fully engaged in prevention, care and support for an AIDS-free society in Kenya.

MMAAK's mission:

To demonstrate decisively that men can make a measurable difference in
HIV and AIDS prevention, care and support at all levels of their social interaction

MMAAK's general goal:

To enhance popular, effective and male participation in HIV and AIDS prevention, care and support

The specific goal of this manual:

To support the building of men's competent capacities at various levels in HIV and AIDS prevention, care and support in order to achieve considerable and measurable reductions in HIV and AIDS prevalence rates in the next five years.

Objectives of this manual:

Provide adequate information on HIV and AIDS to men especially at the grass-roots and middle management levels within the community, in NGOs and CBOs, and in the private and public sectors

Identify and undertake training of core male trainers in every district to train men at community level on the role men can play in HIV and AIDS prevention, care and support at various levels

Produce a sizeable pool or cohort of skillful, gender responsive and resourceful men to reach out to other men infected and affected by HIV and AIDS (Men-to-Men approaches).

guidance for facilitators

How to get the best out of this manual

Those who take the lead in promoting the role of men in responding to HIV and AIDS may have a great deal of experience as trainers or facilitators or they may have very little. We offer those trainers and facilitators this guidance to help them achieve optimum results during the training programmes. These ideas should help to make the training sessions practical, increase the acquisition of skills, and make the instruction and learning fun and enjoyable for both the trainees and trainers. This approach applies to all the modules and sessions in this manual. The exercises and sessions in this manual are participative. The authors therefore hope and expect that many parts will become enriched and reinforced by its various users and the environments in which they work.

Facilitators and trainers are asked to ensure that they:

- Apply human rights principles and participatory learning methods throughout the training sessions in this manual
- Always seek to understand and appreciate the special circumstances, difficulties, sensitivities of people living with HIV and AIDS (PLWHA) - both infected and affected
- Use the training not only as an opportunity to build capacity, but also as an opportunity for restoring hope, validating humanity and human rights and human dignity.
- Recognise that you are being called to a very specific time and place to use this manual as a tool of deep reflection, new vision, renewed spirit and commitment to the vision: an AIDS-free society
- Support the building of the rapport or team approaches necessary to set the climate for open, frank and adequate sharing and that enable learning by example
- Encourage leadership formation during training sessions including asking participants to lead discussions, volunteer to write on the flip charts
- Support and enhance confidence and trust building between and among participants
- Encourage dialogue and ensure equal participation and contribution by all participants
- Use examples in ways that demonstrate the different possible reactions generated by HIV and AIDS from various perspectives
- Ensure that "No Harm" is done by way of further stigmatization or discrimination of PLWHA. This is part of the call to sensitivity, including avoidance of negative or critical language and comments
- Ensure that facts and myths are clearly distinguished: reinforce facts and redress inaccuracies
- Recognise that it is important, useful and recommended that if the trainer is not a person with a social welfare or medical background or other specialist orientation for these sessions, that during Module Five sessions a resource person be additionally available to encourage in-depth discussions around some of the technical content matters
- Use resource persons (even if they are drawn from within the group of trainees) to lead practical experience exercises for Modules Five, Six and Seven.
- Limit numbers for optimum learning: training sessions should consist of a maximum of 30 participants. It is ideal, whenever possible, to have a mix of participants from the various social backgrounds in the community. This will reinforce a multi-sectoral and multi-disciplinary approach to HIV and AIDS management and expand the learning base and enhance the desired learning exchange.

Recommended ways to use this manual

There is no limit to the variety of ways you can apply the lessons in this manual. However, from our experience we recommend those that we know can enhance the process you have embarked upon. Try to combine two or more formats as they seem most appropriate to the objectives and content of the sessions, including:

- Field visits (for example a clinic, VCT centre or home-based care)
- Plenary sessions (the whole group together in one place)
- Brainstorming in pairs or small groups
- Small working groups for exercises or problem solving
- Use of case studies, story-telling, role plays and drama
- Guest speakers and co-facilitators
- Audio-visual materials (including posters, video tapes and music tapes)
- Homework assignments

Use plenary to introduce each Module, session or topic and any new material

The facilitator should always provide a short overview to inform participants of the contents of the topics to be discussed in a given module or session. Once that is achieved you can continue in plenary or break into smaller groups or pairs for the activity.

Introduce only one topic at a time and address it fully before introducing the next

Each module contains one or more training sessions. These have been broken down into a series of "steps" for facilitators to follow.

Interactive work is easier in smaller groups, though some techniques work in plenary too

Use brainstorming, role-plays and other interactive methodologies to engage participants and to find out from them what they already know about each topic. In a common format, facilitators introduce new topics in plenary, followed with interactive and deepening discussions in small working groups.

The facilitator/assistant should always deal with responses or questions

If it is not possible to deal with them immediately then record them on paper or a board to be dealt with later when it is appropriate. Do not ignore ideas or opinions that come from individuals or working groups – they deserve a response or to be discussed by the larger group.

Remember, adult learning takes place when participants are challenged by a problem

Therefore, give adequate problem solving opportunities on given scenarios. Participants also learn best when they are encouraged to create/ generate some product or solution. Assignments should be given as a group to encourage bonding, teamwork and the inter- and multi-sectoral approaches so badly needed in HIV and AIDS management.

The participants rely on their facilitator to explain how they should work, what their objectives are and what the results of any exercise should be: how, why and what

Introduce the case study or exercise and explain its purpose and how it will be used in the sessions. Give participants adequate time in small working groups to read and understand case studies and other materials used for enhancing learning. Tell them what form the reporting back will take. Monitor each small group and draw out the best ideas in the plenary: always build on what participants already know, gently facilitate their organizing what they already know in ways that develop usable information, skills and plans.

The commitment of your participants allows the facilitator to give homework assignments as a means of supplementing classroom sessions

Ensure that instructions for the homework are clear with concrete expected results. You can encourage team or group work even for homework assignments.

It will help if you keep accurate records of participants' reactions, perceptions and responses

These will form important building blocks for designing the intervention programme and help you with evaluation. Don't assume you will remember all the issues and opinions that arise.

Monitoring the progress of your group

We strongly recommend that you take these further simple steps to help you to monitor the progress your group makes as a result of the training. Below is a set of questions that the group should answer individually if possible, both at the start of the training and again once all modules have been completed. If participants are unable to complete their own questionnaires this could be made a small group activity. Ideally, you will assign each trainee a number so they do not need to put their name on their paper. When you post results you can use the numbers, or give each trainee their results in private: either way, no other trainee needs to know their colleagues' results. How great an improvement you see will depend on many factors besides the quality of your training, but recording an improvement will give you some confidence in the programme. If you identify areas where there has been little or no improvement you may wish to review how those modules were delivered and how trainees responded to them.

MMAAK pre- and post-training assessment
Please write your number on the paper rather than your name

1 Men's involvement in HIV and AIDS is the campaign to have more men employed in HIV and AIDS programmes and organisations (TRUE or FALSE)

2 Men are more vulnerable to HIV infection for reasons of physiology (TRUE or FALSE)

3 What is masculinity?

4 What is gender?

5 Lack of effective communication in relationships is a major factor in the development of extra-marital affairs (TRUE or FALSE)

7 Why are men's HIV support groups needed?

8 Describe "disclosure"

9 What is the difference between sex and sexuality?

10 Name three ways HIV can be transmitted

11 Which individuals and organisations in our community can have an impact on levels of new HIV infection?

The whole purpose of this manual is to help men play their effective role in HIV and AIDS prevention, management and control. Remember that we teach, instruct and guide by example. The facilitator should ensure that the principles of equity, equality and tolerance of diversity are upheld at all times.

Nurture the following attitude:

"I can do it. You can do it. Men can do it. Together, we can do it".

"Pamoja, Tuangamize Ukimwi Kenya"!

good luck!

module 1

What can men do?
Individual and community responsibilities

OBJECTIVES

Participants will understand their own role within their communities. They will help devise tools for mapping the key figures and organisations that have impact on their lives.

Introduction

By our actions we can influence the course of HIV and AIDS in our country. We can avoid new infections by changing our own behaviour and educating others to do the same, and by challenging ignorance, stigma and prejudice we can improve the integration, care and treatment of people living with HIV and AIDS. Because, as men, we can change the face of this epidemic, we have a responsibility to do whatever we can.

But the responsibility does not rest with us alone. Responses to AIDS in Africa have already shown what can be achieved when individuals come together to face their problems, in self-help groups and networks. Existing organisations and institutions that face up to their responsibilities can bring about change across whole communities. When there is reluctance on the part of these institutions we all have a right to speak up and call for action.

This manual will touch you as an individual and the individuals you are able to reach with your own programme of meetings and training. But it should not stop there. If successful this manual should enable individuals to recognise and live up to their responsibilities, and at the same time to engage with the institutions and organisations that have influence over communities at local and even national levels.

To achieve this your group should map out the roles of the institutions and organisations that touch their lives. As they progress through this manual they will be able to determine what implications each module has for those groups as well as for themselves personally. This module describes two processes:

- Institutional mapping – participants establish which institutions affect their lives and how they interact with them
- Role planning – participants revisit the "map" at the end of each module to plan what role they will press these institutions to take in achieving their objectives

Creating the map is the first part of the whole process: this helps your participants to understand their own roles in the community and how they relate to other institutions. It is a good icebreaker and should build the participants' confidence. You will be prompted to undertake or repeat the second stage – role planning – at various points through the manual.

Session 1: Institutional mapping

Duration
Allow up to forty-five minutes for the whole session.

Materials
Pens, flipchart paper, institutional mapping tables

STEP 1
Explain the purpose of the exercise based on the introduction above. Write up this list to help define the types of organisation the groups will discuss:

- local community-based groups
- community leadership / councils
- churches and religious groups
- schools
- any providers of local services
- local, regional and national government agencies
- elected leaders or representatives
- sports clubs
- other agencies, eg larger NGOs

Ask the group to add to this list, without adding specific names of organisations.

Break the large group into two or three smaller groups (between four and eight in a group would work well). Each group has fifteen minutes to list all the organisations they think should be considered in the institutional mapping exercise. Bring everyone back together and ask them to write their suggestions on three separate sheets of paper, one for each of the following categories:

- local organisations that are locally controlled or managed
- organisations that provide services locally but are managed regionally or nationally (or from overseas)
- institutions that affect our lives but have no local presence or operations

Explain there are four levels of influence that we must consider:

LEVEL 1
We have responsibility for our own actions and how we influence our families and friends

LEVEL 2
Within our immediate community we should expect our voices to be heard by our leaders and our own institutions – in return for our support and involvement

LEVEL 3
Services we receive here but which are managed elsewhere should nonetheless be effective and to the benefit of our community

LEVEL 4
Those who affect our lives with their policies or their funding decisions should be interested in our views: elected government needs our support; the international community is less accountable locally but should hear the voices of those they purport to help.

Looking at the three lists, discuss how the group can achieve a dialogue with each organisation or institution: is there someone in the group who is a direct or obvious link; does the group know the name of a local representative/manager; is there a way of getting more information?

Tell the group you have the start of the institutional map. The next step is for you to process the information so the group can use it later for role planning.

STEP 2
On your own, away from the group, or with one or two others who volunteer to help, transfer the lists of organisations and names to the following table. This will be the basis for role planning in several future modules. If you can, make several copies of these tables for future use.

Locally managed organisations

Organisation	Contact(s)	Desired action

Organisations providing services locally but managed elsewhere

Organisation	Contact(s)	Desired action

Organisations that influence local provision by their policy or funding decisions

Organisation	Contact(s)	Desired action

Session 2: Role Mapping and action planning

Duration
Up to half an hour

Materials
Institutional mapping lists and tables and action planning tables

At the end of Modules 2 to 9 the group should undertake action planning and role mapping exercises. These will ensure commitment to action, whether for personal behaviour, direct action in the family or wider community, or to petition or advocate for action by organisations and institutions.

Explain that the actions, whether for individuals or institutions, should be **SMART:**

Specific **M**easurable **A**chievable **R**elevant **T**imed

At the end of each module there should always be actions for the individual participants. There should also be actions for some of the organisations identified in the previous session, but not all of those listed will be relevant to every module. Agree which are relevant and which of those should be prioritised – the group will not have time to follow up every idea. Those that will be pursued should be allocated to one or more members of the group – they will be asked to report progress at future sessions.

Identify the gaps or factors that constrain these institutions in the effective achievement of their roles. List these factors for future use in designing action plans sessions. Identify the sex and sexuality and HIV and AIDS issues in your community/ programme/organisation that you will address after this training. Be explicit about what groups you will target with your actions and explain why they are important. The tables help you to identify the institutions and people in those institutions you will work with, but remember to identify any resources you will need to implement your action plan (skills and teaching materials could be part of those resources). Try to predict the problems or barriers you may encounter and plan how these will be overcome. Consider what allies or supporters you could work with on these actions.

Table of actions

Action	By whom (person and, if relevant, organisation)	By when (date)

Examples

The local organisation table might look like this after Module Two:

Organisation	Contact(s)	Desired action
Village council	Leader, other members of the group	Request support for actions agreed
Primary school	Head teacher Class teachers Parent/teacher liaison	Meet to discuss sex education for 10 and 11 year olds
Health clinic	Nurse, outreach worker(s)	Meet to discuss services and information for families, information and services for teenagers
Church	Sunday school committee	Meet to review relevant teaching
Large employer	Managers, union reps	-

The table of actions after Module Two might look like this:

Action	By whom (person and, if relevant, organisation)	By when (date)
Discuss with our wives the sex education of our sons and daughters	John, James, Thomas, Michael and Allan	By the end of this week
Discuss contraception with our wives	David, John, Peter, James, Thomas, Julius, Michael, Joe and Allan	This weekend
Request a meeting to discuss sex education, HIV and AIDS etc. (to occur after all modules have been completed)	John to approach the Primary School Head – Michael and their wives to be included in the meeting	By the next session (next Friday)
Obtain more information on stance of Sunday School	Peter, as member of Sunday School Committee	Their next meeting (next month)
Update the Village Council on our group's progress	Michael as Council leader	Their next meeting
Invite clinic nurse to attend meeting with school	John to raise this at next meeting with clinic about this project	Clinic liaison meeting: five weeks' time

module 2

Human sexual development

OBJECTIVES
Participants should understand the physical differences that enable men and women to reproduce.

