BENEFITS*

ABOUT THIS ACTIVITY

Time: 45 minutes

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

- Identify the different state and federal benefits available to persons with disability or needing assistance
- Discuss the impact of employment to their benefits
- Identify the return to work plans offered by Social Security Administration
- Reference a list of resources to further gather information related to back to work issues

In This Activity You Will…

- Share definitions with group (15 minutes)
- Demonstrate how a person balances pros/cons of returning to work (10 minutes)
- Lead a group discussion about impact earned income may have on benefits (10 minutes)
- Lead a group discussion to summarize (10 minutes)

Materials:

- Computer
- Projector
- Screen/White Wall

Preparation: None

Instructions

Go through Benefits Powerpoint slides.

Talking Points (Powerpoint Slides):

Basics

- Benefits are "means tested"-personal information is gathered to determine if you qualify for benefits/assistance
- Critical that employment income is reported if you receive any state or federal benefits
- You can work and still receive benefits
- Falsification of information to SSA can result in disqualification of SSI or SSDI for 6-24 months or recovery of SSI/SSDI overpayments

Glossary

- ADAP-Aids Drug Assistance Program
- MHIP- Missouri Health Insurance Pool
- SSA-Social Security Administration
- SSI-Supplemental Security Income
- SSDI-Social Security Disability Insurance
- PASS-Plan for Achieving Self Support
- TTWP-Ticket To Work Program
- TWP-Trial Work Period
- FS-Food stamps

What is SSI & SSDI?

- Both programs are administered by the SSA and offer benefits to individuals who are unable to work due to physical or mental disabilities which at least 12 months
- SSDI provides benefits to disabled or blind individuals who are "insured" by workers' contributions to the Social Security trust Fund. These contributions are required by the Federal Insurance Contributions Act (FICA) which created Social Security taxes which are paid based on your earnings or those of your spouse or

* This module comes from the Missouri People to People Training Manual, 2008.

your parents.
- SSI makes cash assistance payments to aged, blind and disabled individuals (including children under age 19) who have limited income and resources or do not qualify for SSDI or whose SSDI is less than the SSI standard amount. Federal Government funds SSI from general tax revenues.
- A person is said to be "concurrent" if they receive benefits from both SSI and SSDI.
- Apply for benefits at SSA and eligibility is determined

How Employment Earnings Affect SSI

- Must report your earnings monthly to SSA
- When other income goes up, your SSI goes down
- When you earn more than your SSI limit (max $637 in 2008), your payments will stop for those months
- SSA disregards the first $85 you earn
- Disregards Impaired Related Work Expenses (prescription drugs, transportation, personal attendant, job coach, cane, a wheelchair or any specialized work equipment)
- Disregards ½ of your earned income

Example: You work and earn $1,000 in December. You receive no other income besides your earnings and your SSI. SSA would deduct $457.50 from your SSI payment for December.

$1,000-$85
$915 divided by 2= $457.50

December SSI check would be:
$601-$457.50=$143.50

December income would be:
$1000 (earned income) + $143.50 (SSI) = $1143.50

- If you lose your SSI b/c your income exceeds your SSI payments and you become unable to work again because of your medical condition, you may ask SSA to start your payments again. You will not have to file a new disability application if you make this request within 5 years after the month your benefits stopped.

How Employment Earning Affect SSDI

- It is possible to work and receive SSDI benefits
- The 9 month Trial Work Period-SSDI recipient can earn unlimited employment income
- Employment Income above $670 (2008) per month is counted as a Trial Work month (within a 60 month period)
- You can continue to receive benefits during the trial work period with an extension of 3 months
- SSDI benefits will end if you demonstrate the ability to maintain Substantial Gainful Employment ($940.00 in 2008) beyond your Trial Work Period
- If SSDI benefits lost because you have earned income beyond your Trial Work Period and you become unable to work again because of your medical condition, you may ask SSA to start your payments again. You will not have to file a new disability application if you make this request within 5 years after the month your benefits stopped.

SSA Ticket to Work Program

- Available to SSDI or SSI recipients
- Voluntary program
- Recipient receive a "Ticket" they can use to obtain services from a State Vocational Rehabilitation agency-Employment Networks to assist in return to work training at no cost to the recipient
- Expedited reinstatement of benefits if unable to work within 60 months of termination of benefits due to employment
- Deferral of Continuing Determination Reviews (usually done every 2 years)

BENEFITS

PASS Program

- Plan to Achieve Self-Support
- SSI beneficiaries eligible
- Requires a written application and approval from SSA
- PASS allows you to set aside income to pay for education, vocational training, or start a business along with all the related expenses to achieve your goal
- Money saved for PASS is not considered in SSI payment determination

Public Assistance Programs managed by Missouri Family Support Division

Medicaid

- Must live in Missouri and intend to remain
- Max. income is $999.00-single or $2,000-couple
- SSI recipient who works can get Medicaid up to 12 months if gross income is $, still disabled and eligible for SSI
- Medicaid Spenddown –medical assistance coverage for a person whose income is over the Medicaid limit $695. The spenddown amount is the amount above $695 monthly plus a $20 personal income exemption. For example if my income is $800, then my spenddown amount is $85. The spenddown amount is the deductible that must be paid in cash or you can wait to incur expenses before you have full Medicaid insurance coverage.
- 1619(b) Plan –Continued Medicaid coverage even if your earnings are at the SGA level-$940 and over. There is eligibility guidelines (need Medicaid to work, still disabled and eligible for SSI at least 1 month) Please talk with MFS Division worker.

Food Stamp Program

- Nutrition assistance program for low-income individuals/families
- Purchase of nutritional food
- Eligibility based income-means tested

Household size	Max. gross monthly income (9-06)
1	$1,037
2	$1,390
3	$1,744
4	$2,097
5	$2,450
6	$2,803
7	$3,156
8	$3,509

- Property not counted-home, vehicles, personal belongings, life insurance cash value
- Must have less than $2,000 in property (cash on hand and in the bank)

Medicare Impact

- Available to SSDI recipients after 24 months
- Medicare Part A covers hospital charges
- Medicare Part B is medical insurance
- Medicare Part D is the drug benefits plan
- SSDI recipient who returns to work will have continued coverage for 8 1/2 years

Contact Information:

- Missouri Family Support Division
- Medicaid Recipient Services Unit: 1-800-392-2161 or your local county office.
- Medicare: 1-800-medicare (1-800-633-4227) or www.medicare.gov
- Social Security Administration: 1-800-772-1213 or www.socialsecurity.gov

BENEFITS

Create a Plan of Action

What is your goal?

- Supplementing your income
- Testing your ability to work
- Job that accommodates your medical needs
- Resuming an old career
- Finding a new career
- Finding full-time work
- Improve your benefits portfolio

Determine Your Goal

- What's important to you
- Don't sell yourself short
- Some suggestions:
  Have some fun with the process
  Set your goals incrementally
  Be bold yet realistic

Plan Your Future

- Take the time to create a plan
- Get focused
- Do your homework
- Begin the process of creating a plan with a backup
- Above all be patient with yourself and the process

Summary

- Thinking about returning to the work force after being diagnosed with a disability and receiving benefits requires thorough research as you explore how a salary or a stipend may impact your benefits.

- Be sure to review
  How benefits maybe affected by employment income;
  Your State and Federal Funds guidelines to ensure that you make the best decision for yourself;
  The resources provided today so that you can personally meet with a benefits expert who will give you that one-on-one guidance you seek.

- As you can see, this is a wealth of information for anyone to digest in helping them determine the impact of returning to the work form, while still ensuring that their benefits are the least impacted. We strongly suggest scheduling a face to face meeting with a Social Security Administration staff person to help you figure our your situation. If you receive public benefits we suggest meeting with your MFS worker to determine impact of employment income to your benefits.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from the Missouri People to People Training Manual, 2008.

SESSION HANDOUT

peopleto people

Back to Work: Balancing Benefits

peopleto people

Back to Work: Balancing Benefits

Basics!

- Benefits are "means tested"
- Income must be reported if you receive benefits
- You **can** work and receive benefits
- Falsification results in disqualification of benefits for 6 - 24 months

peopleto people

Back to Work: Balancing Benefits

Glossary

- **ADAP** - AIDS Drug Assistance Program
- **EI** - Earned Income
- **SSA** - Social Security Administration
- **SSI** - Supplemental Security Income
- **SSDI** - Social Security Disability Insurance
- **PASS** -Plan for Achieving Self Support
- **TTWP** - Ticket to Work Program
- **TWP** - Trial Work Period
- **FS** - Food Stamps
- **FICA** - Federal Insurance Contributions Act
- **HIPAA** - Health Insurance Portability and Accountability Act

peopleto people

Back to Work: Balancing Benefits

What is SSI & SSDI?

- Administered by SSA to individuals unable to work due to physical or mental disability that last minimum of 12 months.
- SSDI to disabled or blind individuals who paid into FICA
- SSI assistance to aged, blind and disabled individuals (minors<19) who have limited income and do not qualify for SSDI or whose SSDI is less than the SSI standard benefit amount-$637 in 2008
- If a person receives both SSI and SSDI they are said to be "concurrent"
- Apply for these benefits through SSA who determines eligibility

How Employment Earnings affect SSI

peopleto people

- Report earnings to SSA
- When income goes up, SSI goes down
- SSI stops if income is more than limit: $637 in 2008
- SSA disregards the first $85 of earned income
- Disregards Impaired Related Work Expenses (transportation, wheelchair, medications, transportation, job coach, etc.)
- Disregards ½ of your earned income
- Example: In December you earned $1000. Your income is Earned Income plus SSI. SSA will deduct $457.50 from your SSI payment for December.

$1000 -
$85
$915 divided by 2 = $457.50

SSI check will be $637 - $457.50 = $179.50

December income $1000 (EI) + $179.50 = $1179.50

- If you lose SSI because of EI and then lose your job, you can request to have your SSI benefits begin again. No new disability application needs to be completed if it's **within 5 years** of benefits stopping.

peopleto people

Back to Work: Balancing Benefits

How Employment Earnings affect SSDI

- You **can** work and receive SSDI benefits
- 9 month TWP-SSDI recipient can earn unlimited income
- EI >$670 (in 2008) to be counted as a TWP month (within 60 months)
- You can request a 3 month extension of your TWP
- SSDI benefits end if you demonstrate Substantial Gainful Employment ($940) beyond your TWP
- If you lose SSDI and 2 years later you are unable to maintain employment, you can request from SSA that your SSDI payments begin again. No new application required if **within 5 years** after your benefits stopped.

BENEFITS

SESSION HANDOUT (cont.)

Back to Work: Balancing Benefits

SSA Ticket to Work Program

- Available to SSDI or SSI recipients
- Voluntary Program
- Recipient receives a "ticket" they use to gain services from a State Vocational Rehabilitation Agency
- Employment Networks to assist in return to work training programs at no cost to the recipient
- Expedited reinstatement of benefits if unable to work **within 5 years** of termination of benefits due to employment.
- Deferral of Continuing Determination Reviews (usually done every 2 years).

Public Assistance Programs managed by Missouri Family Support Division

Medicaid

- Must live and intend to remain in Missouri
- Means Tested
  - *Maximum income*: $999/single; $2000/couple
- Medicaid Spend down - medical assistance for persons whose income is greater than $695. Spend down amount is the amount above $695 plus an exemption of $20 personal income.
  - For example, if income is $800, then spend down amount is $85
  - Spend down amount is a deductible paid monthly before you have full Medicaid insurance coverage.
- 1619(b) Plan-Continued Medicaid coverage for a person whose income is over $940. There are eligibility guidelines (need Medicaid to work, still disabled and eligible for SSI at least 1 month) Please talk with your MFS Division Worker.

Public Assistance Programs managed by Missouri Family Support Division

Food Stamp Program

- Nutrition assistance program for low-income individuals/families
- Purchase of nutritional foods
- Means tested
- Property not counted: home, personal belongings, life insurance cash value
- Must have less than $2,000 in property (cash or bank)

Medicare Impact

- Available to SSDI recipients after 24 months
- Medicare Part A covers hospital charges
- Medicare Part B is medical insurance
- Medicare Part D is the drug benefits plan
- SSDI recipient who returns to work will have continued coverage for up to 8.5 years

Contact Information

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Medicare: 1-800-MEDICARE (1-800-633-4227) or www.medicare.gov

Social Security Administration: 1-800-772-1213 or www.socialsecurity.gov

Create a Plan of Action

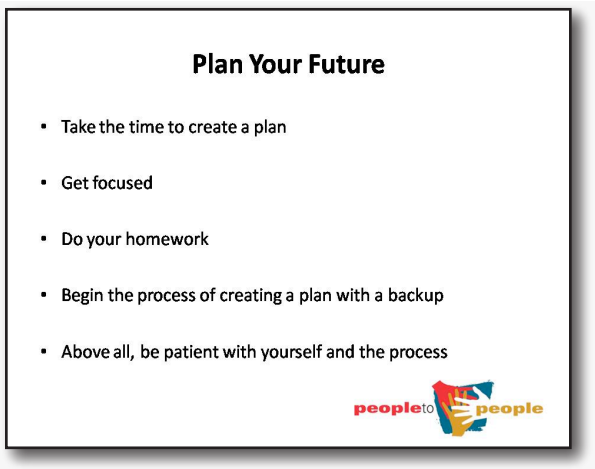
- What is your goal?
  - Supplementing your income
  - Testing your ability to work
  - Job that accommodates your medical needs
  - Resuming an old career
  - Finding a new career
  - Finding full time work
  - Improve your benefits portfolio

Determine Your Goal

- What's important to you
- Don't sell yourself short
- Some suggestions:
  - Have some fun with the process
  - Set your goals incrementally
  - Be bold, yet realistic

BENEFITS

SESSION HANDOUT (cont.)



CRISIS MODULE*

ABOUT THIS ACTIVITY

Time: 90 minutes

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

- Identify someone in crisis.
- Know how to respond to crisis.
- Help someone in crisis develop a safety plan.

In This Activity You Will…

- Facilitate a discussion of crisis situations (30 minutes).
- Conduct case study exercises in small groups (30 minutes).
- Debrief the case study exercise (30 minutes).

Materials:

- Handout – Crisis Intervention Case Studies
- Handout – National Suicide Prevention Lifeline
- Trainer Sheet - Crisis Intervention Case Studies – Possible Responses

Preparation:

- Print handouts

Instructions

1. Follow talking points below.

- Although the chance of having a crisis situation come up is rare, peer leaders have a moral obligation to assist their clients through mental health challenges. If you suspect that someone might be suicidal or homicidal, it is important to do something about it and not ignore it.

- Many persons living with HIV/AIDS have either attempted suicide or have had suicidal ideation. Thus, potential suicide may be the type of crisis you might encounter most as a peer leader.

- Often a decision to commit suicide is not a rational decision, so don't expect to have a rational discussion in which you talk a person out of it. Be supportive by letting the person know you care. Listen to them with respect. Do not make moral judgments. Don't challenge or dare a person to commit suicide thinking you will shock them out of the idea. The impulse to end it all may be temporarily overpowering, but does not last forever. The short term goal is ensure immediate safety. Often discussion of the feelings will help to deescalate the situation.

- This type of crisis is reportable and is the only instance in which confidentiality can be broken. Peer leaders should inform their clients early on in the relationship that this is the only time in which the organization is morally obligated to break confidentiality.

- Don't simply take it upon yourself to make the report. Your agency most likely has a policy about how to handle these situations and there might be a point person that handles this. Learn your agency's protocol and ALWAYS consult with your supervisor or program director.

* This module comes from Support Group Facilitation Training, JRI Health Peer Support Services, 2006.

- If you are doing peer work after hours, make sure you have your supervisor or point person's telephone number so that you can call on them for help. If after making these attempts you still can't locate anyone, then you should proceed by making the report yourself.
- It is extremely important that you have the local crisis team contact information handy at all times. Additionally, there is a national suicide prevention lifeline that you can call or have the client call. The contact information is in one of your handouts.

2. Pass out Lifeline handout.

- Be aware of the signs of potential suicide. Here are some common signs that someone may be suicidal:
  Direct or indirect statements about suicide, hopelessness or death.

  Final arrangements: A person may put their affairs in order, change a will, give away possessions, or talk vaguely of going away.

  Sudden elevated mood: Paradoxically, a depressed suicidal person may suddenly appear better after making a decision to end their life. A burden has been lifted, as they no longer have to agonize over the decision.

  Risk taking or self-destructive behavior: This may represent a death wish. In other words the person isn't ready to take their own life but tempts fate by taking an extreme risks.

- If someone indicates that he/she has a history of suicide attempts, has the intent to harm him/herself, and has a lethal plan, it is necessary to take the threat seriously and follow your agency's protocol.

- Contrary to popular belief, you are not putting ideas into the persons head if you ask them about suicide. Bringing the subject out into the open and discussing it is one of the most helpful things you can do. It is normal to have suicidal thoughts when faced with a life threatening disease.

- Develop a safety plan:
  Encourage the person to seek assistance from their doctor/therapist/case manager for potential mental health assessment and treatment

- Ask direct questions: This enables you to assess the potential suicide:

  What thoughts do you have about hurting yourself?
  Have you tried to hurt yourself in the past?
  How do you think that you are going to act on these feelings?
  What ways have you thought about hurting yourself?

- Have the person promise you verbally or in writing that they won't hurt themselves for X amount of time (until a check-in with the crisis team or suicide prevention lifeline). Having the promise be set for a specified amount of time is achievable in many cases. Build into the plan an agreement that the person will call for help if they do not feel they can keep this promise. Check ins from you and other professionals in your agency can be helpful. This also shows the person that someone cares about them enough to check in.

3. Tell participants to break out into 4 small groups and discuss the case study assigned to their group; they will have 30 minutes to do this.

4. Have each group select someone to record responses to

All I do is cry. Really, I thought I was going crazy. Finally, someone who gets it and understands.

Client of a
WORLD Peer

the accompanying questions on newsprint, and someone to be a spokesperson to report out to the larger group.

5. Assign case studies and go around the room during the exercise to assist with questions and support the small group process.

6. Have each group take a turn reporting out to the larger group.

Summary

Wrap up session.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from Support Group Facilitation Training, JRI Health Peer Support Services, 2006.

CRISIS INTERVENTION CASE STUDIES

Case Study 1

John has been HIV positive for nearly 10 years. He has been your client for about a year. In the past year, his partner died and John has had to leave his job and go on disability due to his own health issues. He reports that although he struggles with depression periodically, he doesn't consider himself depressed and wouldn't do anything to harm himself. He states that he understands why people consider suicide, though.

1. What are some ways that you could respond?

2. How can you be supportive in this situation?

3. What issues should you make sure are addressed?

4. What planning steps may be helpful?

Case Study 2

Vincent tested positive for HIV just three weeks ago, and was referred to you immediately. During the first encounter with you he was very quiet. Today, however, he has been much more talkative, speaking of how difficult it has been for him to accept his diagnosis. He says to you, "I don't think I am going to be able to deal with this. I can't tell my family or friends and I think that I might have infected my partner. I feel so horrible I don't think I can take it anymore. I have been having thoughts of hurting myself – is this normal?"

1. What are some ways you can respond?

2. What are things that should be covered in this discussion?

3. How would you plan to follow up?

SESSION HANDOUT #1 of 3 (cont.)

CRISIS INTERVENTION CASE STUDIES (CONT.)

Case Study 3

Dana has been HIV positive for 14 years. She has had several opportunistic infections but lately her health has been stable. She brings up the fact that she is a member of an organization that supports the right to die for people with terminal illnesses. She mentions that she has had a store of enough medication to kill herself for several years now. She says it gives her comfort to know that she has that as an option, if her health worsens again. However, she states that she is not feeling that she would be using that option any time soon.

1. How might you respond?

2. What subjects might be discussed in the ensuing conversation?

3. What follow up, if any, is needed?

Case Study 4

Damon was diagnosed with HIV about 2 months ago. He has spoken on more than one occasion of being depressed and feeling hopeless. Today he seems as if he is carefree, and is much more animated than he has been in previous group meetings. He mentions that he knows how he would kill himself but quickly changes the subject. He tells that you may not see him anymore because he is going to be doing some traveling. When you ask where he is going, he responds, "Let's just say that I am going to much better place."