They will learn by practising how to explain the basic phases of sexual development and reproduction to other adults and children.

Background
As you approach this first session dealing explicitly with sex and reproduction remember how you felt about discussing these issues before your training or before you read this manual. The participants are at the start of a journey and many of them will find it difficult: most of us are not used to talking about sex in this kind of setting, while some people may never have talked about it in the kind of detail you will cover. This module has been designed to be an introduction to both the basic facts about sex and the difficult task of talking openly and sensibly about it.

Session 1: Icebreaker exercise

Duration
twenty minutes

Materials
flipchart paper and pens

STEP 1
Explain to the group that you want to begin this module of work by exploring briefly the extent to which we have all experienced the taboo of sex and human reproduction. Split them into two groups. The first group should come up with the longest possible list of ways they were answered (or indeed have answered themselves) on asking "Where do babies come from?"

The second group should come up with another list – this time a list of words for penis and vagina.

Five minutes should be plenty of time for this.

STEP 2
Ask the first group to read out their list. Then ask all the participants to suggest why these stories or myths are invented: why children or parents or other adults cannot simply offer a truthful and accurate answer to the question "Where do babies come from?" Write those ideas up yourself. They might include: embarrassment; maintain a child's innocence; don't know how to explain the true answer; don't want children to experiment. Ask "What are the dangers of maintaining these myths about reproduction?"

Then ask the second group to show their list – it may be a mixture of childish words and what we might consider vulgar words. Ask all the participants to explain the difference between the childish and the crude words – what makes one acceptable and the other unacceptable? What effect does using these words have?

Conclude this exercise by saying that our discussions of sex and sexuality must be grounded in fact. We are going to learn the correct names for parts of the body and their functions so that we can distinguish between these and the myths and misunderstandings that are so common. We should be able to use these words without embarrassment and without making others feel threatened or inferior.

Session 2: Sexual development

Duration
One and half hours

Materials
flipchart paper and pens, module 2 Handout 1

OBJECTIVES
Participants will learn the ages at which sexual development occurs.
They will consider the implications for sex education and practise providing clear answers to questions about puberty and reproduction.

STEP 1
Ask the group to form pairs. Each pair should think of two questions or myths about sex that they would find it difficult to answer or discuss with a friend, or their wife or their child. Allow no more than five minutes for this.

Ask the pairs to report the questions and myths in plenary and write them up on the flip chart. If the ideas are too repetitive ask for others or add ideas of your own. Explain that you will not be answering these questions, but that by the end of this session they should be able to answer these and others. Of course you must make sure that these are covered in the session that follows, if necessary in addition to the material provided. If there is a question that none of you can answer confidently, brainstorm where you might find the answer and make it a homework exercise to undertake to bring the answer yourself to the next session.

STEP 2
Introduce a discussion of puberty. Explain that there are many stages of sexual development, but there are many variations in the ages at which these occur so it would be wrong to be alarmed at what we might think of as early or late signs of puberty. The physical and emotional changes we notice during this period are caused by hormones.

Hormones are chemical messengers made by one part of the body (like the brain or the ovary) to affect another part of the body. Hormones do not just affect sex – thyroxine for example is made in the thyroid and controls how fast most of the cells in the body work. Without sex hormones, babies would not grow up and we would not want sex, girls would not release the egg each month and the fertilised egg would never develop into a baby.

The main female sex hormones are oestrogen and progesterone. They are mostly produced in the ovaries, but their production is controlled by hormones from the brain. The ovaries in women also make a small amount of the male sex hormone – testosterone. Men make ten times as much testosterone as women, and women make ten times more oestrogen and progesterone than men.

The production of sex hormones for the first time or in greater quantities than before triggers the changes we call puberty, and their reduction later in life will cause reduction in performance and the menopause.

When body-builders take steroids, they are taking sex hormones. By overdosing like this they can put on extra muscle, but they can also damage their genitals.

Distribute "Sex education: sexual reproduction" (Module 2: Handout 1) to the group.

Talk through the handout, discussing any questions that arise as you go. Tell the group that this is a resource designed for children who may be experiencing puberty themselves or worried that they have not yet begun puberty. Ask the group to break into small groups of three to answer three questions:

- **When is the right age to explain puberty and sex education to children?**
- **Who should provide sex education to children?**
- **What are the potential benefits of providing good, accurate sex education to young people?**

Allow the groups no more than ten minutes to discuss and answer these questions. Back in plenary, compare the different ways the groups have responded to the questions and lead further discussion. Remind the group that:

- **There is evidence that sex education reduces experimentation and early sex**
- **Leaving sex education entirely to others puts it out of your control**
- **Not instigating discussion of sex with your family sends the message that you do not want to be asked about it.**

Sex education: sexual reproduction

What is puberty?

Between the ages of 10 and 14 most boys and girls begin to notice changes taking place to their bodies. These changes, which take place over a number of years, also include emotional changes and are sometimes referred to as puberty.

One of the main physical changes of puberty is the growth and development of the sex organs. Boys and girls both have sex organs that are on the outside of the body and can be seen. They also have sex organs inside the body. Those on the inside are usually called the reproductive organs, and those on the outside the genitals. Two of the main sex organs in a girl's body are the vagina and ovaries. In a boy's body two of the main sex organs are the penis and testicles.

Some more about a girl's sex organs

The opening to the vagina is one of three small holes that a girl has between her legs. At the front is the urethral opening which a girl urinates through. The anus is the opening at the back from which she defecates.

From the vaginal opening in the middle there is a passageway or tube called the vagina which leads to a girl's internal sex organs. When a girl has her period the blood comes out through her vagina.

Inside the vagina is a thin skin called a hymen. The hymen partly covers the vaginal opening, but there is still enough of a gap for blood to get through.

Another important sex organ is the clitoris. This is about the size of a pea and it is at the front of a girl's outside sex organs. The outer lips (labia) of a girls sex organs, the clitoris and the vaginal opening are together known as the vulva.

Some more about a boy's sex organs

The boy's sex organs on the outside of his body are his penis and testicles (testes).

A boy's penis hangs down between his legs at the front of his body. The main part of the penis is called the shaft. The end of the penis is called the glans. The foreskin is skin that covers the glans. Usually it can be pulled back quite easily. If it is tight it can be stretched by gently pulling it over the glans. All boys are born with a foreskin, but some have it removed. This removal of the foreskin is called circumcision.

The scrotum is a loose wrinkly pouch of skin that hangs down behind a boy's penis. It contains the testicles (testes). As a boy goes through puberty his testicles move lower down his scrotum. One of the testicles usually hangs lower than the other.

Eggs and sperm

A girl has two ovaries inside her body. These ovaries contain a girl's sex cells or eggs. During puberty the ovaries begin to release eggs. Usually they will release one egg every month. These eggs are very small, each one being no bigger than the head of a needle.

A boy's sex cells are called sperm and they are even smaller than a girl's eggs. At puberty a boy's testicles will start making sperm. Sperm leaves a boy's body through his penis, usually when it is hard and erect. This is known as ejaculation. When a boy ejaculates millions of tiny sperm are sent from his testes up through his penis and out through the end.

When sperm from a boy meets up with an egg from a girl they can join together, and from this a baby grows. This joining is sometimes called fertilisation.

How do sperm and an egg meet? - Sexual intercourse

Sperm and an egg can meet when a boy and a girl have sexual intercourse. Sexual intercourse is when a boy's hard penis goes inside a girl's vagina, and he then ejaculates sperm through his penis.

A boy is physically able to become a parent when he first starts to ejaculate sperm. A girl is physically able to become a parent when her ovaries start to produce eggs.

What happens to an egg if it meets with any sperm?

When an egg is released from a girl's ovaries it travels down inside one of her fallopian tubes towards the uterus or womb. Whilst this is happening the uterus starts to get ready for a fertilised egg by developing a thick lining. If the egg is fertilised on the way, then it settles in the uterus and this is where the baby starts to develop.

What happens to an egg if it does not meet with any sperm?

When the egg is not fertilised, there is no need for the thick lining of the uterus. The lining slowly begins to come away and flows through the cervix or "neck" of the uterus which connects the uterus to the vagina. It then comes out of the girl's body through the vagina. This is the blood that comes out when a girl has her period. As soon as a girl starts to have her period her ovaries start getting ready to release another egg. The length of time between one period and the next is the menstrual cycle.

What are the main physical signs of sexual feelings?

The main sign for boys that they are getting sexually excited is when they get erections.

The main sign for girls is when their vagina begins to get moist. The clitoris gets bigger too.

For both boys and girls when they are sexually excited extra blood comes to the surface of the skin, particularly around the penis and vagina. You can feel warm and sensitive and sexy just about anywhere on your body.

At what age do boys and girls start to get sexual feelings?

A person can have sexual feelings any time in their life, but these change around puberty. You might find some sexual feelings just seem to happen to you. But sexual feelings mostly come about from things you choose to do, either on your own or with someone else.

One way that people express their sexual feelings is by touching their own genitals. This is called masturbation. Some people don't masturbate at all, or hardly ever. Other people masturbate every day. Masturbation does not cause you any harm.

Some girls enjoy touching their clitoris. Many boys enjoy touching their penis, particularly the tip.

When a person is masturbating they become more and more sexually excited. They may then reach a peak of sexual excitement which is called having an orgasm or "coming". This is when all the tension and excitement that has built up is suddenly released. Boys ejaculate when they have an orgasm and their penis will then go limp.

For many people masturbation is their first sexual experience.

Sexual feelings in relationships

When people have sexual feelings for each other they will usually want to do sexual things together. There is no set time or order in which to do things.

They often want to kiss and cuddle and hold hands. When people kiss they sometimes 'French kiss'. This is when both people open their mouths when they are kissing and their tongues touch together.

People also like to touch each other through their clothes or put their hands inside to stroke or touch each other's genitals.

There are a variety of other sexual activities that people will also do including sexual intercourse.

It can seem natural to bring sexual feelings into a relationship. But it can also change how people feel about each other and about themselves. You might want to do something because you feel curious about it. Or because you think it will make you feel good. And you might want to do it because you feel very close to someone.

But it's important not to do any of these things because you feel under pressure. And it's important that you think about the consequences and how you'll feel afterwards.

Sexual intercourse

Sexual intercourse is when a boy's hard penis goes inside a girl's vagina. This is often called having sex or making love. For many people this can be the most important sexual thing they can do with someone. It can be very enjoyable and fulfilling. For some people it can be the way they can most show their love for each other.

But there are a lot of things to consider. A girl can become pregnant from having sexual intercourse. There are also infections, including HIV that boys and girls can get if they have sexual intercourse with a person who already has the infection. These are called sexually transmitted infections or diseases. A person can't always tell if they've got one.

You also need to think about your feelings and what you believe. If you have sex because you were pressurised, were drunk or were just curious to know what it would be like, then you may regret it later.

You also need to consider the law. Countries may have differing ages of consent – the age below which it is unlawful to have sexual intercourse.

Pregnancy

If a boy and a girl have sexual intercourse the girl can get pregnant.

She can become pregnant even if:

- She has not had her first period;
- The boy withdraws his penis from her vagina before he ejaculates;
- She is having her period;
- It is the first time she has had sexual intercourse.

The first sign that a girl may be pregnant is that her period does not start when she expects it to. If this happens then it is very important to see a doctor or talk to some other adult as soon as possible.

Contraception can be used to prevent pregnancy occurring when a boy and girl have sexual intercourse. Some contraceptives, like the contraceptive pill, are used by girls. Boys can use condoms. Condoms also prevent sexually transmitted infections from being passed from an infected person to another person during sexual intercourse.

Help and advice

Puberty is a time when you are going through many emotional and physical changes. There may be times when you feel concerned about what is happening to you or how you feel. It can be really hard to do, but it can really help to talk to other people.

It can be really helpful to talk to your parents or guardian. If you cannot talk to them, or you want to talk with someone else as well, there are other people who can help. You might be able to talk to someone at school, either a teacher or another adult.

module 3

Understanding sex and sexuality

OBJECTIVES
Participants should be able to use the terminology of sex correctly. They should understand the meaning of consent and its legal implications.

Session 1: What these words mean to us

Duration
Two hours

Materials
flipchart paper and pens, module three handout 1

STEP 1
Write these words and phrases on the flipchart:

- Sex
- Gender
- Sexuality
- Sexual orientation
- Human rights

Explain that understanding what we mean by these words in the context of sex and AIDS education is very important. You will spend some time in this session discussing their meaning and then using them in further discussions.

Distribute Module Three Handout 1 – Definitions and talk through each definition in turn. Allow at least half and hour for this.

STEP 2
Once you have covered all the definitions split the group into five smaller groups and allocate each one of the words or purposes from the flipchart. Explain that they have fifteen to twenty minutes to prepare a presentation "What this means to us" – you do not want them to repeat the definition from the handout, you want each group to explain why this word (and its correct interpretation) is important to them as men.

Encourage the groups to use different styles of presentation: they could share the presenting among them, use drama, use the flipchart and so on. Tell them their presentations should last no more than five minutes, and allow time for feedback on each presentation.