1. How might you respond?

2. What should the you make sure is addressed in the ensuing discussion?

3. What should be included in the follow-up plan?

CRISIS INTERVENTION CASE STUDIES – POSSIBLE RESPONSES

Case Study 1 - John

Possible responses:
- Sounds like John believes in the right to die on his own terms; therefore, he's not suicidal
- Assure him that is normal to have these feelings and that they are very common with people who are newly diagnosed
- Although John doesn't sound serious about suicide, you may want to check it out
- Ask direct questions: "Have you had thoughts of hurting yourself? Do you think that you might act on these feelings?" If there is substantial reason to believe that John might attempt suicide, proceed to making a safety plan as discussed earlier

If you determine that John is serious about suicide:
- Encourage John to seek assistance from family, friends, or professionals with whom he is currently involved.
- John may also be in need of support services, meals on wheels, home health care. A referral for these and other services should be offered.
- Discuss how recent events might be exacerbating his depression and that these issues will not always be so intense over time.
- John may still be grieving the recent loss of his partner. Talking about grief and loss and sharing your own experience of grief and loss can be helpful and communicates to him that he is not alone.
- Also, ask him: "How have you dealt with depression in the past? What helped you?" Whatever worked in the past may work in the present.

Case Study 2 - Vincent

Possible responses:
- Ask Vincent: "What thoughts do you have about hurting yourself? Do you think that you are going to act on these feelings? If you have reason to believe he might attempt suicide, then proceed to making a safety plan
- Assure Vincent that is normal to have these feelings and that they are very common with people who are newly diagnosed
- Explain that even though things are feeling very intense right now, it will not always be that way
- Vincent may benefit from joining a newly diagnosed support group; offer a supported referral
- Here a self disclosure of any experience you've had with suicidal feelings and how you dealt with it could be appropriate. Make sure that the sharing does not shift the focus away from Vincent's feelings
- Provide national suicide prevention hotline and/or other local crisis hotline
- Other referrals include mental health services and case management. Follow your agency's policy on making referrals

SESSION HANDOUT #2 of 3 (cont.)

CRISIS INTERVENTION CASE STUDIES – POSSIBLE RESPONSES (CONT.)

Case Study 3 - Dana

Possible responses:

- This may not actually be a suicidal case but simply the belief in rational suicide and right to die issues
- Ask direct questions: "What thoughts do you have about hurting yourself? Do you think that you are going to act on these feelings? If you have reason to believe she might attempt suicide, then proceed to making a safety plan using the same strategies used in the previous 2 case studies.

Case Study 4 - Damon

Possible responses:

- Damon is showing signs of potential suicide, e.g. pre-suicide statements, vaguely talking about going away, sudden elevated mood
- Ask direct questions: "What thoughts do you have about hurting yourself? Do you think that you are going to act on these feelings? If you have reason to believe he might attempt suicide, then proceed to making a safety plan
- Notify supervisor, program director of other point person
- Encourage Damon to seek assistance from family, friends, or professionals with whom he is currently involved.
- Give him the national suicide prevention lifeline telephone number and/or local crisis hotline

SESSION HANDOUT #3 of 3

NATIONAL SUICIDE
PREVENTION LIFELINE

1-800-273-TALK

(In Spanish: 1-888-628-9454)

WWW.SUICIDEPREVENTIONLIFELINE.ORG

Continuing Education

DOCUMENTING OUR EFFORTS: GROUP DISCUSSION & PRACTICE*

ABOUT THIS ACTIVITY

Time: 40 minutes

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

- Defined reasons for documenting our efforts.
- Discussed ways to communicate interactions with outreach peers.
- Reviewed Peer Education Training Site (PETS) documentation forms.

In This Activity You Will…

- Facilitate a discussion about the purposes and importance of documentation (15 minutes).
- Walk through a scenario and work with peers to document findings (25 minutes).

Materials:

- Handout- Documentation Scenario
- Handout- Educator Clinical Notes (one for each participant)
- Blank flipchart
- Markers

Preparation:

- Identify a peer volunteer to read the scenario.

Instructions

1. Ask what the purpose of documentation is. Record responses on the flipchart sheet. Make sure the list includes the following:

- To communicate with team members
- To record and evaluate progress
- To determine what works and what doesn't
- For billing purposes
- To remember what is being worked on
- To document that it happened

2. Explain the importance of documentation for PETS purposes.

- Documentation is very important. You have mentioned some positive things about it, and also some problems.
- Peer Educators work closely with other health care providers to provide the best care. As Peer Educators, you will be responsible for documenting each contact you have with the peers you work with.
- In many health care disciplines, they say, "if you didn't write it down, it didn't happen." It is very important to make a brief note every time you have an interaction with a peer for future reference.

3. Discuss the essential components of documentation, record on a flipchart sheet.

- Documentation is different from other kinds of writing, like journals or letters. What are your ideas about how a chart or clinical notes should be written? [Make sure the list includes the following:]
- Include "just the facts" (objective)
- Describe behaviors, not opinions
- Keep it simple and succinct (K.I.S.S.)
- Note critical information, like the person has thoughts of suicide or death.
- Avoid judgmental terms
- Avoid descriptions of illegal or other activities that could affect

* This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

insurance coverage
- Write notes immediately after seeing patient
- Record what is necessary to know as opposed to "nice to know"

4. Introduce the key "rules" for documentation

- Unless your clinic says otherwise, there are some general guidelines about documentation. [Elicit group feedback about this. Record on a flipchart. The list should include the following:]
- Write neatly, legibly
- Use black ink
- If there is an error, don't use white out. Write a single line through the error and add your initials and the date above.
- Use only agency approved abbreviations
- Except for professionals, no other person's name should be included. You can use. "Joe's boyfriend."
- Complete the records in a timely manner

5. Introduce PETS documentation forms.

- Clinics often have their own forms and protocol for filling them out. If the clinic or organization where you're working has their own form, then you should use those. However, many organizations don't have specific forms, so let's create a good sample note together that might be helpful to you in the future. Please take out your peer educator clinical notes handouts.

- Let's use the documentation scenario to practice writing a note. Will someone be willing to read the scenario? Using our PETS documentation, let's write a progress note together.

6. Following the peer educator clinical notes handout, go through the scenario with participants. Record details from the scenario on a flipchart.

Summary

Wrap up session.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit. This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

DOCUMENTING OUR EFFORTS: GROUP DISCUSSION & PRACTICE

SESSION HANDOUT #1 of 2

DOCUMENTATION SCENARIO

Jane Doe has come to the clinic only twice but seems eager to follow a medication regimen. She had a high viral load at the first visit and was started on her first regimen after her second visit. She has now missed two appointments and her health care provider is concerned that she may be lost to follow up at a time when her viral load was already high. He also tells you that Jane has a history of drug use, and that he suspects that she may be using at this time.

You contact Ms. Doe and she agrees to meet you at her home which, at the time, is a motel. When you are invited in, she tells you that she is living with her husband in the motel because they have not been able to find housing or afford the initial deposits. You notice that Ms. Doe has a bruise over her cheek and that she seems withdrawn. After you have introduced yourself and asked Ms. Doe if you can talk about her health, she agrees and tells you that her husband wants to be a part of her health care decisions. During your conversation, Ms. Doe says that her husband questions why she has to take all her medicines when they make her sick. She also tells you she is now pregnant and that she and her husband think that the medicines will hurt the baby.

There are a number of knocks on the door as you are talking to Ms. Doe. As you talk to her, you recognize that Ms. Doe seems to like you. When you tell her that you are a peer and are also HIV+, she tries to talk more.

DOCUMENTING OUR EFFORTS: GROUP DISCUSSION & PRACTICE

SESSION HANDOUT #2 of 2

Patient Name:_____

Medical Record Number: _____

PEER EDUCATOR CLINICAL NOTES

Date: _____ Length of session: _____ minutes

Setting: _____ (i.e. home, clinic, other)

Referred by:_____

Reason:_____

Today we discussed the following issues (check all that apply):

_____ How things are going in general.
_____ Treatment plan (a plan that patient and provider agreed upon to manage HIV infection).
_____ How patient has been taking care of self (check all that apply):

Adequate Self Care	Area of Concern	Addressed in Session
Exercise		
Nutrition		
Body image		
Rest		
Faith or spirituality		
Disclosure		
Relaxation or recreation		
Social support		
Substance abuse (ex: drugs, alcohol, tobacco)		
Safer sex practices.		
Keeping appointments		
Medication adherence		

DOCUMENTING OUR EFFORTS: GROUP DISCUSSION & PRACTICE

SESSION HANDOUT #2 of 2 (cont.)

Patient Name:_____

Medical Record Number: _____

The patient identified the following strengths s/he can draw on:

I assisted the patient in developing the following action plan:

Actions to take:

I made the following referrals for assistance:

Suggested topics/issues to address during the next session with the patient:

Signature of Peer Educator: _____ Date:_____

Continuing Education

MOTIVATIONAL INTERVIEWING SKILLS*

ABOUT THIS ACTIVITY

Time: 65 minutes

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

- Assist clients in increasing motivation toward positive change

In This Activity You Will…

- Review the basic skills of motivational interviewing (20 minutes)
- Facilitate groups of 3 to conduct 3 role plays each (40 minutes)
- Summarize and transition to the next activity (5 minutes)

Materials:

- Handout – OARS+E: The Basic Skills of Motivational Interviewing
- Handout – Open-Ended Questions and Affirmations
- Handout – Reflective Listening
- Handout – Summarizing
- Handout – Eliciting Change Talk
- Handout – Scenarios

(continued next page)

Instructions

1. Distribute the following five handouts:
- *"OARS +E: The Basic Skills of Motivational Interviewing"*
- *"Open-Ended Questions and Affirmations"*
- *"Reflective Listening"*
- *"Summarizing"*
- *"Eliciting Change Talk"*

2. Describe these five key skills one at a time, and then review the examples provided on the handouts. Note that first four skills are focused on a client-centered approach, and the fifth, "Eliciting Change Talk", describes the directive nature of motivational interviewing. Spend as much time as is needed to ensure that participants are thoroughly familiar with them. Reinforce how these skills, along with the four principles of motivational interviewing, may be used to diminish resistance and promote motivation to change.

   Important: Be sure to note that, although these are the foundational skills, they are not the only skills used to enhance motivation. It is also appropriate at times to ask closed-ended questions, change the focus, provide information, state an opinion, give advice when requested, and so forth.

3. Divide the participants into groups of three. Assign a specific role to each person in the working groups: the peer who is conducting the interview, the client being interviewed, and an observer.