Definitions

Gender
Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female in a particular point in time.[1]

Gender equality
Gender equality means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.[2]

Gender equity
Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men. It often requires women-specific programmes and policies to end existing inequalities.[3]

Gender discrimination
Gender discrimination refers to any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights.[4]

Reproductive rights
Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.[5]

Sex
Sex refers to the biological characteristics that define humans as female or male.[6]

These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred. People use "sex" as shorthand for "sexual activity" or "sexual contact" often meaning sexual intercourse (as in "Did you have sex?") but also other forms of contact involving the sex organs – oral sex, anal sex, masturbation – or that result in sexual stimulation or orgasm. In this manual we will try to be more specific about the activity or form of contact under discussion – it will help you to do the same in your own work.

Sexuality
Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.[7]

Sexual orientation
Sexual orientation (or 'sexual preference' or 'inclination' – which are often not favoured because they imply a choice) may be described as heterosexual, homosexual or bisexual, according to one's sexual attraction to people of the opposite sex, the same sex, or both sexes. There is debate as to whether behaviour alone can define sexual orientation, or a combination of behaviour and self-identification, or self-identification alone. It is certainly true that some men engage in sex with other men but do not identify as gay or homosexual, or as bisexual. In sexual health, when describing this behaviour the term men-who-have-sex-with-men (or MSM) is used.

Sexual health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[8]

Sexual rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations (see handout – Sexual consent);
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.[9]

Cross-dressing

Cross-dressing means dressing in the clothes of the opposite sex. There are many reasons why men may dress as women: some may do it once or twice as a joke; some may get pleasure from wearing women's underwear (often as a prelude to having sex with their wife or girlfriend); some may do it habitually as a kind of performance, adopting an alter ego (as drag queens do); for others, transvestites, there may be a compulsion to dress as a woman that they find it difficult to resist. There is no evidence that these men are either all heterosexual or all homosexual. Unfortunately some people find cross-dressing disturbing and react negatively because they do not understand the motivation or they make assumptions about why an individual might do it. Do not make assumptions about someone's sexual orientation based on cross-dressing and try to see them as an individual.

Transsexuality

The medical definition of a transsexual is someone who feels strongly that they should belong to the opposite sex - that they were born in the wrong body. The person will feel a sense of estrangement from their own body coupled with a sense of distaste for the parts of it that identify their sex. They will seek surgical and medical treatment so that they can physically resemble the sex that they feel they should have been and they desire to live as a member of that sex in the community. As with all medical definitions in this field it is not set in stone: not all transsexuals will have every indication. In some countries transsexuals can access hormone therapy and surgery to reassign their sex, but often they remain legally defined by their birth sex. The term transgender is also often used, but sometimes more broadly to cover transsexuals and anyone else who acts in ways obviously not associated with their own sex.

references

1, 2, 3, 4 Transforming health systems: gender and rights in reproductive health. WHO, 2001.
5 ICPD Programme of Action, 1994, para 7.3
6, 7, 8, 9 WHO Draft working definition, October 2002

Session 2: Sexual development

Duration
One hour

Materials
module three handout 2

STEP 1
Begin by recapping the key messages that emerged from Session One. This should include:

- Our sex – being men – is a major and a constant part of our identity
- We can be defined by our gender – how society sees what we do that makes us male or masculine – or we can help to define it
- Men and women are sexual beings – we need to try to understand the sexuality of women
- Some men and some women are attracted to their own sex – this may be outside our experience or understanding but we should not condemn or belittle them for it
- Every single human being should have the right live free of fear and oppression, in private as well as in public – each of us can help achieve that by the way we treat others

Explain that Session Two will explore something that is fundamental to sexual relations between men and women – the issue of sexual consent. Many men have difficulty understanding how sexual consent should work in practice, harbouring misconceptions about what constitutes consent. In nearly all the focus groups and discussions run by MMAAK with men in different parts of Kenya it has emerged that men assume consent to sexual intercourse has been given once any sexual activity is embarked upon. In circumstances where some sexual contact has been enjoyed these men could not believe that whatever followed could be considered to be rape. Nor could they believe in the concept of rape within marriage.

If we are committed to delivering human rights we have to consider people as individuals and not dismiss their views or their wishes. But the beliefs of the men in these focus groups contradict this notion of human rights: we must begin to challenge the notion that women's views on sex and their experience of it are unimportant, or at least less important than men's views and experience.

Sexual intercourse is the most intimate contact two people can have, and the potential consequences for each partner are now both life changing and life threatening. If we demean or trivialise sex we can equally trivialise its consequences and the gravity of making someone have sex against their will. But sex is a serious subject: issues of consent, contraception, pregnancy, STIs and HIV and AIDS demand that we look hard at our beliefs and our behaviour.

STEP 2
Distribute Module Three Handout 2 – Sexual consent, and read through this with the group. First clarify everyone's understanding of the handout: invite questions and comments. Next structure the remainder of the discussion by asking two questions:

- What do we lose as men by adopting this definition of consent?
- What could we lose if we cannot change our beliefs and behaviour on sex?

Finish with an action planning session as usual, reminding the group that relationships will be further explored in the next module.

Sexual consent

Consent is the single most important issue in cases of sexual assault or rape. What does consent mean? It means saying yes to sexual intercourse because you want to say yes and you mean it. Different countries' rape laws and their interpretation of them vary - this handout is about how we as men should define consent, not about the law in any particular country.

This means we cannot safely assume someone consents to sexual intercourse through their silence or our interpretation of their actions. And if someone says "No" we must assume they mean it.

What if this someone is your wife or girlfriend – you have had sexual intercourse before – how can she be raped or sexually assaulted by her husband or boyfriend? If she doesn't want to have sex but you have sex with her anyway, that is rape.

What if someone changes their mind? After they have kissed you, or invited you in, even after they have taken off their clothes, they change their mind for whatever reason (they realise this would be a mistake, they become frightened, they feel sober when before they felt drunk etc.) and say "No, I don't want to have sex." To go ahead and have sex anyway is rape.

No means no – in all these examples you would be forcing sex on a woman who does not want to have sex. That is rape.

Who can give consent?

For consent to be meaningful the person giving consent must be old enough and sufficiently in control of themselves. To have sex with someone who is unconscious, or too young or too drunk to give meaningful consent is rape. The law tells us the "age of consent" below which young people are considered too young to be able to give proper consent. So sex with someone under that age, even if they say that they give their consent, is rape, statutory rape.

What is the impact of rape or sexual assault?

Not all rape is violent or committed by strangers, but all rape is a demonstration of power and disregard for another person's wishes, for their body, for their humanity. Rape damages the perpetrator and the victim – and society is damaged when rape is not recognised or dealt with.

module 4

Relationships

OBJECTIVES
At the end of this module the participants should be able to explain how society has affected gender roles and what impact this has on individuals and their relationships. They will be able to suggest ways those roles might be challenged and how relationships can be improved by rejecting stereotypes and improving communication.

Session 1: Explaining gender

Duration
35 minutes

Materials
flipchart paper and pens

SESSION 1
This first session explores the ways we are socialised as men and women in our communities. Begin by explaining gender.

STEP 1 -15 minutes
Unlike one's sex, gender is not determined by physical characteristics. Gender – what we believe to be masculine or feminine – is defined by our environment, our community and wider society and can change in its definition over time, and from place to place, which makes it more complex!

Caring	Loving	Resourceful	Violent	Political
Protective	Creative	Powerful	Faithful	Home builder
Nurturing	Inventive	Gentle	Selfish	Bread winner

To explore gender in our own society we will spend some time describing how we view masculine and feminine roles and characteristics. Starting with this list, and then adding your own, build two descriptions on flip chart paper – masculine and feminine. Allow the group to reject any of these words as inappropriate if they wish.

When you have finished the two lists thank the group and say you will come back to them after they consider the case study.

STEP 2 – 20 minutes
Read the case study or ask a group member to read it out.

Case study

Mary and Thomas were married after a courtship of many years – they were childhood sweethearts. After their marriage Mary was still regarded as a very special and unique person by her husband – they would spend a lot of time together. This was until their first baby was born (or just before the child was born). Thomas began to feel that the child was taking over his space and place in the home. Even his wife's name changed from her own name to being known as mother of the new baby – "Mama Fulani" ("so and so's mother"). This seemed to widen the space between Thomas on the one hand and his wife and child on the other. Before the birth of the child their life had so much romance - outings, dinners, lunch dates, company when going to work and so on. After the arrival of the baby, Thomas felt he was deprived of that attention and Mary was always too tired or busy to take that attention from him. He began to see his role reduced to provider of resources for the baby's welfare.

His friends and colleagues did not help: when Thomas complained that he could get no rest and no attention at home they said it was not his place to hang around the house like some woman, he should get out and enjoy himself, after all he works hard. So Thomas began to spend more time with friends at work or in the club. When Mary asked where he had been or why he was late he told her she had become a nag, she complained too much, and was not giving him enough recognition as the man and head of the house. She should be grateful that he is out struggling to fend for the family.

Mary sees things very differently. After weeks of this behaviour she began to think that every time Thomas was late to return home it must be that he was busy with another woman. She developed a very suspicious, negative attitude. Their marriage didn't feel happy any more: she had her baby, her pride and joy, but Thomas didn't seem to share in that. He didn't understand how difficult it was for her suddenly to be a mother, to feel so responsible. She wasn't just Mary anymore – she was a mother, and sometimes she missed those carefree days of romance and laughter. So it was a relief that her mother and sisters began to spend so much time at the house, even though this irritated Thomas even more.

Things were made worse by the poor communication between the couple. They began to keep quiet with each other. When they did talk they would just throw the words at each other. When they were quiet, the quiet was so loud you could cut it with a knife. Without communication the distance between the couple could only become greater – they could not understand how the other was feeling or how they were changing.

After many months the two now relate as if they are being forced to live together. Neither one can take the initiative to try to correct the situation. Mary and Thomas both confide in friends outside the family. While they feel the need to do this themselves, each sees the other's actions as betrayal or gossip. Mary's concerns that Thomas will seek more than just advice outside their marriage may now be close to the truth. Where will all this end?

When they have heard the whole story ask the group:

- What could Thomas have done to avoid these problems?
- What could Mary have done to avoid these problems?
- How can the couple resolve these problems now they have occurred?
- How have gender roles and stereotypes contributed to the problems?

Session 2: Building successful relationships

Duration
2 hours

Materials
Session 1 gender lists, flipcharft paper and pens, module 4 handout 1- relationships

STEP 1
Look back at the gender lists you drew up in Session 1 – begin to challenge them and ask the group to help you: "When can it be masculine to take a part in child care?" "What is un-feminine about being strong?" and so on. Ask for real examples from the lives of those in the group that contradict the norms or stereotypes.

Ask the participants to split into groups of four or five and prepare to present their views on "Positive and negative aspects of masculinity". Each group will need to feedback using flipchart paper or some other means of communication. Allow them fifteen minutes to prepare.

STEP 2
When the groups have made their presentations (remember to give them all some positive feedback) move the discussion to the wider impacts of masculinity. If it has not already been mentioned, suggest that rigid adherence to traditional views of male and female roles can be damaging:

- this promotes inequality in society between men and women
- that inequality can result in women being marginalised, dominated and powerless
- this creates a lack of education, poverty, ill health, and unstable families or broken homes
- HIV and AIDS thrive in circumstances like these.

Ask the same groups to discuss another question: "What would be the characteristics of the perfect marriage?" taking into account whether or not they want children, how communication and companionship can produce contentment and understanding, and that in a perfect marriage BOTH husband and wife are happy. Allow ten minutes for their discussion.

STEP 3
Take feedback from the groups in turn. Now ask why it is difficult to achieve these perfect unions. Use some or all of these questions to lead a discussion:

- Do you think that there are problems in marital relationships between women and men in your community?
- Do you think that there is diffficulty in a married man and his wife understanding each other?
- Do you think that there is a relationship problem between men and men here?
- Do you think that there is a problem between women and men in this country outside marriage?
- What kinds of problems do you think exist between men and women in this country outside marital relationship?
- As a man, do you think that it is difficult to understand women?
- Is it all women or some women? If some, which women?
- As a man, do you believe that all women the same?
- Do you believe that all men are the same?
- If you have had problems in understanding women, would some of those women be your mother, sister, grandmother, wife or daughter? What kinds of problems have you experienced with these women? Are the problems different according to the relationship?
- As a man, what do you think are the most difficult things to understand about women generally, and sexually?
- As a man, what do you think are the most difficult things to understand about other men?

STEP 4

Explain to the group that it is easy to fall into behaviour that society deems to be "normal" or that we have been subjected to ourselves without considering the consequences. In relationships there is often a subtle exercise of power that may be more or less obvious. Most of the following kinds of behaviour are common in that many people act like this occasionally, but consider the effect when this behaviour is regular or frequent. What is happening in a relationship or a marriage where this is typical?

- Does your spouse/father/mother/teacher/boss/brother/sister/colleague/fellow student make you feel as if you can never do anything right?
- Does this person make you feel you never care enough?
- Do they criticise you in public?
- Tell you to grow-up or stop behaving like a child/woman?
- Only he/she can do the right things and/or has to have the last word on everything
- Stop you in the middle of your sentence?
- Walk away as you are talking to them/hang up the phone on you?
- Make you nervous, for instance when you are late?
- Will never tell you "I am sorry" or ask for forgiveness from you?
- Will never confide in you, keeps his/her secrets from you?
- Will not trust your judgement or decisions?
- Will never consult you on the relationship or matters affecting your relationship?
- Refuses to talk to you for sometime?
- Makes threats against you?
- Blackmails or manipulates you?
- Call you names such as "You are crazy, you are stupid, you are useless, you are hysterical, you are too sensitive"?
- Insist on their terms always?
- Withholds privileges from you?
- Controls through their anger or moods?
- Promises to do things and then they don't?
- Ignores or brushes you aside as if you don't exist?
- Accuses you of nagging too much?
- Tells you how much other people like his/her ways and it does not matter if you don't?
- Takes off without saying where they are going and don't expect you to ask when they return?
- Makes you ask for money for everything you need and never offers you money if you don't ask?
- Asks how you have spent the money in detail—you have to account for every penny?
- Tells you: You have a problem and it's your problem - leave me out of your problem. That's too bad!

Distribute Module Four: Handout 1 and read through the list with the whole group. Now ask the participants if they have ever seen or experienced such behaviour in relationships?

Ask participants why they think people stay in such relationships?

Write the responses up on the flipchart.

Explain that these are all potential signs of a controlling or abusive relationship. Abusive relationships are about power and control.

Any person is potentially a perpetrator if they use their power over someone to control that person. In fact, all these forms of violence have one thing in common. They are meant to hurt, demean, belittle, shame or discipline the other person – the victim. Perpetrators use their power to put the other person down, control or show their superiority over the victim. Victims of any abusive relationship can become emotionally depressed, anxious, unstable and even physically sick as a result.

Of course there are many kinds of abuse. Abuse that begins as verbal or emotional can escalate over time to become physical or even sexual.

STEP 5

Characteristics of an abusive relationship

Explain that abusive relationships come in many forms and can involve people of any age, sex, social class and other social categories. It can come from a parent to a child -mother or father to a child. It can come from one parent to the other. It exists between siblings or between work mates (often, but not only between a boss and a subordinate) or indeed among pupils who intimidate or bully others.

The various types of abuse include:

■ Verbal ■ Emotional ■ Physical ■ Sexual

Verbal abuses include saying hurtful words or threats to someone. They can be said once or repeatedly over and over at different times. They diminish one's self- esteem and can hurt someone emotionally.

Negative realities

The behaviour described here may not be typical, but it is a reality and has real effects that we are all aware of.

Discuss these examples

One negative way in which men's masculinity manifests itself is through sexual gender based violence against women (SGBVAW) by men. An act of gender based violence against women demonstrates the man's power over the woman: the man feels that woman is inferior to him, is inherently immoral and "good for nothing else other than for sex". These acts are intended to harm and humiliate the woman. These include rape of all kinds, sexual assault to cause emotional or physical damage, public assault or exposure.

Some men have perpetuated the mistaken belief that sex with a virgin can cure HIV and AIDS, thus condemning girls and even babies to terrible sexual assaults and even death. By failing to understand the facts about HIV and AIDS men continue to put themselves and women and children at risk.

When a man is determined to take a chance, to take risks for pleasure, he does not want to be reminded of those risks or persuaded to take precautions. This makes it hard for his friends or his wife or girlfriend to suggest he might avoid danger – for himself and others. Promoting condoms to men at these times is difficult.

Emotional abuses include: verbal abuses or insults, manipulation, blackmailing, telling lies about someone, backbiting, constant blaming, showing a lack of trust in someone, false accusation and making the person feel guilty, withholding privileges, intimidation, the threat of physical or sexual abuse

Physical abuse includes: pushing, slapping, pinching, kicking, beating someone, like mother or father beating a child, domestic violence, pupils beating another.

Sexual abuse: insisting on a sexual relationship without the true, willing consent of the other person, forcing oneself on the other, harassing, coercion, forced kissing, touching or flirting, sexual assault, child sexual abuse, incest, rape (of women and men).

Some men are too proud to ask for help: they would rather suffer in silence than admit they are ill, especially if they think it is their own fault. So perhaps they won't test for HIV even though they are worried. And the idea of attending a support group is not manly – suggesting he needs that kind of help is like killing him slowly, just as HIV is doing.

These examples are extreme, but they are not fanciful. These are real problems that we must address. The good news is that these attitudes and behaviours are learned, therefore they can be unlearned and new attitudes and behaviours learned in their place.

The negative side of masculinity is not the only side. We must develop strategies that build on the greater, positive side of masculinity and the desire from men and women to have fulfilling relationships, built on love, trust, communication, respect and sharing of responsibilities.

End with a discussion of role mapping – how can we empower women, men and our leaders to identify, understand and supportively nurture and reinforce men's self-imaging and valuing of men as a measure towards redressing the negative aspects of masculinity?

What is wrong with these relationships?

Does your spouse/father/mother/teacher/boss/brother/sister/colleague/fellow student:

- Make you feel as if you can never do anything right?
- Make you feel you never care enough?
- Criticise you in public?
- Tell you to grow-up or stop behaving like a child/woman?
- Let you know only he/she can do the right things and/or has to have the last word on everything
- Stop you in the middle of your sentence?
- Walk away as you are talking to them/hang up the phone on you?
- Make you nervous, for instance when you are late?
- Never tell you "I am sorry" or ask for forgiveness from you?
- Never confide in you, keeps his/her secrets from you?
- Not trust your judgement or decisions?
- Never consult you on the relationship or matters affecting your relationship?
- Refuse to talk to you for sometime?
- Make threats against you?
- Blackmail or manipulate you?
- "Call you names such as "You are crazy, you are stupid, you are useless, you are hysterical, you are too sensitive"?
- Insist on their terms always?
- Withhold privileges from you?
- Control through their anger or moods?
- Promise to do things and then they don't?
- Ignore or brushes you aside as if you don't exist?
- Accuse you of nagging too much?
- Tell you how much other people like his/her ways and it does not matter if you don't?
- Take off without saying where they are going and don't expect you to ask when they return?
- Make you ask for money for everything you need and never offer you money if you don't ask?
- Ask how you have spent the money in detail—you have to account for every penny?
- Tell you: You have a problem and it's your problem - leave me out of your problem. That's too bad!

module 5

HIV and AIDS

OBJECTIVE
To equip participants with factual, accurate and up to date information about HIV and AIDS in order to achieve shared understanding of their definitions, signs, symptoms, modes of transmission and how to prevent it.

EXPECTED RESULTS
By the end of Module One participants should be able to:

- Define HIV and AIDS
- Describe and explain the signs and symtoms of HIV and AIDS
- Identify myths associated with HIV and AIDS and differentiate these from facts
- Identify and explain HIV transmission modes
- Understand HIV prevention and control measures

Introduction
This module introduces us to HIV and AIDS. It is divided into seven sessions, each with specific objectives and intended results. The sessions or exercises require a level of knowledge from the facilitator and preparation to ensure you are prepared for questions, can run the session to time and so on.

1. Definition
2. Modes of transmission
3. Signs and symptoms
4. Myths
5. Impact
6. Prevention and control measures
7. Management and care
8. Support to people living with HIV and AIDS (PLWHAs)

Preparation
You will find the following texts useful, in addition to any training you have received from MMAAK or other agencies:

- The current National HIV and AIDS Strategy Document
- Psychosocial Support Training: Manual for Community Health Workers on Orphans and Other Children Made Vulnerable by HIV/AIDS, FHI USA
- HIV Treatments Training Manual, NAM UK
- The materials required for each session are listed: allow yourself time to obtain these in sufficient quantity. Even if you prepare a long way ahead, make sure you refresh your memory and your plans just before the session is due to take place.

Session 1: Definitions

Duration
30 minutes

Materials
Flip chart or board with pens or chalk Handout 1 – What is HIV? What is AIDS?

OBJECTIVE
Participants will be able to define HIV and AIDS and explain the differences between them. They may begin to question some of the things they thought they already knew about HIV/AIDS.

The first exercise deals with what the names HIV and AIDS mean. This involves presenting some of the history of HIV/AIDS. It is also an opportunity to explain that HIV is a virus and what that means.

STEP 1 10 minutes
Begin by asking the group to tell you what they know about HIV – record all the responses on the board or flipchart. Do not comment on these responses as you go – but you can ask for clarification so that your note accurately reflects what the participant says.

When you have about six or seven responses ask the whole group if they have any comments: some will agree or disagree with some of the "facts" you have written up. Tell the group that all of these issues – and more – will be covered during their training. First though, you will concentrate on what HIV and AIDS mean.

STEP 2 5 - 10 minutes
On a new sheet or clean board write the letters H I V one below the other. Ask if any member of the group can tell you what the letters stand for. Allow discussion: there may be disagreement. Finally write the name out in full and explain what each word tells us:

H Human	Only humans are affected by HIV and only humans can transmit it
I Immunodeficiency	Means that the body's immune system is deficient or weakened
V Virus	HIV is a virus – viral infection means cells of the body are attacked

STEP 3 5 - 10 minutes
On a new sheet or clean board write the letters A I D S one below the other. Ask the group again if they know what these letters stand for. After some discussion write up the words and explain their meaning:

A Acquired	This condition develops over time
I Immune	It affects the immune system
D Deficiency	It damages and weakens the immune system
S Syndrome	This is a collection of symptoms that result from that damage and weakness or from the direct action of HIV on other cells

STEP 4 10 minutes
Explain that AIDS was observed (1981) and given a name (1982) before its cause, the virus, was discovered (1983) and finally named HIV (1986). Tell the group when the first case of HIV or AIDS was reported in your country.

AIDS has a collection of symptoms because many different illnesses can result from the damage HIV does to the immune system. HIV uses the cells of the immune system to reproduce itself and over time the body can no longer repair this damage.

A healthy immune system is able to fight off most infections, but once it is sufficiently weakened over time by HIV the immune system cannot do the job it is supposed to do. Some infections that take advantage of this situation are called "opportunistic infections" – they would not normally be life-threatening. Others, like TB, are dangerous for everyone, but much more common among people living with HIV.

Someone may be infected with HIV and remain healthy for a very long time – 6 to 10 years – and during this time they cannot know they are infected without taking an HIV test. Most infected people in the world do not know that they are HIV+. "HIV+" is your status if there is a positive test for the antibodies to HIV in your blood.

There is no cure for HIV or AIDS. Anti-retroviral (ARV) drugs can stop HIV reproducing itself and allow the immune system to recover, but these drugs must be taken for life. If you stop taking ARVs, HIV will recover and attack the immune system once more.

AIDS refers to the period once illness(es) results from immunodeficiency. You can be HIV+ and not yet have AIDS. But everyone who has AIDS also has HIV infection.

Distribute Module Five: Handout 1 – What is HIV? What is AIDS? – and take questions and comments for a few minutes.

STEP 5
End the session by recapping what has been learned:

AIDS – the Acquired Immune Deficiency Syndrome is caused by the **HIV** – Human Immunodeficiency Virus which attacks the body's immune system until it cannot fight off opportunistic infections.

Many people living with HIV do not know it. They can be healthy for many years.

HIV can be controlled but not cured.

Otherwise HIV infection leads to AIDS – it is the only way to develop AIDS.

What is HIV? What is AIDS?

HIV

HIV stands for Human Immunodeficiency Virus.

Viruses are extremely small organisms that can only reproduce inside living cells, such as those which make up the human body and circulate in our blood. Infected cells stay infected for the rest of their lifespan and must be destroyed in order to get rid of the virus.

In ways that we still do not fully understand, HIV stops the immune system working properly. Normally the immune system would fight off infections, but HIV infects the key cells (called CD4 cells) that coordinate the immune system's fight against infections. Some of those cells are destroyed by being infected, others no longer work properly.

AIDS

AIDS stands for Acquired Immune Deficiency Syndrome.

AIDS is the result of damage to the immune system. The immune system is made up of many different kinds of specialised cells which move around the body to where they are needed to remove poisons and cells that may cause diseases. When the immune system is damaged by HIV, it becomes unable to protect the body against certain specific opportunistic infections and tumours. These are also known as HIV-related diseases.

The term *opportunistic* is used for diseases caused by organisms that are normally controlled by the immune system, but which take the opportunity to cause disease if the immune system has been damaged.

Unlike most other diseases, different people with AIDS may experience different symptoms and clinical problems, depending on which opportunistic infections they develop. This is what **syndrome** means – a collection of different signs and symptoms that are all part of the same underlying medical condition.

In many countries the most important HIV-related disease is tuberculosis (TB). This is not strictly an opportunistic infection because it can make people ill regardless of their HIV status. However, people with HIV are very much more vulnerable to TB than people without HIV. People who are HIV-positive (HIV+) and have active TB should therefore be included in the category of people with AIDS because it is very important that they are properly diagnosed and treated.

HIV causes AIDS

It is widely accepted throughout the scientific community that infection with HIV is the necessary precondition for the development of AIDS.

Although it is clear that HIV has a central role in the development of AIDS, there remain unanswered questions about some of the specific mechanisms by which it damages the immune system. The immune system is immensely complex and there are many ways it can be affected by a retrovirus such as HIV.

It is clear that many factors contribute to the speed with which HIV disease progresses. As with every known disease, as a result of genetic factors, some people are naturally more resistant and others more vulnerable. Newborn babies and older people are most vulnerable, those exposed to the virus as adolescents or young adults less so. Additional factors include a person's nutritional state and other diseases to which they may be exposed.

Session 2: Modes of transmission

Duration
40 minutes

Materials
Flip chart or board with pens or chalk Handout 2 – True or False questionnaires

OBJECTIVE
Participants will be able to explain how HIV is and is not transmitted.

Exercise: HIV transmission – true or false?
STEP 1
The facilitator should explain that we have a clear understanding of how HIV is transmitted based on more than 20 years of medical and social experience. Distribute the True or False questionnaire (Module Five: Handout 2) – for this exercise participants are asked only to answer the first of the two sets of questions: "HIV transmission"

Ask participants to write T (for True) or F (for False) for the following ten statements (here the answers and discussion points are shown):

1. You can become infected with HIV from mosquito bites (T/F)
FALSE The mosquito does not transfer HIV from the blood of one person to another even if it bites them both

2. Anal sex is the riskiest form of sexual contact for HIV transmission (T/F)
TRUE Anal intercourse is riskier as it is more likely to cause damage to the anus, especially if no additional lubricant is used (unlike the vagina, the anus does not produce natural lubrication)

3. You can become HIV infected if you perform oral sex on a man (T/F)
TRUE The risk is considered lower, and may be greater when oral health is compromised (mouth ulcers or sores) but cases have been recorded

4. Indigenous herbs are known to cure AIDS (T/F)
FALSE There is no cure for AIDS. Some traditional remedies can help improve appetite or reduce pain or discomfort, but they will not cure HIV infection or AIDS

5. People with an STI have a higher risk of HIV infection than those who do not have STIs (T/F)
TRUE Some Sexually Transmitted Infections cause sores or breaks in the skin on or around the genitals and this makes it much easier for HIV to enter the blood stream. STIs often have no symptoms – anyone who thinks they may have been at risk of contracting an STI should have a check up. Treatment is usually straightforward and effective.