4. Ask the "clients" to select a scenario from the box and read it. They should not reveal the scenario ahead of time to the persons in either the peer or observer roles.

5. The persons in the peer role begin by asking an open-ended question, such as "How might I be of help?" or "What brings you here today?" The person in the client role should create a personal story around the scenario. The peer's goal is to use the skills to understand the client's situation, thoughts, and feelings. Allow about eight to ten minutes for each interview.

* This module comes from A Kaleidoscope of Care: Responding to the Challenges of HIV and Substance Use, 2004, http://www.hdwg.org/kaleidoscope

ABOUT THIS ACTIVITY (CONT.)

Preparation:

- Print out, fold and place the scenarios below in a box for the training session.
- Write the discussion questions on newsprint:

For the client:
How did it feel to be interviewed with these techniques? Did they feel heard? What techniques worked best for them? What techniques didn't work as well?

For the observer:
What examples of the four principles and the methods did the provider use during the interview?

For the peer:
Which techniques worked best for them? What was the most challenging aspect of the micro-skills approach?

TRAINING TIP

Be sure to note that, although these are the foundational skills, they are not the only skills used to enhance motivation. It is also appropriate at times to ask closed-ended questions, change the focus, provide information, state an opinion, give advice when requested, and so forth. training session.

6. The job of persons in the observer role is to jot down examples of the peer's use of the five techniques – open-ended questions, affirmations, reflective listening at various levels, summarizing, and eliciting change talk.

7. After each role-play, the three participants should debrief for about four minutes around the discussion questions listed on the newsprint.

8. If possible, ask each working group to repeat the role-play twice more using different scenarios so that each participant has an opportunity to play all three roles.

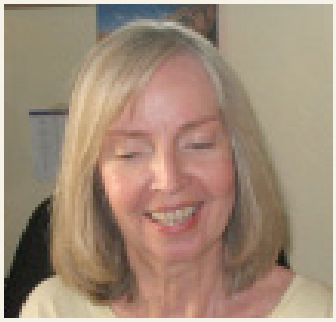
Summary

There are five specific methods that are useful throughout the process of motivational interviewing. The first four, Open questions, Affirmations, Reflective listening, and Summarizing, are derived largely from client-centered counseling. In motivational interviewing they are used to explore ambivalence and clarify reasons for change. The fifth method, Eliciting change talk, is more clearly directive and is specific to motivational interviewing. It integrates and guides the use of the other four methods.

At the end of the activity, thank the group for their willingness to practice these skills. Encourage them to learn more about approaches to enhance motivation and to continue practicing these core skills in their work

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from A Kaleidoscope of Care: Responding to the Challenges of HIV and Substance Use, 2004, http://www.hdwg.org/kaleidoscope

MOTIVATIONAL INTERVIEWING SKILLS



…. Ask open-ended questions. For example, if they tell you that they feel bad because their family doesn't accept them because they are HIV + , if you say "Does that make you feel bad?" you'll get "yes", but if you ask "How does that make you feel when your family has that attitude?" it opens up the dialogue.

Carol Garcia
Peer at Christie's Place
San Diego, CA

Optional Materials

- TV and VCR
- "Motivational Interviewing Tape C: Handling Resistance," recorded in 1998 by William R. Miller and Stephen Rollnick, and directed by Theresa B. Moyers. This videotape can be ordered at the following website:

  http://www.motivationalinterview.org/training/miorderform.pdf

Instructor Notes

1. Preview all or part of the videotape cited above.
2. To find the segment of the tape to be shown during this activity, fast-forward approximately 32 minutes into the tape to a 15-minute section entitled: "Case Example: Responding to Resistance." In this part of the tape, the interviewer (woman sitting on the right) effectively demonstrates the use of basic motivational interviewing skills with a client who is reluctant to address his substance use problem (middle-aged man wearing vertically striped shirt).

SESSION HANDOUT #1 of 6

OARS+E: THE BASIC SKILLS OF MOTIVATIONAL INTERVIEWING

The motivational interviewing approach is a way of being with clients. It is not only what you do, but how you do it that is important.

There are five methods that are useful throughout the process of motivational interviewing. The first four, summarized by the acronym OARS (Open questions, Affirmations, Reflective listening, and Summarizing), come from client-centered counseling. In motivational interviewing they are used to explore ambivalence (uncertainty) and clarify reasons for change.

The fifth method, Eliciting change talk (+E), is more directive. It integrates and guides the use of the other four methods.

Although these five methods appear simple, they are not always easy to use. They require considerable practice. Peers must think about how to incorporate them into their practice. The reward is that these methods can help clients move in the direction of positive change.

This handout was adapted from Motivational Interviewing (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

SESSION HANDOUT #2 of 6

OPEN-ENDED QUESTIONS AND AFFIRMATIONS

Open-Ended Questions

Open-ended questions encourage people to talk about whatever is important to them. They help peers build a relationship, gather information, and increase understanding. Open-ended questions ask for more information about the subject. Closed-ended questions are the opposite, they are questions which require only a limited response, such as "yes" or "no" and they provide only a limited increase to the knowledge of the interviewer.

Open-ended questions invite people to tell their own stories in their own words from their own points of view. Their answers reveal a richness of content that goes far beyond mere facts and allows the listener to hear "what makes the person tick." Open-ended questions should be used frequently in conversation with clients.

The example below shows the difference between an open-ended and a closed-ended question. Notice that, although the questions focus on the same topic, the second question is more likely to bring about a detailed response.
- Did you have a good relationship with your parents?
- What was your relationship with your parents like?

Here are a few more examples of open-ended questions:
- Would you tell me more about . . . ?
- Would you help me understand . . . ?
- How would you like things to be different?
- What are the positive things and what are the less good things about . . . ?
- What do you think you will lose if you give up . . . ?
- What have you tried before?
- What do you want to do next?

Affirmations

Affirmations are statements and gestures that recognize a people's strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations help to build people's confidence in their ability to change. To be effective, affirmations must always be genuine and congruent.

Examples of affirmations:
- I am really impressed with the way you . . .
- That's great how you've reached your goal of cutting back on your drug use.
- Using protection shows that you have real respect for yourself and your partners.
- I was hoping I would have the opportunity to meet with you again.
- You have a quite a gift for . . .

* This handout was adapted from motivational interviewing materials developed by David B. Rosengren, and from Motivational Interviewing (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

SESSION HANDOUT #3 of 6

REFLECTIVE LISTENING

"Listening looks easy, but it's not simple. Every head is a world." Cuban proverb

Reflective listening is an important skill. It is the path to engage clients in a relationship, build trust, and help motivate people to change. Reflective listening appears easy, but it takes hard work and skill to do well.

To listen reflectively, you need to learn to think reflectively. This way of thinking shows an interest in what people say and respect for their inner wisdom.

What you think the person means may not be what they really mean. Listening may break down in any of the three ways listed below:
- The speaker does not say what is meant.
- The listener does not hear correctly.
- The listener gives a different interpretation to what the words mean.

Reflective listening helps close the loop in communication to ensure that breakdowns don't occur. The listener's voice turns down at the end of a reflective listening statement. This helps to clarify things and leads to greater exploration. Some people find it helpful to use some standard phrases like the following:
- "So you feel . . ."
- "It sounds like you . . ."
- "You're wondering if . . ."

There are different ways that reflective listening can increase the level of intimacy:
1. Repeating: The listener repeats phrases, staying close to what the speaker has said.
2. Paraphrasing: The listener uses different words to say the same thing as the speaker, asking if this is what the speaker meant.
3. Reflecting feeling: The listener emphasizes emotional aspects of communication through statements that express feelings; this is the deepest form of listening.

Before I can start educating anyone I have to counsel, I have to listen.

Fred Glick
Peer at Truman Medical Center
Kansas City, MO

This handout was adapted from motivational interviewing materials developed by David B. Rosengren, and from Motivational Interviewing (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

SUMMARIZING

Summaries are special applications of reflective listening. Although they can be used throughout a conversation, they are particularly helpful at transition points. For example, summaries are often helpful after someone has finished speaking about a particular topic or recounted a personal experience or when an appointment is coming to an end. Summarizing helps to ensure that there is clear communication between the speaker and listener. It can also provide a stepping-stone toward change.

Structure of Summaries

Begin with a statement indicating that you are making a summary. For example:
- "Let me see if I understand so far . . ."
- "Here is what I've heard. Tell me if I've missed anything . . ."

Give special attention to what are known as "change statements." These are statements that a person makes that point toward a willingness to change. There are four types of change statements, all of which overlap:
- Problem recognition: "My use has gotten a little out of hand at times."
- Concern: "If I don't stop, something bad is going to happen."
- Intent to change: "I'm going to do something, I'm just not sure what it is yet."
- Optimism: "I know I can get a handle on this problem."

If the person expresses ambivalence, it is useful to express both sides of their ambivalence in the summary statement. For example, "On the one hand, it seems that . . . while on the other hand, it sounds like . . ."

It is acceptable to include information in summary statements from other sources, such as your clinical knowledge, research, courts, or family.

Be brief.

End summary statements with an invitation. For example:
- "Did I miss anything?"
- "If that's accurate, what other points are there to consider?"
- "Is there anything you want to add or correct?"

Depending on the person's response to your summary statement, it may lead naturally to planning for or taking concrete steps toward the change goal.

This handout was adapted from motivational interviewing materials developed by David B. Rosengren, and from Motivational Interviewing (2nd edition) by William Miller and Stephen Rollnick, published in 2002 by Guilford Publications, New York.

ELICITING CHANGE TALK

Eliciting change talk is a direct strategy for resolving ambivalence (uncertainty). If you only use open questions, affirmations, reflective listening, and summarizing, it is possible for the client to remain stuck in uncertainty. The idea is to have the peer help the client engage in change talk, that is, for the client to present the arguments for change.

Four Categories of Change Talk

- Recognizing disadvantages of the status quo
  "I guess this is more serious that I thought."
- Recognizing advantages of change
  "I'd probably feel a lot better."
- Expressing optimism about change
  "I think I could probably do that if I decided to."
- Expressing intention to change
  "I've got do something."

Methods for Evoking Change Talk

- Asking evocative questions
  "What worries you about your current situation?"
- Using the importance ruler (also use regarding client's confidence to change)
  "How important would you say it is for you to_____? On a scale of 0 to 10, where 0 is not at all important and 10 is extremely important, where would you say you are?"