6. You can't get HIV infection if a man withdraws before ejaculation (T/F)
FALSE HIV is found in vaginal secretions, in semen and in "pre-ejaculate" – the male secretion before ejaculation – so neither party is protected from infection by withdrawal

7. Condoms prevent HIV transmission (T/F)
TRUE But only if they are of good quality and used properly.

8. You cannot get HIV if you immediately douche or bathe after sexual intercourse (T/F)
FALSE This does not guarantee to remove all infected body fluid before infection has taken place

9. HIV can be transmitted more easily during dry sex than wet sex (T/F)
TRUE Dry sex is more likely to damage the lining of the vagina and the head of the penis, making it easier for HIV to enter the blood stream

10. You cannot contract HIV from sharing the same bed with someone with HIV (T/F)
TRUE If you just share domestic or work space (or someone's bed) – live with, work with or care for someone living with HIV/AIDS – you will not become infected

Quickly ask participants for their answers – a show of hands for True and for False would work well.

STEP 2
Now you can explain the three modes of transmission in full:

- Sexual
- Blood to blood
- Mother to child

Tell the group that the virus, HIV, is found in the following body fluids in sufficient concentration to be transmissable from one person to another, provided that fluid can get into the other person's blood stream.

- Semen, pre-ejaculate and vaginal secretions
- Blood
- Breast milk

It is not found in other body fluids in dangerous quantities unless they themselves contain infected blood. So saliva, sweat and tears do not present a risk. Nor do urine, vomit or faecal matter – unless they contain infected blood.

Sexual transmission

We know which body fluids pose a risk of infection. But they only pose that risk if they can get into the uninfected person's blood stream. This is very difficult, which is why only certain types of behaviour pose a risk. Our skin is very robust and provides a strong barrier against infection – splashing infected body fluid against your skin is not risky. But if you have an unhealed cut or sore on your skin then this provides an entry point for the virus. Not all skin is the same. The membranes inside the vagina, at the head of the penis and inside the anus are much thinner and often have small fissures or tears. Something as small as HIV can pass through these membranes and be absorbed into the blood supply.

This is why genital contact with sexual fluids, penetrative vaginal or anal intercourse pose a high risk of HIV infection. We know oral sex carries a risk but it is not clear why some people have become infected this way while others have not. It could be that oral sex poses a lower risk because the mouth and throat have strong linings and flush matter into the stomach which is an unfriendly environment for any virus. But if someone has mouth ulcers, sores or bleeding gums they may be at a higher risk.

Blood to blood transmission

Injecting infected blood into an uninfected person's blood stream is the surest way to infect them – this is why groups of injecting drug users have experienced such rapid epidemics when it has been their practice to share needles and syringes. Blood transfusion services have to be careful to screen out infected blood for the same reason. Any practice that involves cutting or grazing the skin of one person and then using the same tool to do the same to another poses a similar risk: so tattooing, ritual cutting or marking, and shaving pose risks. Tools and implements should be properly cleaned and sterilised between individuals, patients or customers.

If someone suffers an accident and they bleed it is common sense to take care over the blood – but there is no real risk to someone offering help or first aid unless they get the blood in contact with their own blood somehow and this is unlikely. If you have sores or an open wound you should keep it covered to avoid infections of all kinds. There is no case documented of someone becoming infected by giving first aid.

Mother to child transmission

This form of transmission is sometimes referred to as MTCT. HIV is sometimes passed from a pregnant woman to her unborn baby during pregnancy, at the point of birth, or later through breastfeeding. The newborn baby is vulnerable to the HIV in breast milk, especially in the first two months when there is a higher amount of HIV in the milk, because its throat and gut are not fully formed at this time. Not all babies of women living with HIV will be HIV+ themselves. The chances of transmission can be reduced using a short course of antiretroviral drugs (ARVs) and ensuring there is not too much contact with blood during the birth. HIV+ mothers are advised not to breastfeed so long as they can manage to provide a good alternative source of baby milk.

Babies born to women living with HIV will test positive for the antibodies to HIV because they inherit their mothers' antibodies, but this does not mean they are infected with the virus. It is only possible to tell with an HIV test some months later when the baby will have developed antibodies of its own.

STEP 3: Recap
Now go back to the list of questions and run through them again: participants should understand why any wrong answers they gave earlier are inaccurate. Recap the important points on each question. Ask for other examples of safe behaviour, eg sharing cutlery, water fountains, hugging and so on.

Transmission / Signs and symptoms

1 Transmission

Write T (for True) or F (for False) for the following statements:

1. You can become infected with HIV from mosquito bites (T/F)
2. Anal sex is the riskiest form of sexual contact for HIV transmission (T/F)
3. You can become HIV infected if you perform oral sex on a man (T/F)
4. Indigenous herbs are known to cure AIDS (T/F)
5. People with STI have a higher risk of HIV infection than those who do not have STIs (T/F)
6. You can't get HIV infection if a man withdraws before ejaculation (T/F)
7. Condoms prevent HIV transmission (T/F)
8 .You cannot get HIV if you immediately douche or bathe after sexual intercourse (T/F)
9. HIV can be transmitted more easily during dry sex than wet sex (T/F)
10. You cannot contract HIV from sharing the same bed with someone with HIV (T/F)

2 Signs and symptoms

Write T (for True) or F (for False) for the following statements:

1. Only a man who has slept with a commercial sex worker should worry about AIDS (T/F)
2. You should go to VCT only when your spouse or intimate partner shows signs of AIDS (T/F)
3. One can tell that someone has AIDS just by looking at the person (T/F)
4. Loss of body weight means someone has AIDS (T/F)
5. You cannot catch AIDS if you are intimate lovers (T/F)
6. You always know when you or your partner has an STI or AIDS (T/F)
7. If someone looks fat and healthy, they cannot have AIDS (T/F)
8. No great African leader has died from AIDS (T/F)
9. Not all persons with AIDS suffer all the symptoms (T/F)
10. If you have no symptoms you cannot infect anyone else (T/F)

Session 3: Signs and symptoms

Duration
25 minutes

Materials
Prepared flip chart or board with pens or chalk or Overhead Slide: HIV progression Handout 2 – True or False questionnaires

OBJECTIVE
Participants will be able to explain how HIV and AIDS diagnoses are made, and the progression of the disease.

STEP 1 Exercise: Signs and symptoms – true or false? Time: 10 minutes
It commonly thought that there are tell-tale signs that someone may be HIV+ or have AIDS. The truth is more complicated and although there are symptoms that are common among people living with HIV and AIDS when suffering from HIV-related illness or opportunistic infections, these symptoms are not necessarily unique to PWLHAs. The facilitator will explain this later; the starting point is another True or False questionnaire, also found on Handout 2. As with the Transmission questionnaire, ask participants to complete this and then quickly canvass for the numbers answering True and False.

Allow five minutes for the questionnaire and spend another five minutes establishing how many selected "True" and how many "False". Then leave the questionnaire until later in the session.

STEP 2 Presentation: HIV progression Time 15 minutes
Using either Overhead Slide 3 or flipchart or boards with the same information, present the phases of HIV progression to the group.

PRIMARY HIV INFECTION
Remind the group that HIV is a virus. The only way to know that someone is infected with the virus is to test them. The HIV test is not really a test for the virus itself – it is simpler to test for the antibodies that are produced when someone is infected. But when someone is first infected with HIV it takes some time for enough antibodies to be produced to show up in the test – between three and six months.

Some people experience a short illness after infection – a sore throat, a fever or a rash – but many do not. This coincides with the immune system beginning to fight the new infection. People are infectious during this period, sometimes called the window period, even though they may not yet test positive for HIV antibodies.

ASYMPTOMATIC INFECTION
Asymptomatic means an absence of symptoms. This period of HIV infection can last for months or years. Although HIV is damaging the immune system there may be no outward signs of this. Some PLWHAs experience swollen lymph nodes during this period (PGL – persistent generalised lymphadenopathy) but this is not evidence of damage to the immune system. The health of the immune system can be measured by laboratory tests that measure the number of CD4 cells – these are the main type of cells that HIV targets in the immune system. A high CD4 count is good and a low one is cause for concern, but CD4 counts vary from day to day even in people who are not infected with HIV. We can also test for the amount of virus in the blood (viral load testing) and this shows that HIV is reproducing from the point of infection and continues through the period of asymptomatic infection.

SYMPTOMATIC INFECTION
The longer someone is infected the more likely it is that they will become ill due to their HIV infection. If this illness does not in itself trigger an AIDS diagnosis (see over) it is described as symptomatic infection.

AIDS DIAGNOSIS

AIDS is defined as the stage of HIV disease in which there is serious damage to the immune system. There is no single test for an AIDS diagnosis – doctors will consider a variety of symptoms and tests. When the term AIDS was coined it described a collection of symptoms which ultimately proved fatal. Even after HIV was discovered, AIDS remained the final stage of infection and was seen to be irreversible. Antiretroviral treatment is now able to support recovery in patients with an AIDS diagnosis to the extent that they appear to revert to the asymptomatic or symptomatic stages of disease (see below).
Where ARV treatment is not available it is still possible to treat or prevent many of the serious opportunistic infections that define AIDS and prolong healthy living - but it is not possible to sustain this in the face of continuing damage to the immune system.

In their separate guidance on ARV treatment, the World Health Organisation and the US Centre for Disease Control use different stages and categories of HIV disease to determine at what point a person living with HIV or AIDS should be given treatment. National programmes like the one adopted in Kenya are encouraged to use similar protocols, adapted where necessary to the availability of local resources, including laboratory testing. In any case, the decision to treat (where ARVs are available) will be based on one or more indicators of the level of damage being suffered by the immune system and the consequent risk of serious or life threatening illnesses.

AIDS-defining illnesses caused by infections or cancers can fall into many categories:

- Skin problems, like Kaposi's sarcoma and herpes simplex
- Breathing or lung problems, including pneumonia and candida
- Problems with other organs, including eyes, liver and brain
- Wasting syndrome

STEP 3 What next?

Following an HIV diagnosis it is important to look after your general health, as described in Module 7 – living positively. Measuring the CD-4 count, explained above, is one way to monitor the effect HIV is having on the immune system and may be used to predict the likelihood of AIDS illness or to determine when to start ARV treatment.

TREATMENT FOR OPPORTUNISTIC INFECTIONS

Most of the infections that take advantage of the suppressed state of the immune system can be treated to some extent and the possibility should always be investigated, especially where ARV treatment is not available. Some opportunistic infections can be prevented with the use of drugs – prophylactic treatment. Once the immune system becomes severely weakened or these infections become repeated, these treatments will not work indefinitely.

HOW DOES ANTI-RETROVIRAL TREATMENT WORK?

Together, the cells of the immune system act as a barrier that protects us from infections. HIV is a virus that damages the cells of the immune system, like a demolition man destroys a wall. Once someone is infected, HIV can enter the cells of the immune system. HIV uses the cells to make copies of itself. HIV continues to copy itself, using the immune cell to do so. Once it has used up and destroyed that cell, the new HIV disperses to other immune cells.

The process begins all over again, damaging more and more cells, creating more and more virus, until the immune system is severely weakened. Anti-retroviral treatment - with drugs that control HIV - stops HIV copying itself and invading cells, but does not kill it.

With HIV locked away in parts of the body where it cannot copy itself, the immune system can rebuild itself and function as it used to. But if ARV treatment stops - even for a short time - the HIV can start to copy itself again. This time the new HIV may be drug-resistant.

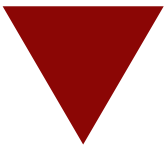
But if ARVs are taken regularly they will enable the immune system to recover, and the person who was previously ill or susceptible to Opportunistic Infections should enjoy good health.

To sum up:

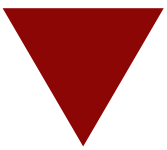
- HIV infection cannot be cured but it can be controlled
- HIV treatment - ARVs - must be taken regularly and cannot be stopped
- With ARV treatment some people living with HIV or AIDS can enjoy many additional years of good health.

Stages of HIV Infection

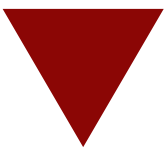
Primary HIV infection



Asymptomatic infection



Symptomatic infection



AIDS diagnosis

module 6

The role of men in prevention, care and support

INTRODUCTION

The theme of this module is that of this training manual: that Men Can Make A Difference, specifically in HIV and AIDS prevention, care and support. In this session, participants will discuss and acquire practical skills such as affirmation, giving and showing love, care and support in order to make men and other family members feel acknowledged, wanted, appreciated, needed and respected, even when ill-disposed.

Sessions 1 & 2

Duration
1 hour for each session; 2 hours over all

Materials
Flip chart or boards with pens or chalk, tape Reference materials: if you can have them to hand, the results of the earlier sessions with this group on self understanding and valuing, positive masculinity.

OBJECTIVES

To enhance men's adequate understanding of the concrete roles men can play in achieving a measurable impact in HIV and AIDS prevention, care and support at all levels of their social interactions in their country.

By the end of the module, participants will:

- Know that men can assist in HIV and AIDS prevention, care and support at their individual level wherever they exist and operate, whether that is as a father, son, brother, grandfather, uncle, colleague, to other men or family members living with HIV and AIDS
- Know how to support men in their families, communities and workplaces and how to assist individuals, families and communities in HIV and AIDS prevention, care and support
- Be able to provide guidance to boys or other men on how to positively and effectively manage matters of sex and sexuality
- Know how to adapt and apply positive male attributes in HIV and AIDS prevention, care and support at all levels of social relations
- Have enhanced their understanding, motivation and responsibility in making positive life choices and have some of the requisite skills for doing so
- Know how to create safe and emotionally secure forums for children, adolescent boys and adult men to meet and share life's experiences with HIV and AIDS so they can have a shared vision and goal to prevent HIV and AIDS

Session 1: Understanding the value base, concepts and processes in this module

Duration
One hour

Objectives
By the end of the session the participants would be able to describe the basic principles of problem solving processes.

STEP 1
As the facilitator you need to introduce the session topic, objectives, process and expected results (above). You should also point out that:

- This session builds on all of the previous sessions, but especially on the self-valuing, self-understanding and masculinity sessions.
- It is important to start at the family level with prevention, care and support: that is where we can have an almost immediate impact.
- The biggest intervention in HIV and AIDS is the understanding or belief that men can make a measurable difference: this should be the motivating factor for men's involvement.
- When they know and appreciate life's choices, life's decision-making processes, and the consequences or the implications of those choices, then parents and children within and without the families and communities can build healthy attitudes and actions that protect them and preserve their lives.
- HIV transmission has got to do a lot with our not understanding the choices we make and the consequences of those choices.
- Love is one of the basic cornerstones of HIV prevention, care and support and that we will learn how to show, give and receive love from our family members.
- Every member of the family has a right to receive and a responsibility to give familial love.
- Loves comes from within and not from outside an individual.
- Familial love should be unconditional. That means that is it does not depend on receiving anything in return, nor on what we do or do not do for each other, but it comes from the fact that we are humane. Thus it is human nature to want to give and receive love.
- Beyond the pillars of human survival, in addition to our basic needs for security, shelter and sustenance, is the concept of achieving happiness and that, like love, happiness comes from within.
- The session will cover how people can generate and sustain happiness even within the reality of HIV and AIDS within the family.
- The session will review the concept of family, help participants to understand the importance of family and how we can build strong, happy families. This module explains how a strong family can bring happiness to its members in relation to the types of values they do or do not hold or follow.

STEP 2
Identifying problems facing families and communities today

The facilitator should guide participants through the following exercise of identifying and specifying problems facing the family unit today, especially poor families. Remind the group that some aspects of the questions have already been tackled in previous sessions. You can help participants to identify the relevant reference sessions from before.

Ask participants to brainstorm on this first question for ten minutes (if you have a large group split them into smaller groups of about five or six, and ask each group to record their ideas on flipchart paper):

"What do you think are the practical problems facing family units in this country today?"

As each group to report back their list of problems – tape up each sheet in turn. The lists will probably include some or all of these problems:

- Poverty
- Lack of trust/love between father and mother
- Single motherhood (children born to unmarried mothers without the support of a partner)
- HIV and AIDS
- Lack of communication between family members
- Struggle to send all the children to school

STEP 3

Then ask the whole group to suggest causes for each of these problems – there may be more than one suggested cause for a problem and individuals may disagree with one another. This is not a problem: record ALL the suggestions on flipchart paper.

STEP 4

Then in the original smaller groups ask the participants to suggest ways these problems might be addressed and record them on flipchart paper – allow ten to fifteen minutes for this. Again share the solutions the groups come up with – this time take one solution at a time form each group until you have heard a good selection. Keep all the flipchart paper taped up in view of the group.

STEP 5

Conclusions from the brainstorming of solutions to family problems might include some of the following – reiterate these important points.

- Many families in this country today are faced with nearly all of the problems identified by the participants.
- It is not through their fault or anyone else's fault that things are the way they are. It is better to recognise and acknowledge that things are bad and to devise ways of tackling them than burying one's head in the sand.
- A problem shared is a problem half solved, so individual family members, whether father, mother or children should be able to bring their problem to the family where it can be tackled or resolved.
- That the father (or father figure) in the family should take a lead in encouraging other family members to discuss problems.
- That each family member can have a role to play in finding ways of tackling the problem(s). That fighting or accusing one another does not help with the problem at hand but only makes it worse or breeds more problems.

Session 2: Identifying signs of unhealthy relationships within a family set-up

Duration
One hour

OBJECTIVES

This session is designed to help increase participants' understanding of the basic negative attitudes and practices that can cause a friction or rift amongst members of a family, what might make a happy family, and how men can contribute to the type of strong family environment that can minimise HIV prevention and deliver proper HIV and AIDS care and support.

STEP 1
Tell the group that they are going to consider the following questions:

- What does everyone in a family need to be happy?
- How can members of a family be responsible for each member's happiness and other more basic welfare needs?

You will do this by considering what happens in one family, so you need volunteers – to play a father and five children. You will take the role of mother yourself. The other participants – the audience – should observe carefully and take notes of the points they notice.

STEP 2
You begin by describing the problems this family faces, and talking them through a typical evening. Ask the characters to take their positions and read or tell the story of that evening:

This is my family – I am Jane, the mother and here are my five children: Mary (17), Grace (13), Margaret (12), James (9) and baby George (1 year). This family is poor. We live here in Shaurimoyo (or name a local district with very basic housing) in this one room: we have divided it with a curtain into a sleeping area and a sitting area in the day. In the night, all five children sleep in the sitting area and my husband and I sleep behind the curtain

My husband James has casual work some days – he is still out working now, but it is six o'clock and he will be home soon. I am a vendor and I have been here since five o'clock with all my children. I am trying to cook dinner – I have the baby on my back, as I have had all day.

So I say to Mary, my first born child:
"Mary Could you please give me a hand and finish cooking this ugali while I try to settle your brother to sleep. It is going to burn."

And to Grace:
"Can you help to your sister Margaret with her homework?"
The baby is crying on my back because he wants to sleep and needs to sleep nurse.

Mary says to me:
"Hey, me? I am busy, can't you see? I am just leaving for the "Y" - I am already late for the basketball game and I am on the team." And she leaves without her dinner!

Grace says to me:
"Hey - Kwani, who helped me with my homework when I was in school? She just has to learn the same way as I did. And anyway, me I am doing my own homework."

So I say to myself:
"Haki this children of today. Now they know if the father comes in he will want his food ready and if that ugali burns, here—all hell will break loose!"

Meanwhile James, the 9 year old, is also falling asleep before eating. I am simply overwhelmed and before I can figure out what to do, there is a knock on the door. My husband has arrived.

The first thing he says is:
"What's happening in this house, why is there so much heat and noise?"

The children I was working so hard to settle all wake up and start yelling. **So he continues:**

"Woman, can you get these your children out of my face, I want to sleep and I don't want any of their noise; Kwani you can't even manage simple things like just managing children? And by the way, what is that ugali doing burning on that stove? Who do you think will eat burnt ugali; and anyway, what were you doing all day and now is when you are running around like a chicken without a head? Let me assure you, I want my food right away before I go into that bed to sleep and where is Mary?"

Before I can answer he has given me a barrage of questions. I do not know which one to answer. I just stand here watching helplessly. By now, the ugali is charred, all my children are awake and looking frightened because it is a familiar scene, waiting for their father to slap their mother. They are all clinging onto their mother's dress.

STEP 3

With the characters still in position, ask the other participants to describe some of the problems this family has – write them up on the flipchart or board. In ten minutes you should get most of the obvious ones. Tell your actors that during this they should be thinking of ways their characters can behave that will solve or avoid these problems – creating a happy family for all its members.

These questions can be used to prompt

- What can you identify as the negative aspects of the family members represented?
- How are these negative attitudes, practices impacting on the welfare of this family?
- Who has suffered or been affected?
- How do the offended people in this family feel?
- If you are always told that you never do anything right, how can this affect you?
- Who can they turn to for help in this family?
- How does calling a person names affect them? How does the offender feel? To whom can they turn to for help in this family?
- Who makes the decisions in this family?
- Is it good that one person makes all the decisions in the family?
- What is the impact of only one person making all the decisions in the family or workplace?
- How does such a family set-up help build trust/love/support/happiness among its members?

As the facilitator you can point out how the negative attitude and practices can lead to other problems. One major outcome is living in an environment of fear where no one is able to express himself freely. Point out that an environment of fear stunts or kills the spirit of happiness/love and closes down channels of communication. It also kills a person's spirit of creativity.

In the scenario the tyrannical nature of the husband has also created a distance between the parents and their children and between the siblings themselves. They appear not to care about the other. Each one only looks out for their individual interests. So the negative attitude of "I, myself, me" is prevailing. It is also seen in the father and perhaps has been learned by some of the children. In the spirit of individualism, there is no nurturing of sharing – of time, space, knowledge or other resources. The father and the two older children show a selfish attitude, only concerned about "I, myself, me". This leaves the mother overworked, overwhelmed and almost dysfunctional.

Ask participants why they think people want to control things or other people and sometimes intimidate others or appear harsh.

Some of the characteristics of a poor family environment the participants may identify:

- Overwork of some members
- Controlling and demeaning attitude and behaviour
- Inexplicable and misplaced anger
- Fear and frustration
- Intimidation
- Lack of family unity
- Competition
- Rebellion
- Animosity or hostility
- Lack of confidence
- Lack of creativity
- Poor performance
- Lack of regard for one another/selfishness
- Quick tempers
- No sense of belonging and therefore, no sense of responsibility

Ask participants if they agree with the following conclusions:

- There is no love/happiness/support/meaningful relationship within this family

- Such a family cannot weather any serious family storm such as HIV and AIDS because there is no foundation to support or build on. Love is the fundamental building block and love is not expressed in this family.

- The father and mother should be the source of security for each other and their children but in this family, the anger and frustrations from whatever cause appear to be seeping through and affecting the family's relationships and welfare

- However, it is still possible to help such a family. It is not too late to find help. Support groups can help the father, mother and children on how to build love and happiness

- The family members need to be helped in how to manage stress and possible frustrations through counselling

STEP 4

Now it is time to reverse the scenario and make it a family scene where all the family members offer each other support, love and consideration. This time the actors playing the characters make up their own lines and actions, but you can still take the lead as the mother. You should get more help from your children this time around – and more understanding and affection from your husband! This exercise should be fun, but don't let it go on too long – people can get carried away!

STEP 5

Now the participants, including the actors, can review the second scenario, the role-play. Ask the group to identify the positive attitudes and behaviours they have seen or demonstrated – once a character's behaviour has been noted ask the actor to comment on how they were trying to behave and whether that was difficult. When the group has made all its comments on the scene ask them to add any other characteristics of a happy home that have not been shown on this occasion.

The full list may look like this:

- Expressions of affection and regard for one another
- Confidence
- Peace – lack of arguments
- Offering help to one another
- Sharing: things, ideas, resources, time, space, knowledge, support, chores, responsibilities
- Sacrifice for others
- Leading by good example: being a positive role-model
- Collective/consultative decision-making
- Positive attitudes
- Good communication between family members
- Honesty in the family
- Sensitivity for each others' problems/needs
- Flexibility

STEP 6

Ask participants if they draw the following conclusion:

We all need to be affirmed and acknowledged: this will work wonders in interpersonal relationships. The family environment can become one where everyone is affirmed and recognised. This is conducive to nurturing and building love, togetherness, peace and support for one another within the family. In turn this will be reflected in relationships and behaviour beyond the family.

STEP 7

The group now has an idea of what happy and supportive families look like and how men may need to behave within those families. But some of the forces that create the negative feelings and behaviour may not be in our control. We need to find ways of dealing with those forces and we need to find support for men trying to change so they might achieve the positive attributes within their own family settings.

In the large group ask the participants:

- What factors lead to negative attitudes or behaviour from men in the family or relationships?

Possible answers:

- Their own upbringing and role models – how their fathers behaved
- Peer pressure – how their friends and male relatives behave or the advice they give
- Being tired – from trying to earn enough to keep the family, not sleeping
- Stress – from worrying about money, housing, health, the future
- Ill health
- Frustration – feeling unhappy with their lot, trapped, lack of sexual outlet

Then ask:

What can improve any or all of these?

Possible answers:

- More openness and honesty
- Sharing concerns with their wife or partner – and planning to deal with them
- Gaining greater confidence in their own way of doing things
- External support – extended family, friends, community, specialist agencies

Now bring the discussion back to HIV and AIDS. Ask the group:

- How is a happy family better able to deal with HIV and AIDS?

Possible answers:

- A contented husband may be a faithful husband
- If a couple can discuss things everyday they may discuss HIV transmission, condom use etc. If children have self-esteem and respect for their parents they may listen to HIV prevention messages
- The family may offer support and care instead of blame and recrimination

STEP 8

Spend some time considering this last question:

- How can we help men attain positive attitudes and behaviour in relation to HIV and AIDS prevention, care and support in the family?

Encourage the group to consider who should do what to make this happen and what skills are needed to achieve it. Split them into smaller groups to consider the question and ask each group to list activities men can do in their various roles as fathers, sons, brothers, uncles, grandfathers, workmates, bosses, community leaders in bringing out these positive traits. What activities can men do in their various places of social interaction in relation to HIV prevention, care and support and how can this affect the family?

Each small group should report its ideas to a concluding role mapping and action planning session.

module 7

Men living positively with HIV

This module consists of two sessions, run with the help of a person living with HIV/AIDS. Different presentations and exercises enable the participants to consider the experience of people living with HIV, how they are affected by stigma and discrimination, and what steps they can take to live healthy, positive lives.

OBJECTIVES

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

- Describe what living positively with HIV and AIDS is all about
- Empathise through discussing the experience of living with HIV.
- Explain what a person living with HIV or AIDS goes through
- Identify what to do in case they test HIV positive
- Describe what kind of diet could keep them healthy
- Explain how to start a support group for men
- Know where to refer men for support

Session 1: Living positively – psychological and emotional steps

Duration
Two hours

Materials
Flip chart, enough space, markers, and resource people, VIP or file cards.