0	1	2	3	4	5	6	7	8	9	10
Not at all important										Extremely important

- Exploring the decisional balance
  "What do you like about your present pattern?" "What concerns you about it?"
- Elaborating
  "What else?" Ask for clarification, an example, or to describe the last time this occurred.
- Questioning extremes
  "What concerns you most about? What are the best results you could imagine if you made a change?"
- Looking back
  "What were things like before you? What has changed?"
- Looking forward
  "How would you like things to be different a year/three years from now?"
- Exploring goals and values
  "What things are most important to you?"

(Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002, The Guilford Press)

SESSION HANDOUT #6 of 6

SCENARIOS

You are a 17-year-old, homeless Caucasian youth who has tested positive for HIV. To survive, you make money by having sex, usually unprotected, with various regular customers.

You are a young Latino woman who is in early pregnancy and is infected with HIV. You are afraid to see your doctor, because you are ashamed of your HIV status.

You are a 50-year-old African American man who is infected with HIV. You have remained drug-free for the three months since you successfully completed a long-term residential treatment program for your heroin addiction. You report that you've recently been having intense cravings to use again.

You are an immigrant man in your thirties from West Africa. You recently tested positive for HIV. You don't believe that you could possibly be infected, and you refuse to discuss it with anyone.

You are a formerly homeless Native American woman in your early forties living with HIV. You've recently found permanent housing, but it seems to be more of a problem than a solution. You report that you feel walled in, that you don't like being alone, and that people are constantly knocking on your door trying to sell you drugs that threaten your recovery. You report feeling more and more depressed and are considering moving out. You say you were happier living on the streets.

You are a 29-year-old Caucasian woman who is infected with HIV. You are trying to regain custody of your two young children. You recently moved into clean-and-sober transitional housing after successfully completing in-patient treatment for polysubstance use. You tell your provider in confidence that you've been drinking and using crack occasionally, but you are not doing any of that "other stuff." You report that you only use on the weekends when you are away from the transitional housing facility.

You are a man in your thirties who is infected with HIV. A few months ago you were released from prison after serving a lengthy sentence for multiple drug-related offenses. You are currently on parole with the requirement that you not use drugs. For the first month after release you went back to smoking crack almost every day, but now report feeling very proud that you've been able to cut back to smoking crack only on weekends.

(Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002, The Guilford Press)

MOTIVATIONAL INTERVIEWING SKILLS

SESSION HANDOUT #6 of 6 (cont.)

You are a 28-year-old Latino male who has tested positive for HIV. You probably contracted the virus by having anonymous unprotected sex with men at gay sex clubs. You are married with a child and do not consider yourself to be homosexual. You are afraid to disclose your HIV status to your family.

You are a 25-year-old woman who is involved in a long-term abusive relationship with a partner who is infected with HIV and uses injection drugs. You are quite concerned that you might also test positive for HIV, but your partner refuses to let you get tested or seek medical help. Your partner says in a dismissing manner, "What you don't know won't hurt you."

NAMING STIGMA THROUGH PICTURES*

ABOUT THIS ACTIVITY

Time: 60 minutes

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

- Identify different forms of stigma in different contexts;
- Describe how stigma affects people with HIV.

In This Activity You Will…

- Break into small groups and discuss pictures (10 minutes).
- Report back to the large group (20 minutes).
- Conduct a full group role play (30 minutes).

Materials:

- Handout - Stigma Pictures
- Flipchart

Preparation: None

Instructions

1. Picture discussion

- Divide into groups of 2-3 people.
- Ask each group to select one of the pictures.
- Ask them to discuss: "What do you see in the picture? How does this picture show stigma?"

2. Report back

- Put up one picture at a time and ask the group to present their analysis.
- Record points on flipchart.
- One other recorder should make a running list of common issues, which should be presented at the end.

Man seated all alone on a bed (A)
No one is caring for him. Utensils under bed – shows that people are not sharing utensils with him. Looks lonely and worried – seems to have lost all hope.

Parents pushing pregnant daughter out of house (B)
Unwanted pregnancy. Is she HIV positive? Maybe she will get abortion, drop out of school, or become a sex worker to survive.

Woman sitting all alone crying (C)
Maybe she has just learned that she is HIV positive and people are rejecting her. Depressed, hopeless, anxious. No one to share her problems with.

Sick man in bed with children visiting (D)
Looks depressed. Worried about future for his children once he dies. His children look worried – they don't know what to do if their father dies.

* This module comes from Support Group Facilitation Training, JRI Health Peer Support Services, 2006.

NAMING STIGMA THROUGH PICTURES

> *I learned to accept myself and not be ashamed.*
>
> Graduate of the
> Lotus Training Program

3. Summarize as follows:

- Effects: PLHA feeling isolated, rejected, condemned, forgotten, useless, kicked out of family, house, work, rented accommodation, organization, etc. Drop out of school (resulting from peer pressure – insults), depression, suicide, alcoholism not accessing services, not taking advantage of opportunities, social withdrawal.

Forms of stigma:

- Internal and external stigma
- Isolation, insults, judging, blaming
- Self-stigma – PLHA blaming and isolating themselves stigma by association – whole family affected by stigma by looks/ appearance/type or occupation.

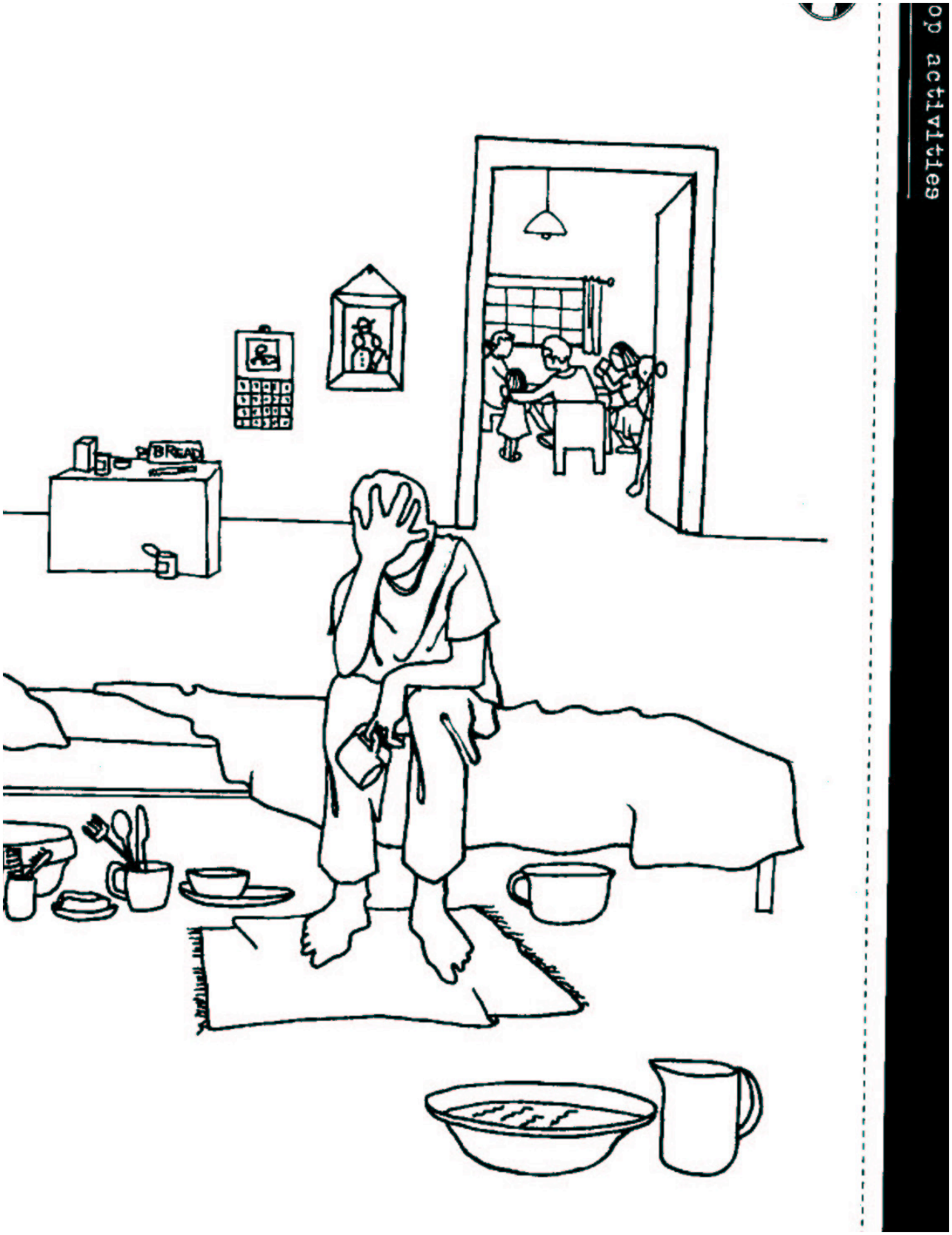
Summary

Wrap up session.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from Support Group Facilitation Training, JRI Health Peer Support Services, 2006.

NAMING STIGMA THROUGH PICTURES

SESSION HANDOUT



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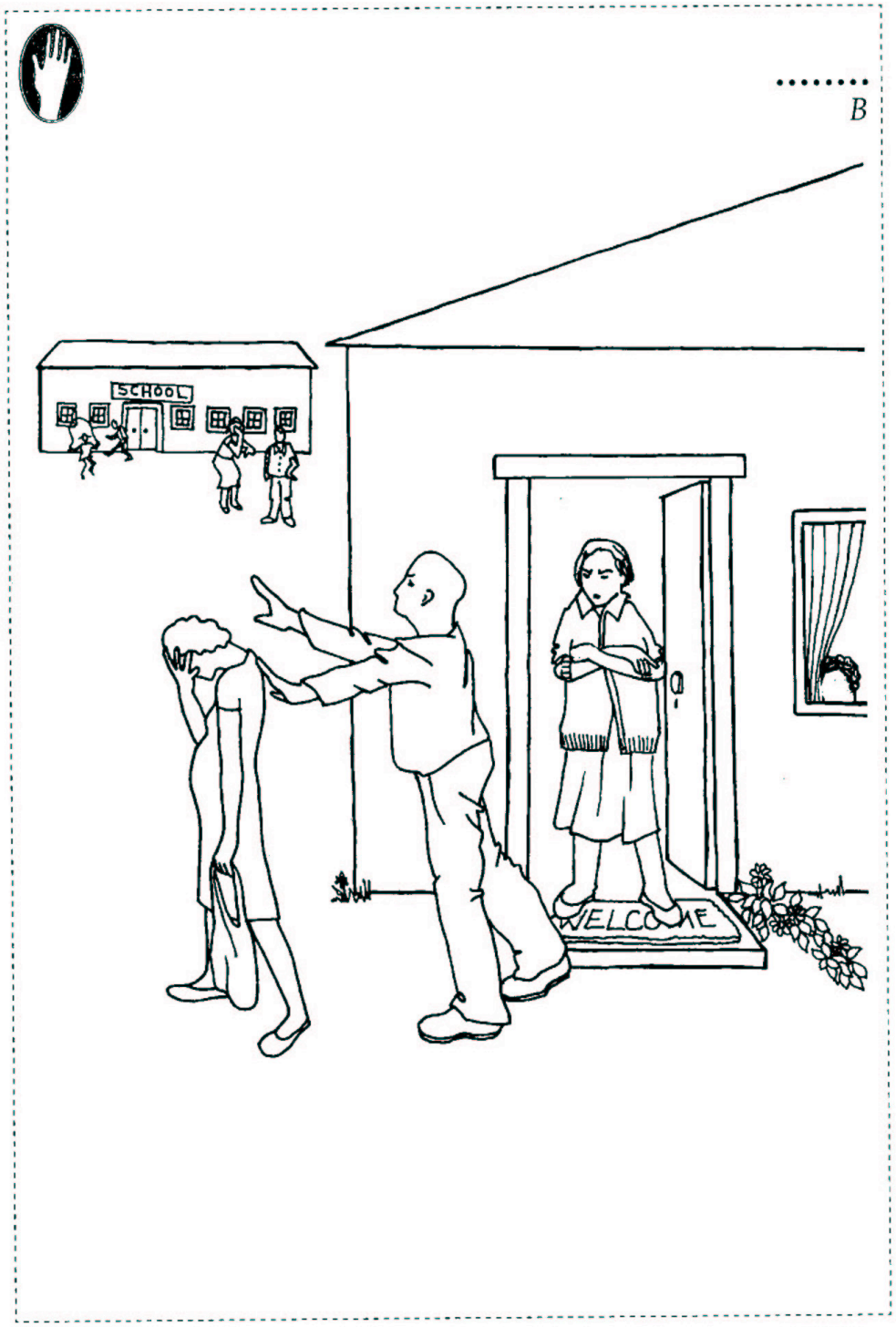
NAMING STIGMA THROUGH PICTURES

SESSION HANDOUT (cont.)

Resource pack - To reduce stigma related to HIV and AIDS



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NAMING STIGMA THROUGH PICTURES

SESSION HANDOUT (cont.)

SESSION HANDOUT (cont.)

Resource pack - To reduce stigma related to HIV and AIDS

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Continuing Education

ORIENTATION TO CLINICAL PRACTICUM*

ABOUT THIS ACTIVITY

Time: 40 minutes

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

- Have had an opportunity to critique a rapport-building role play.

In This Activity You Will…

- Review communication skills (5 minutes).
- Facilitate two roles plays and a discussion (25 minutes).
- Review the Clinical Practicum Checklist (10 minutes).

Materials:

- Handout-Helpful Communication Techniques
- Handout-Roadblocks to Communication
- Handout-Peer Educator Clinical Practicum Checklist
- Handout-Rapport Building/Clinic Introduction Role Plays

Preparation: None

Instructions

1. Begin with a review of communication skills. Review the communication skills handouts.

2. Trainers and PETS staff should demonstrate how to start a peer session by performing the two role plays at the end of this section.

3. Review and discuss Peer Educator Clinical Practicum Checklist.

Summary

Wrap up session.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

SESSION HANDOUT # 1 of 4

HELPFUL COMMUNICATION TECHNIQUES

1. Using silence	
2. Accepting	Yes. Um Humm.
3. Giving recognition	It is difficult to talk with someone you don't know. Hello Jane, we've talked before.
4. Offering self	I'll be here till 3:00. I'm interested in what you have to say.
5. Giving broad openings	Is there something you'd like to talk about? Where would you like to begin?
6. Offering general leads	Go on. And then? Tell me about it.
7. Placing the event in time or in sequence	When did this happen? Was this before or after…?
8. Making observations	Your voice sounds shaky when you talk about… It makes me feel uncomfortable when you…
9. Encouraging descriptions of perceptions	Tell me when you feel anxious. What does he do when he "gets ugly"?
10. Encouraging comparison	Was this something like…? Have you had similar experiences?
11. Restating (especially useful when you can't identify the feeling)	"My lawyer doesn't believe me when I say he hit me when I was pregnant." Your lawyer doesn't believe your story.
12. Focusing	This point seems worth looking into.
13. Exploring	Tell me more about…
14. Giving information	This line is answered 24 hours a day. My purpose in being here is...
15. Seeking clarification	I'm not sure I follow. What would you say is the main point of what you've said?

ROADBLOCKS TO COMMUNICATION: COMMUNICATION STOPPERS

1. **Directing, ordering:** To tell someone to do something in a manner that gives the other person little or no choice.
2. **Warning, threatening:** To tell the other person that if the behavior continues, then certain consequences will happen.
3. **Moralizing, preaching**: To tell someone things they ought to do.
4. **Persuading, arguing:** To try to influence another person with facts, information, and logic.
5. **Advising, recommending:** To provide answers to a problem.
6. **Evaluating, criticizing:** To make a negative interpretation of someone's behavior.
7. **Praising:** To make a positive evaluation of someone's behavior.
8. **Supporting, sympathizing:** To try to talk the other person out of his or her feelings, or to deny someone's feelings.
9. **Diagnosing:** To analyze the other person's behavior and communicate that you have their behavior figured out.
10. **Diverting, bypassing:** To change the subject or not talk about the problem presented by the other person.
11. **Kidding, teasing**: To try to avoid talking about the problem by laughing or by distracting the other person.
12. **One-upmanship:** To try to "top" the persons problems by telling a worse one
13. **Killer Phrases**: For example, "Don't worry, things could be worse." "Cheer up." "What do you have to feel sorry about?"

PEER EDUCATOR CLINICAL PRACTICUM CHECKLIST

Name: _____
Date: _____

Before session begins, clinician should give input on what peer educator should discuss with the patient.

Establishes Rapport

_____ Greets patient.
_____ Introduces self and explains role.
_____ Explains purpose of session.
_____ Explains confidentiality and privacy.

Assesses Patient

_____ Checks in with patient by asking how things are going in general.
_____ Asks patient if s/he has a treatment plan (a plan that patient and provider agreed upon in order to manage HIV infection).
- If no, asks what his/her provider discussed about medications.
- If yes, asks what's been going well and what's been challenging.

_____ Asks patient how s/he has been doing in regards to adhering to medical appointments.
_____ Asks patient how s/he has been doing taking care of self:
- Exercise: "What are you doing for exercise?"
- Nutrition: "How's your diet?"
- Rest: "Are you getting enough rest?"
- Recreation or play: "What do you for fun?"
- Social support: "Who can you talk to when you need support?

_____ Asks patient how s/he has been doing with safer sex practices.
_____ Asks patient how s/he has been doing with avoiding substances that are harmful (e.g., drugs, tobacco).
_____ Assess patient's strengths: "What's going really well in your life?"
_____ Asks patient what other concerns s/he has at this time.

SESSION HANDOUT # 3 of 4 (cont.)

PEER EDUCATOR CLINICAL PRACTICUM CHECKLIST (CONT.)

Advises Patient

_____ Briefly summarizes information in session
_____ Selects one or two issues peer can help patient with (e.g., adherence, referrals, safer sex issues, etc.)
_____ Assists client in developing an action plan in a nondirective manner.
_____ Offers assistance if appropriate.
_____ Works with clinician to make necessary referrals.

Reports Back to Mentor after Patient Leaves

_____ "What was your assessment of this patient?
_____ What did you learn about the patient?
- Their strengths?
- Their needs?

_____ What communication skills did you observe or use that were particularly effective?
_____ What might you have done differently?
_____ What other questions do you have about the session?

RAPPORT-BUILDING/CLINIC INTRODUCTION ROLE PLAYS

#1—Poor Communication

Roles:
Peer Educator: Mary Brown
Patient/Peer: Carmen Baker

Facilitator: Mary Brown works as a peer educator at the Mountain AIDS Alliance Clinic. Carmen Baker is an HIV + peer, making her first visit to the clinic. Carmen enters the clinic consultation room.

Mary: (Mary is wearing a baseball cap or is dressed in another inappropriate manner. She speaks without making eye contact or smiling; doesn't shake hands or greet Carmen). So, what can we do for you today?

Carmen: Umm, well, I came in to talk to someone about some problems I've been having.

Mary: Lord I know about problems! My phone was turned off this morning and I got a flat tire on the way to work! But what's going on with you?

Carmen: Well, I'm in this new relationship and things have gotten serious, and I just wanted to talk about…umm…you know, my options?

Mary: Are you using condoms?

Carmen: Well, no…I actually wanted to talk about other options. You see----

Mary: (interrupts) There really are no other options. For safer sex, you really should use condoms every time you have sex to protect your partner.

Carmen: You don't understand—my partner is a woman.

Mary: Oh. Well I guess that does change things. Sorry about that. There are some things you can use for safe sex like dental damns and---

Carmen: Umm, well...have to go. I have to be at work soon.

Mary: Well thanks for coming in. I'm sorry you had to cut your visit short. Hey, I'll walk out with you. I need a smoke anyway.

RAPPORT-BUILDING/CLINIC INTRODUCTION ROLE PLAYS (CONT.)

Facilitator: What are some things you noticed about this interaction?

Responses may include one or more of the following:

- No handshake
- No smile, eye contact
- Doesn't introduce herself
- Doesn't explain the peer educator's role
- Peer educator assumed peer was having sex with a man
- PE immediately jumped into "safer" sex talk instead of listening to peer's needs
- Peer educator had on a baseball cap—she could have looked more professional
- PE mentioned "going out for a smoke"
  - o Why would this be bad? (setting a poor example, unprofessional, etc.)