When planning this module you should invite a man living with HIV to share his experiences of living with HIV with the group. Ask him to join you in your planning – read through this module together and discuss the objectives, exercises and so on. Add any other ideas you come up with to your programme.

STEP 1

Introduce your guest to the group and ask the group members to introduce themselves. Explain that your guest will help to work through this module and talk through the objectives listed above. This module will start with your guest explaining who he is, saying a little about his family or home life, his work and how becoming HIV+ has changed his life. Use the chart below to suggest how this might be structured.

My Story:

- the kind of person I was before I tested HIV+
- how I changed at that time
- how I have changed since
- my needs my desires, my hopes and my ambitions

STEP 2

Once your guest has told his story, discuss the questions the group wants to ask and whether their questions are fair or unfair. Do this by agreeing some principles in advance:

- questions should be relevant to our topic "living positively"
- questions should not be intrusive ("How did you become infected?")
- questions should be open ("How do you feel now about your status?"), not closed ("Don't you feel depressed and ashamed?")
- we all have the right to decline questions we do not feel comfortable answering

Discuss what "living positively" means to the members of the group and to your guest. After that discussion share this suggested definition – and improve it if you can:

Definition:

- Living positively with HIV is the act of accepting that you are HIV positive, then taking precautions not to re-infect yourself, while at the same time protecting others from infection.
- Living positively with HIV is the art of thinking positively about your future and planning with your family, it is about taking control of your life and managing opportunistic infections as they occur by seeking prompt medical attention.
- Living positively with HIV means eating well, exercising and caring for yourself because you have a life that is worth living.

STEP 3

The steps to positive living

- Learning to love and respect yourself as a person living with HIV
- Being honest with yourself and your partner
- Recognising that your life is worth living
- Maintaining your family and social contacts
- Seeking out a support group
- Avoiding infecting others by having protected sex
- Paying attention to your diet, exercise and rest
- Keeping busy
- Avoiding stress
- Seeking advice and counselling when you need them
- Staying updated on current HIV and AIDS information
- Seeking treatment for Opportunistic Infections and other illnesses
- Planning for your future and the future of others

Use these steps to prompt any further discussion you consider necessary: what would people change about this list? How can they achieve these steps, by what strategies?

STEP 4

What is disclosure and why is it important?

Disclosure is used to describe the process of revealing, in a controlled and voluntary way, your HIV status or some other sensitive, personal information. Disclosure can be to just one other person (a spouse or confidant), or to a small group of people (like immediate family or close friends), or to a potentially very large group of people – the local community, fellow workers or the public at large. Whenever someone chooses to disclose it can have major implications – after all it is an irreversible process. This section deals with some of the considerations around disclosure facing someone living with HIV. Invite your guest to talk about their decision to disclose: how they came to the decision, to what extent they have disclosed, how people reacted. Broaden the discussion to brainstorm the potential benefits and dangers of disclosing HIV status. Record two lists, for example:

+

Less secrecy may equal less stress
People can support you
One less barrier to care and treatment
Rumours might stop
You can negotiate safer sex

−

People might discriminate
May be isolating
You cannot take it back
People may abuse your confidence
Your children may be shunned

It is important that the subject of disclosure be handled with a lot of caution. At different levels you will find that there is a need or no need to disclose your status. Different decisions could be taken relating to disclosure to:

- Spouse
- Children
- Relatives
- Colleagues at work
- Community members

One of the advantages of forming or attending a men's support group is the safe space it provides for men living with HIV to share common problems. This level of disclosure may be enough for some men, for others it may be just the start of the process. Men's groups should consider providing disclosure counselling. A counsellor can help their client to consider who they might tell, why and when. This helps the client retain control over the process and manage the flow of information.

Session 2: Living positively – physical steps

Duration
One hour

Materials flipchart paper and pens, module 7 handout 1

STEP 1
Talk through these topics with the group:

Physical exercise
Exercise is an integral part of the process of positive living as it facilitates the uptake of food by the body. Exercise helps deal with stress and by creating a degree of physical tiredness can help facilitate good rest and sleep. A person living with HIV or AIDS should have moderate exercises as excess exercising could cause problems. Being busy helps to reduce some of the psychological effects of living with the condition.

What is nutrition and why is it important?
Explain that nutrition is the process of the body deriving benefit from food and some food supplements. Without a nutritious diet it is impossible to stay healthy in the long-term, and that is especially true for people living with an infection like HIV that damages the immune system. There are six types of nutrients: protein, carbohydrates, fats, vitamins, minerals, and water. In simple terms, nutrients are the chemicals that your body gets from food. A healthy diet can help you to stay well for longer and to recover more quickly from infections when they do come. Distribute Module Seven: Handout 1 – Nutrition or another nutrition leaflet or handbook ("nutrition" published by NAM is recommended, see www.aidsmap.com).

Why might men living with HIV not eat as well as they should?
Ask the participants to give reasons why men might not adhere to good eating habits, even when they need to because of HIV infection. The group might bring up some of the following issues – write up all their suggestions:

- Men don't have the time to prepare meals.
- Women are the ones who are responsible for seeing to it that their men are well fed.
- Men are not supposed to enter the kitchen to cook: it is taboo.
- In cases where the women are not there or are unable to cook for the men then the only option would be to go to a restaurant or take boiled or roasted meat.

There are other reasons associated particularly with HIV and AIDS – add these if the group do not mention them. Eating may become painful or difficult for one or more of these reasons:

- Sore or inflamed mouth
- Throat infection
- Bleeding gums
- Dry mouth
- Difficulty swallowing or chewing

What is a healthy diet?

Ask the group what they think men should eat to stay healthy, and whether men living with HIV should change their diet once they know their status.

Explain that the best diet provides a balance of vegetables, fruit, whole grains and other carbohydrates (eg bread, potatoes, rice), fish, lean meats and other proteins (eg eggs, pulses, cheese), and fat (eg nuts, oily fish, oil, butter). Eating food when it is fresh ensures it gives maximum benefit to the body and reduces the risk of food poisoning. If you can eat food like this you do not need to take supplements. In fact supplements can be detrimental: they can be expensive and so reduce what you spend on food; some supplements actually contain dangerous levels of some minerals and vitamins. It is hard to overdose on vitamins and minerals if you obtain them from normal food!

It is important that people living with HIV and AIDS maintain a healthy diet in the face of all the problems listed above. They may sometimes be too tired to cook or eat: it is dangerous to miss meals and deprive the body of nutrition.

Diet and anti-retroviral therapy

If you are prescribed anti-retroviral drugs (ARVs) you should be alerted to any particular dietary requirements of that treatment. Ask your doctor if any of the following apply to the treatment you are given:

- absorption of the drug will be improved by either eating or avoiding particular foods
- the drugs need to be taken at the same time as you take a meal
- the drugs need to be taken well before or after you eat (two hours)

You or your doctor can find more information about diet and treatment at www.aidsmap.com

Accessing timely clinical care and treatment

Ask the group why, is it important for a PLWHA to access timely and accurate clinical care?
Reasons include:

- People infected with HIV have suppressed immunity hence they are more prone to being attacked by opportunistic infections.
- With the early detection of medical complications medical fitness will be regained as the opportunistic infections would be detected and treated before they can become chronic.
- If the immune system can be monitored treatment decisions can be taken that avoid opportunistic infections or lead to commencement of ARV treatment.

STEP 2
Action planning

Invite the group to consider, in small groups or pairs, how a men's support group can help to improve the psychological and physical wellbeing of its members. When the ideas are reported back ask them to identify external support or resources that would be needed to pursue them successfully.

Nutrition

Balancing your diet

All the food groups listed below are important to us, but the amount we consume should be balanced. Everyday we should eat fresh vegetables and fruit; we need to eat more carbohydrate than protein or fat; we do NOT need to eat fish or meat everyday; healthy fats occur naturally in foods like nuts and fish so do not always need to be added to our diet in other ways; processed foods we may buy like cakes, sweets, pies are often high in sugar, saturated fat or salt – eat these items sparingly.

For more information on nutrition and HIV and AIDS visit www.aidsmap.com or obtain a copy of "nutrition" published by NAM.

Protein

Every single cell in your body is made up of protein. Hair and fingernails consist of fibres of protein called keratin. Collagen is the protein that strengthens your skin, blood vessels, bones and teeth. Even your muscles are held together by the protein fibres called myosin and actin. In fact, about one-fifth of your body weight is protein. Every chemical reaction that takes place in your body — that is a lot — is dependent on proteins. These important nutrients help us build new cells and repair damaged body tissue. Because your tissues are constantly being destroyed and rebuilt, and because unlike carbohydrates your body has no means to store protein, you must make sure you get enough of this important nutrient to keep all your vital processes functioning. During digestion, large molecules of protein are broken down into smaller, simpler units called amino acids. The body requires 22 amino acids in specific patterns to make human protein and thus do its necessary functions. Your body can produce all but nine of these amino acids. The nine that cannot be produced are called essential amino acids because they must be supplied by your diet. In order for your body to properly use proteins, all of the essential amino acids must be present in your system. A food that contains all the essential amino acids is called a complete protein. Examples of foods high in protein include: meats, fish, lentils, nuts, beans, eggs and dairy products such as cheese or yogurt.

Carbohydrates

Most of our energy comes from carbohydrates. Carbohydrates are chemical compounds of carbon, hydrogen and oxygen. They provide us with calories that can be converted into energy. There are two types of carbohydrates: simple, which are sugars, or complex, which are starches. It's a good idea to try to eat more complex carbohydrates because your body gets longer sustained energy from these foods. Examples of complex carbohydrates include: potatoes, pasta, bread, rice, lentils, cereals and fruits and vegetables. Choose whole grain flour, pasta, brown rice etc. over the more refined white versions. Compare these to the simple carbohydrates such as cake, biscuits, sweets and chocolate bars and other sugar foods that provide a quick jolt of energy, but then leave your body craving more. These simple carbohydrates are known as "empty calories" because they lack vitamins, minerals, fibre or anything of value to your system.

Fats

Fat is an important part of our diet, but some fats are better for us than others that are quite bad for us. There are three types of fat: saturated, monounsaturated and polyunsaturated. Saturated fats are the worst type because they raise the cholesterol level in your blood, which can lead to heart disease. The more saturated the fat is, the more solid it will appear at room temperature. This includes animal products such as butter, cheese, milk, lard and meats. Red meat is the worst: by eating less red meat and more chicken or fish you will maintain protein and avoid unhealthy saturated fat. Monounsaturated fats are the types in nuts and fruit and polyunsaturated fats are found in oils. If you are trying to reduce the unhealthy fat content in your diet, try grilling rather than frying your food, use skimmed milk rather than whole milk, and cut down on red meats.

Fibre

Okay, you are right, there is no nutritional value in fibre. But we do know that fibre absorbs water, helping to keep away hunger pangs and to keep the colon healthy by allowing bowel movements to be regular, softer and easier to pass. Fibre has an important role in protecting us from certain diseases, such as heart disease, high blood cholesterol, some cancers and bowel conditions. It also can keep us leaner (people who eat a lot of fibre are less likely to be overweight). Fibre is present in the cell walls of all plants, but is NOT found in any food obtained from animals. It can be found in all foods of plant origin like fruits, vegetables and nuts. It is also found in unrefined breads, cereals, brown rice, corn kernels and beans. Cellulose and pectin, found in all stringy vegetables and apples (and other fruit) cannot be digested, but they are important as roughage.

Water

Our bodies are about two-thirds water, and we need to ensure that we keep up this balance in order to remain healthy. That's why it is recommended that you drink at least eight glasses of water every day. This will keep all your organs hydrated so that they can function properly, and water also helps to flush toxins and other impurities out of your body. Water serves many other crucial functions including: respiration, digestion, metabolism, body temperature regulation and excretion. Water is also responsible for dissolving and transporting nutrients through the body. Only oxygen is more important to sustaining human life than water. So, drink a tall glass of water and stay healthy!

module 8

Men's support groups

OBJECTIVES

- **Participants will be able to describe the benefits of men's support groups.**
- **They will have strategies for sustaining a group and mobilising members.**
- **They will have practised running a session and handling difficult situations.**

This module is a critical part of the manual:
it provides the opportunity to discuss how to establish, run and sustain support groups of men affected by HIV and AIDS. The facilitator will build on these discussions to provide a basic knowledge on how to mobilise men to actively support other men. The module requires a lot of input from the participants: as you are nearing the end of the training programme this should not present too many problems.

Session 1: How to establish a group

Duration
One and a half hours

Materials
flip chart and marker pens

STEP 1
Explain that by the end of the session the participants should be able to:

- Describe a support group
- State the importance of establishing a support group
- List the challenges of starting and running a support group
- Identify strategies and actions for meeting these challenges.

Begin by asking the whole group what they understand by the term support group. As the participants respond to this question record their answers on the flip chart. List all of their suggestions and end by summarising them into a definition that everyone agrees on. One working definition is given here, but use the words of the group:

A group of people affected by a common problem, challenge or condition, coming together to share this in a guided way for therapeutic purposes

STEP 2
Group work
For 15 minutes let the participants list the importance of support groups for men in small groups of 5 or 6. Let each group present before you sum up - include these suggestions if they have not been mentioned:

The importance of starting a men's support group of PLWHA

Working as a group can:

- Help people feel that they are not isolated and alone with their problems
- Provide a way to meet people and make friends
- Help individuals to become more confident and powerful
- Provide a basis to organise activities led by the members
- Make links between people from different back-grounds and increase understanding and tolerance
- Help to share resources, ideas and information, for instance about the latest available treatments or local support services

- Make others in the community more aware of the situation facing people in the group by increasing the visibility of people living with HIV and AIDS
- Lead to change by creating a public or political voice

STEP 3
The challenges of starting a men's support group.