#2—Effective Communication

Mary: (Mary is dressed professionally. She walks up to Carmen; shakes her hand; smiles; touches her arm, etc.). Hi Carmen. I'm Mary Brown, a peer educator at the clinic. We are so glad you came in today. How are things going?

Carmen: Pretty good.

Mary: Glad to hear it! I've really been looking forward to talking with you and trying to help out anyway that I am able. As I mentioned, I'm a peer educator. This means, that like you, I'm HIV +. I'm here to listen to your issues and answer questions you have about the disease, services you may need, staying adherent to your medications and other issues related to HIV. If I am unable to answer your questions, I will find someone who can help us.

Carmen: That sounds interesting. Usually, I talk to my doctor or case manager when I have a problem, but my case manager has moved to another state and my doctor is so busy all the time.

Mary: Well, you came to the right place then. Let's talk about what's going on and see what we can do to help. You mentioned your case manager has moved—is that one of the things you need help with?

Carmen: Yes, actually. I am without a case manager now and I'm having trouble with some of my social services. She always helped me sort through all the paper work—I can't read very well.

RAPPORT-BUILDING/CLINIC INTRODUCTION ROLE PLAYS (CONT.)

Mary: We can certainly help you with that. We'll help you get set up with a new case manager, but in the mean time, maybe I can help you read through your paper work if you brought that with you.

Carmen: That would be great.

Mary: What other things did you want to talk about today?

Facilitator: For the purposes of our demonstration, we'll stop here. Later this week, you'll work with role plays in more detail.

What were some things you noticed about the interaction this time?

Responses may include one or more of the following:

- PE greeted peer with a smile, handshake (or touched her on the arm)
  What do people think about "touching" a peer on the arm or back? (take responses and facilitate a brief discussion on how touch isn't always a good thing—refer to different cultures.)
- PE introduced herself
- PE explained her role in detail
- PE explained that if she couldn't help peer accomplish, she'd find someone who could

STIGMA*

ABOUT THIS ACTIVITY

Time: 30 minutes

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

- Define key terms associated with stigma development.
- Discuss differences between key terms associated with stigma development.
- Identify the relationship between HIV/AIDS stigma and barriers to HIV/AIDS services.
- Discuss the disparities in access to HIV/AIDS services and care experienced by racial/ethnic minorities.

In This Activity You Will…

- Share definitions with group (15 minutes).
- Lead a group discussion about impact stigma has on access to care (10 minutes).
- Lead a group discussion to summarize (5 minutes).

Materials:

- Key terms
- Laptop and projector with screen or blank wall
- Powerpoint slides

Preparation:

- Set up Powerpoint presentation

Instructions

1. Read all 5 key term words and the official definitions of the key terms from power point. (Optional - facilitator can give more examples). Continue through remaining talking points.

Key Terms:

- Stereotype
- Prejudice
- Racism
- Bias
- Stigma

Talking Points (PowerPoint Slides)

Stereotype

A belief that all members of a group possess the same characteristics or traits exhibited by some members of that group.

Prejudice

Preconceived judgment of members of a certain race, ethnicity, gender, religion, or group.

Racism

Discrimination or mistreatment of an individual due to their belonging to a particular race or ethnic group.

Bias

A strong inclination of the mind or a preconceived opinion about something or someone. Prevents objective thought of an issue or consideration.

* This module comes from the Missouri People to People Training Manual, 2008.

STIGMA

Stigma

Negative feelings, beliefs, and behavior directed toward an individual or group due to a particular label or characteristic.

The Formation of Stigma Stereotypes

The creation of stigma is the result of existing stereotypes, prejudice, biases, and other forms of oppression in our society directed at individuals and/or groups.

HIV/AIDS Stigma: Impact on Access to Services and Care

Stigma Impacts:

- Counseling and Testing – a person is less likely to seek HIV testing in environments where he/she perceive workers to be judgmental about sexual and drug use behavior.
- Access to care – individuals who exhibit concerns about stigma are more likely to delay care and/or not adhere to care.
- Disclosure of Status - the decision to reveal one's HIV status is associated with a person's level of comfort; the more accepting, caring and nonjudgmental a social network is towards HIV, the more likely to disclose
- Health disparities- The impact of Racial/Ethnic health disparities among communities of color when accessing HIV/AIDS services

Countering Stigma

1. Multi-level Interventions
- Women of color
- Gay
- MSM of color
- Community at large

2. Interventions
- Individual level
- Community level

3. Reduction Methods
- Information dissemination
- Counseling
- Coping skills
- Contact with those affected

3. Ask the following questions and facilitate group discussion.

Discussion Questions:

- How does stigma affect access to care for persons living with HIV/AIDS?
- How can one make an impact on stigma?
- Can you identify stigma in your workplace or community?
- How can one educate the community or workplace about the negative impact that stigma has on people?

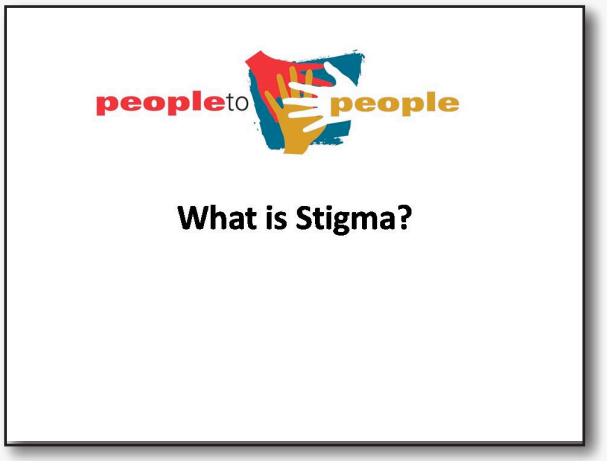
Summary

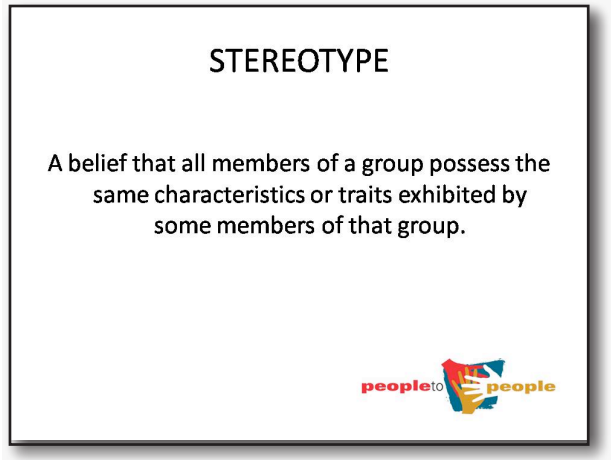
In closing organizations and communities need to be educated about the negative impact that stigma has on our communities. Stigma promotes isolation, creates despair, widens the ethnic divide in our communities with a "me versus you" mentality and promotes social injustice in our society.

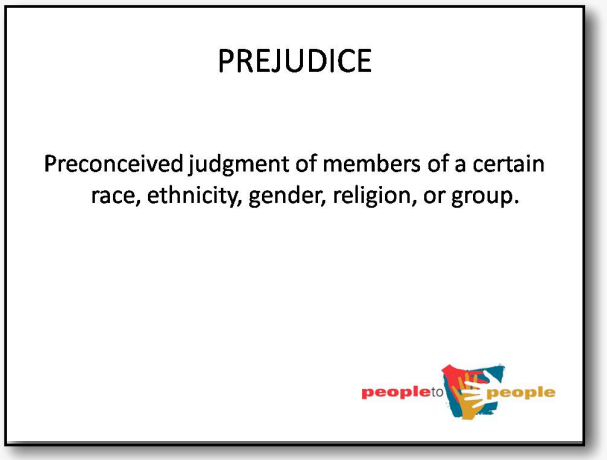
* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from the Missouri People to People Training Manual, 2008.

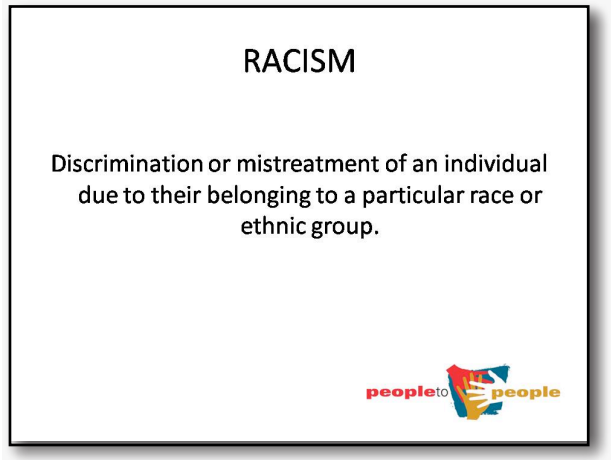
STIGMA

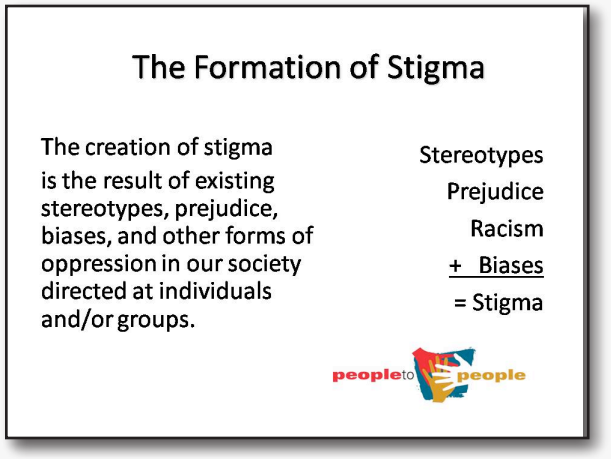
SESSION POWERPOINT





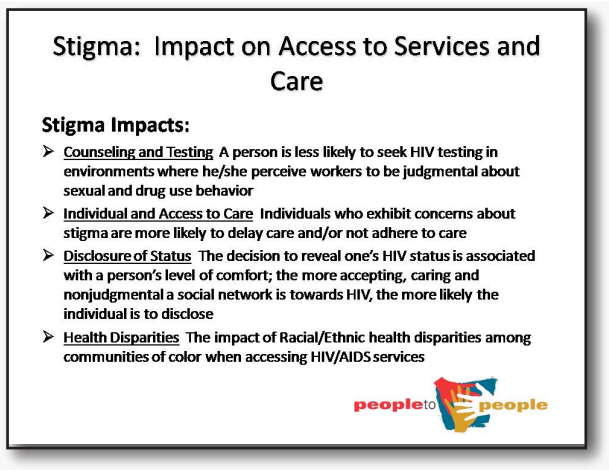


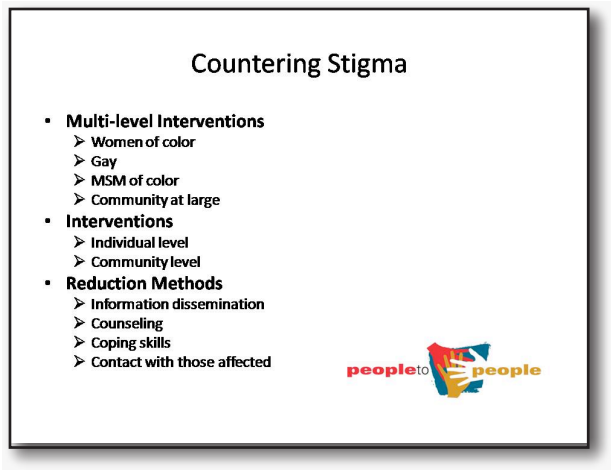




STIGMA

SESSION POWERPOINT (cont.)