Ask the participants to work in buzz groups of two to jot down five challenges of starting a support group. Take their feedback to create one long list – take one idea from each pair in turn – and add any of these that do not get mentioned:

- In some places, it is not possible to be public about your HIV status, which makes people reluctant to join a group in case other people find out.
- Many groups fail because the biggest need of their members is money and other material and economic support - a small support group may be unable to solve this problem alone.
- Group members often have different needs and expectations, which can lead to conflict and disappointment.
- Often a few dynamic individuals set up the group and when these people are no longer involved the group can lose its direction.
- Group members can burn out, especially if the few openly HIV+ people have many demands on them for public speaking, planning services and other activities.
- The issue of acceptance: by the community, the relatives, in the workplace and especially by the wife.
- Fear of not knowing how they will be able to cope.
- Denial of HIV status by men.
- The issue of sharing the information with anyone, not even the wife: "Let them know about it over my dead body."
- "I don't believe that there is HIV or AIDS - this is just a big joke to scare us men folk from having sex with our girlfriends."
- "There is nothing you or anybody can teach me about sex, I started having sex long before."
- "A man is not supposed to see his wife give birth, how can he attend the antenatal clinic?"

STEP 4
Useful strategies
Join the pairs from the last exercise to make groups of four. Ask them to consider what strategies can be employed to establish men's support groups and overcome some of the challenges just mentioned. Conclude this session by running an action planning based on their suggestions. List them including the following suggestions:

- Ensure the group has clear aims and that these are understood
- Use the benefits of support groups to promote the idea to community leaders
- Recruit informally in places men have the time to talk
- Make formal links with service providers that have difficulty reaching men (VCT, clinics, ANC etc.)
- Hold meetings at times and in places convenient to men

Ask the group for the specific actions required to bring these strategies about and try to put them in chronological order, for example:

Strategy	Action	When?
Have clear aims	Agree aims at inaugural meeting of potential group leaders AND Consult on these aims with potential and early members	
Recruit informally	Agree best locations; discuss whether permission is necessary or desirable; work in pairs and report back after a week	

Session 2: Running successful meetings

Duration
One and a half hours

Materials
flipchart paper and pens

STEP1
Preparing for the first meeting
Ask the group, when their members attend the group for the very first time, what will be going through their minds, what will make them want to come to a second and third meeting and to keep coming in the future?

They will need to prepare well enough that they can achieve a balance between explaining how the group could work and what they hope it will achieve, and listening to what the group members want to say – whatever that might be!

Ask the participants to draw up a plan or an agenda for their first support group meeting on flipchart paper, to decide how long it should last, and how they will keep that balance between providing important information and making the event participatory. Ask them to do this in groups of four or so – so you have four or five agendas to compare and discuss. Allow them ten to fifteen minutes for this.

When each group has an agenda or meeting plan ask them to present it and invite comments from the other groups. As they are presented try to draw out what is considered to be the best approach – a consensus agenda. This will mean discussing how things are presented, how long the meeting should last, how many speakers there should be, who should speak, where the meeting should be held, what the members will be invited to say, what ground rules will be established and so on. This is not a theoretical exercise: they will run their own group(s) so they can consider what will really work in their own community.

STEP 2
Another important step is that they have some practice in leading a group and dealing with the challenges that brings. Before they do that, present these ideas for promoting the first meetings and invite suggestions from the group.

Promoting your group's first meeting
- Communicate details directly to the group members you have already recruited
- Tell counsellors, health workers, hospitals and VCT centres
- Put up posters and distribute leaflets in waiting places e.g. VCT, reception areas
- Advise any local AIDS support organisations.
- Alert any sympathetic media – newspapers or radio
- Use word of mouth to reach others: visit people in their homes
- Give out the correct information about the activities of the group
- When and where the group meets and for how long
- Whether the meeting will be confidential - that is closed or open
- Alternative contact details for people who may be too nervous to attend the first time

STEP 3
Helping to lead the group

Ask each participant to imagine that they are about to attend the brand new support group as a new member. Each of them should think of three things they will say or ask when they are in the meeting. Later you will all act out this first meeting and take it in turns to lead the group. You will ask for positive feedback on how each of them does in the

face of the questions, statements or behaviour of their "group members". Once each of the participants has thought of (and written down) their three ideas, ask them to prepare the room for the first group meeting.

- Where is this meeting?
- How do they want the room arranged?
- Will there be any refreshments – if so when?
- Who will record who came or how many came?

Once these points are agreed and the room is ready, explain how the role plays will work. Give each participant a number. Following the agenda agreed to earlier, each of them will act as leader in turn, beginning with number 1, switching over when you tell them to. Everyone else acts as a group member – including you (you may have to model some difficult behaviour that no-one else thinks to do – for example a new member who is very shy and refuses to be drawn out).

If there are a lot of participants you should pause the exercise half way for feedback and then continue, otherwise it is hard to recall how the earlier leaders performed. Be sure to keep your own notes so you can give detailed feedback on each of them. Encourage the others to keep notes too.

After the feedback end with some key points including:

- Ground rules must be laid down
- The agenda should be explained
- Keeping records of attendance
- New members should feel welcome
- All members should have equal status
- The time should be shared
- Ask for contributions
- Do not force people to speak
- Win trust by showing respect and listening properly
- Be responsible for yourself
- Be patient: take one step at a time
- Get involved but also know when to stay quiet
- Help the group stay on the topic, if there is one
- Reflect or repeat ideas or statements that might otherwise get lost
- Disagreement is healthy – even with you!
- Large groups may need to be divided for some activity

Establishing a new group and seeing it thrive is a wonderful thing. But change is inevitable: change in membership or leadership; splitting into smaller groups that are more practical or serve specific needs; change in direction or objectives due to change in services available and so on. Do not be afraid of change – look for it and embrace it!

module 9

Working with young men

OBJECTIVES
This module seeks to establish a methodological base where young men can be helped to cope with the changes around them.

This module shows how young men can be meaningfully involved to facilitate prevention and assist others who are vulnerable.

By the end of the sessions the participants should be able to:
- Define a young man
- Identify thematic areas of working with young people
- Describe how to work with young men in different settings
- Describe the challenges of working with young men

Session 1:

Duration
One and a half hours

Materials
Flip charts, file cards and felt pens

STEP 1
Invite the participants, in pairs, to use the file cards to describe their definition of a young man and report back in a few minutes.

MMAAK DESCRIPTION:
- A young man is a male aged 12 to 25 and can make basic decisions about his life.
- This covers adolescence
- Young men at puberty
- College going students
- Young men who are employed
- Young men in religious settings
- Young men who are not in academic institutions
- Young men in families

STEP 2
In a plenary discussion let the participants agree or disagree with these statements, voting them either true of false, and discuss their views.

- Young men lack adequate information, as the culture doesn't allow the parents to discuss with them (T/F)
- Young men get inadequate or distorted information from friends (T/F)
- Young men in religious settings don't discuss the difficulties to resist the pull and urge to be involved in sex because sex is regarded as sin. (T/F)

STEP 3
In three groups, let the participants discuss ways of working with young men in the family, churches and learning institutions.

After reporting back (after ten to fifteen minutes of discussion) you as the facilitator should give each group a case study to read and discuss. Ask each group to report back to the others on:

- The content of their case study
- At least three learning points they wish to report

Case studies: working with young men

Case study 1

A study conducted in Kenyan pre-urban setting found none of the parents or religious leaders had ever discussed anything to do with sex and sexuality with their children because they assumed the children are taught about sexuality and sex in school. They stated that even when they thought of doing so they were wondering how to go about it.

Jane stood up and said her son, who is now grown-up and married, came to her and asked her whether it was okay for him to go out with girls as his fellow teenagers had already started and were influencing him to start. Jane took the time to discuss this with her son in detail and found out that the approach could work. However it was not her initiation but the boy's initiation.

When the other people asked Jane how this was possible Jane stated that she had started it all when the son was very young. When the child asked her how children were born she sat down with him and told him the truth: that created a confidence in the child when the child realised he was being told the truth. She admitted that she had been particularly very close to this child unlike her other children.

Case study 2

MMAAK was involved in another study with young people in a rural setting.
In this study it was surprising that none of the young people had ever discussed anything to do with sex with their parents. For the young women who were present 40% had an opportunity to discuss sex and sexuality issues after the onset of their first periods.

The young men stated that they really wished to discuss sexuality issues with their parents. When they asked the young men were told: "But you were taught about sex at school". They stated that what was taught had no moral or emotional element, thus they were left in a dilemma, especially as some of the teachers who taught them had very bad records of being involved with young girls in the schools. They stated that they would have wished their parents to communicate with them when they were of reasonable age.

Case study 3

In another study with older men and religious leaders, they agreed that they never discuss sex with their children mainly because of the distance between them and their children. They felt this was due to the disciplining role they always have in the family. This creates a level of distance that does not make it easy to discuss matters like sex.

They stated that they would also have found it difficult to discuss sex with their children because they do not know how to start. They said that in the current situation of HIV and AIDS it is important that they do so. In the African traditional societies older men and uncles would be seated beside the fire at night and discuss the issues of sex and sexuality, and chastity was highly valued then and people would manage. They hoped that even today the young people could access information within their family settings, perhaps from uncles, aunties or a father figure when the parents are empowered to facilitate the process.

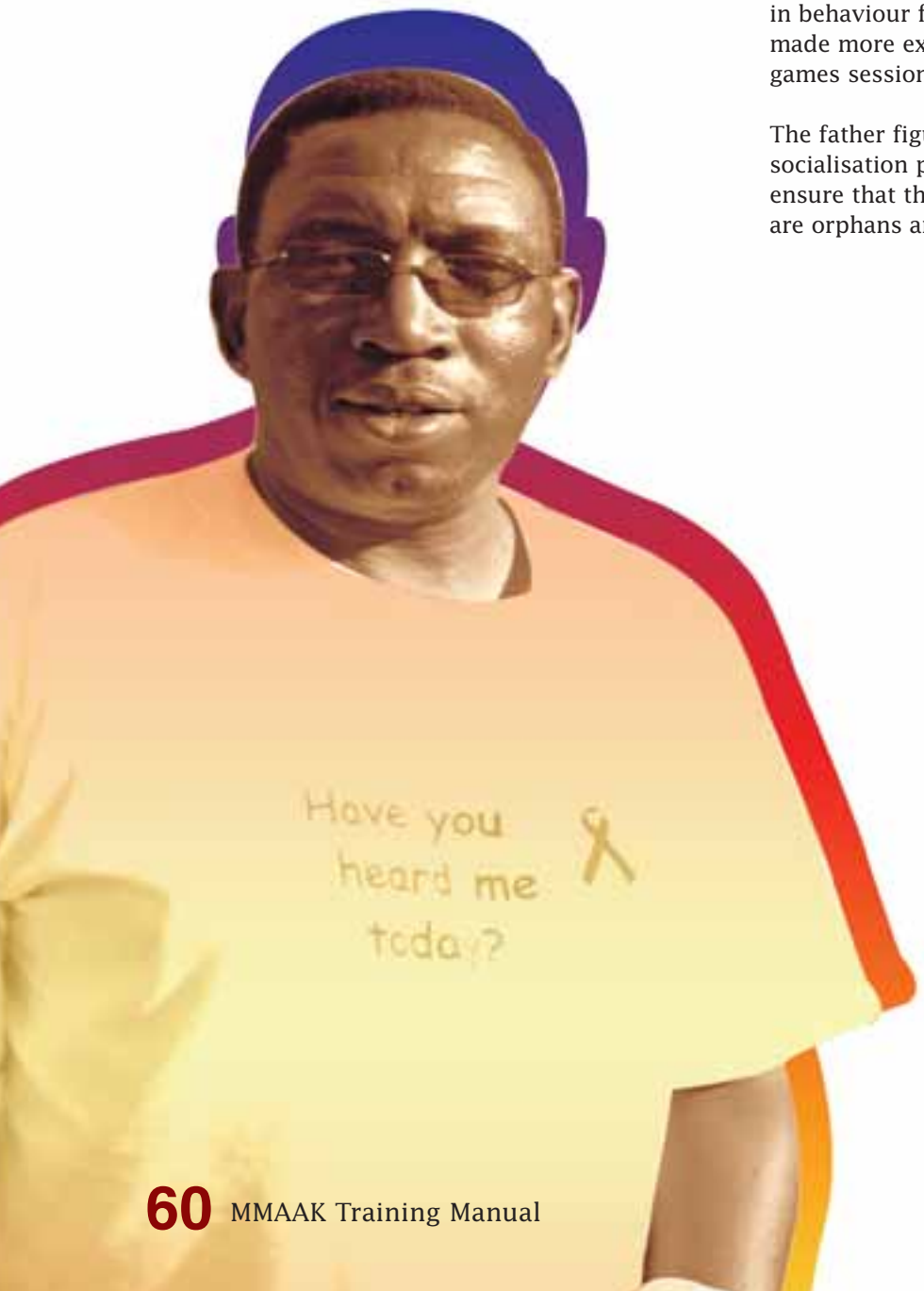
The distance between the children and the parents could be avoided by making sure that the next generation of fathers is close to their own parents from young ages and free and sincere to one another.

STEP 4

As facilitator, read the following examples and conclude by conducting a role mapping that focuses on these three settings: families, schools and religious institutions.

Working with young men in the family

Young men need to feel they are trusted: it helps if they are shown some substantial level of trust from a young age. This would really help the process of improving and maintaining communication between parents and their children.



Working with young men in schools

This is the most important element of working with young men at a time when they are undergoing a lot of physiological changes in their bodies and the onset of adolescence makes them more confused by imagining they know everything. One proposed strategy for helping young men is to build the capacity of boys' schools to meet the needs of young people for counselling.

Working with young men in religious institutions

This could be strengthened by providing the youth clubs within the churches with role models to help in behaviour formation processes; this could be made more exiting when it is done in picnics and games sessions.

The father figure is a key element in the socialisation process: these role models can help ensure that the children who have no father or who are orphans are taken care of.

notes

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