SUBSTANCE ABUSE*

ABOUT THIS ACTIVITY

Time: 60 minutes

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

- Understand the difference between substance use, abuse and addiction.
- Understand the impact substances have on HIV.

In This Activity You Will…

- Conduct a brainstorm on the differences between substance use, abuse and addiction (10 minutes).
- Facilitate small group activity on use, abuse and addiction (20 minutes).
- Facilitate skits on use, abuse and addiction and process discussion (30 minutes).

Materials:

- Markers
- Flip chart
- Color-coded break up method
- Handout – Use/Abuse/Addiction Activities List
- Handout- 3 Substance Abuse Cards (1 category per color -should match the group)
- Answer Key – Use/Abuse/Addiction Activities List -- KEY
- Flipchart – Substance Abuse Continuum

(continued next page)

Instructions

1. Introduce topic of substance use and abuse.

- When I say "substance abuse," what kind of substances do you think of?

2. Give participants the opportunity to respond and list on flip chart.

- Substances include marijuana, cocaine, heroin, inhalants, methamphetamine, alcohol, tobacco, steroids, caffeine and other psychoactive drugs.

- Prescription drugs can also be abused. Some of these substances are legal while others are illegal. They may include: oxycontin, methadone, morphine, valium, xanax, dilaudide.

- Alcohol, drugs and some prescription drugs like pain medications can change the way we feel – usually in a short period of time. What are some of the reasons someone might drink or use drugs to change their feelings? [Note to trainer: offer more responses if necessary. Other responses may include the following:

- Celebrate, party
- Reduce stress
- Improve appetite
- Sleep
- Feel more comfortable socializing
- Overcome hang-ups/fears about having sex
- Forget bad memories/experiences
- "Self medicate" depression
- cope with stress
- control anger
- keep from "jonesing", going into withdrawal

- Not everyone who uses drugs or alcohol are substance abusers. Substance use occurs on a continuum.

* This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

SUBSTANCE ABUSE

ABOUT THIS ACTIVITY (CONT.)

Preparation:

- Prepare Substance Abuse Continuum Flipchart
- Prepare Substance Abuse Cards
- Print handouts

- Recreational/Social Use -> Misuse/Abuse -> Addiction

- Many people can drink alcohol or use recreational drugs from time to time without any problems. These are recreational/social "users."

- Abuse is when you develop a pattern of drug or alcohol use. It can be compared to a new romance: It feels good— euphoric— you look forward to the next time; it takes up a lot of your attention and thoughts. But it also takes your focus away from important activities like work, family and taking care of yourself.

- Addiction is when the drug "takes over the person." They use regularly and it takes more to get as high. It becomes everything: their lover, best friend, confidant, family. The drug, not the person, is in control. The drug becomes more important than children, lovers, work, self-respect and health. Addicts often "chase the high;" they want to feel as good as "the first time, but they can't. Instead of euphoria, they use to escape pain and feel "normal." Even though there it causes a lot of problems, it has become the only coping method. Quitting may seem impossible.

- During addiction, some drugs cause "physical dependence. At this stage, people "jones" or go into withdrawal without regular use. Examples include opiates, like heroin, methadone, oxycontin. Without proper detox, many relapse because they can't stand it. Unlike opiates, withdrawal from alcohol and tranquilizers can be life threatening. If someone is drinking or taking these pills daily, it is urgent that you get them evaluated. Severe symptoms include DTs, seizures, and hallucination. Other health conditions, like hypertension, can exacerbate the problem.

- Now we're going to do an activity to help you better understand the difference between social/recreational use, abuse and addiction.

3. Social/Recreation Use – Abuse – Addiction 2-part activity.
4. Divide group into 3 groups. Explain PART 1 of the activity.

- This activity has 2 parts. After you have completed part 1, then

you will receive instructions for part 2. Note: Only complete PART 2 if there is time.

- PART 1: On the Use/Abuse/Addiction Activities List handout, you will see 15 scenarios or behaviors. As a group, you are to determine which category that behavior fits into—Recreational Use, Abuse, or Addiction—and discuss what excludes that behavior from the other categories. There will be a trainer/facilitator in the group with you to participate in the discussion and go over your answers. **Note: the trainer will have the answer key.**

5. Bring attention to the larger group for processing.

6. Ask group if they were surprised at any of the answers.

- Now that we've talked about the difference along the substance use continuum, what are some of the reasons you think people abuse substances?

Some answers might include:
- Hereditary or genetic – people with family members with addiction problems are more likely to inherit it.
- Environment – living conditions – living in neighborhoods where there is a lot of substance use, poverty, hopelessness.
- Undiagnosed or untreated mental illness, such as depression.
- Substance is a substitute for a condition or behavior that people desire – for example sleep, appetite.

7. Explain PART 2 of the activity.

- PART 2: Each group will present information to the rest of the class. The facilitator has been given a card with instructions for your group to follow during your presentation. Based on your presentation, the rest of the class will guess which category you are reporting on.

8. Allow each group to present their skit.

9. Allow the rest of the class to guess the category then discuss.

10. Ask group for their thoughts on how substance abuse impacts the immune system. Take a few responses and lead into mini-lecture.

- Substance abuse compromises the immune system and makes it harder for the body to suppress the virus and use the medicine that you are taking to boost your immune system.

- Some street drugs interact with medication. The liver breaks down medications used to fight HIV. Protease inhibitors and non-nucleoside reverse transcriptase inhibitors in particular are metabolized by the liver. It also breaks down recreational drugs, including alcohol. When drugs and medications are both "in line" to use the liver, they might both be processed much more slowly. This can lead to a serious overdose of the medication or of the recreational drug. An overdose of a medication can cause more serious side effects. An overdose of a recreational drug can be deadly.

- We know that it's very important to take every dose of anti-HIV medication. When we take all our doses, it's called being adherent. Drug use is linked with poor adherence and can lead to treatment failure.

- Missing doses can cause higher levels of HIV in the blood and can result in resistance to the very HIV medications that someone is taking to help fight the disease. Since there are only a certain number of anti-HIV medications, resistance to one or more of them limits what can be done to fight the virus.

11. Ask if there are any remaining questions or thoughts about substance use and abuse.

Summary

- Many people can drink alcohol or use recreational drugs from time to time and not have a problem. Others cannot use drugs or alcohol without abusing them, and addicts who abuse drugs and alcohol regularly can create serious problems for their health and others.

- In order for us to help and educate others, it's important to remember the circumstances that contribute to people using substances. What are some risks with lecturing others about substance abuse? Answers might include the following:
  Alienating your audience
  Causing your audience to miss the take home message
  It is important to understand the issues surrounding substance use, abuse and addiction.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

SESSION HANDOUT # 1 of 2

USE/ABUSE/ADDICTION ACTIVITIES LIST

Social/Recreational Use	Misuse/Abuse	Addiction

1. Lost your job due to a series of absences because you were too hung-over to work
2. Kids went to foster care because you were out buying crack on the Child Protective Worker's last 3 visits
3. Took a drink to stop arms from shaking
4. Drank wine at a family reunion
5. Drinking causes you to be late to work, school, other appointments
6. Stopped by a friend's house and s/he invites you to smoke a joint
7. Sold your mother's car to buy heroin
8. Spent paycheck on drugs
9. Drank a few beers at a holiday party
10. Lost your keys after taking ecstasy at a bar
11. Smoke pot 1x/day to keep your appetite up
12. Got a DWI
13. Take double doses of pain medications to feel better emotionally
14. Blacked out the night before using a combination of crank and alcohol
15. Drink 6 beers about 4x/week

SESSION ANSWER KEY

USE/ABUSE/ADDICTION ACTIVITIES LIST- ANSWER KEY

Social/Recreational Use	Misuse/Abuse	Addiction
Drank wine at a family reunion	Drinking causes you to be late to work, school, other appointments	Lost your job due to a series of absences because you were too hung-over to work
Stopped by a friend's house and s/he invites you to smoke a joint	Lost your keys after taking ecstasy at a bar	Sold your mother's car to buy heroin
Drank a few beers at a holiday party	Blacked out the night before using a combination of crank and alcohol	Kids went to foster care because you were out buying crack on the Child Protective Worker's last 3 visits
	Got a DWI	Took a drink to stop arms from shaking
	Smoke pot 1x/day to keep your appetite up	Spent paycheck on drugs
	Take double doses of pain medications to feel better emotionally	
	Drink 6 beers about 4x/week	

SUBSTANCE ABUSE

SESSION HANDOUT # 2 of 2

MISUSE/ABUSE

Group Instructions:

1. Create a skit using the scenario below to display the above category. Based on your skit, the rest of the class should be able to determine your substance abuse category.

2. Your skit should demonstrate:
• What Misuse/Abuse looks like;
• How it may affect possible transmission or re-infection of an STD/HIV

Scenario:

You went to a party with a friend. You had a few mixed drinks, but felt no side-effects. You were asked to try ecstasy by someone that you were attracted to and you did. This was the first time that you used it. The next morning, you woke up in bed together. You remember the entire night and had a great time.

SESSION HANDOUT # 2 of 2 (cont.)

ADDICTION

Group Instructions:

1. Create a skit using the scenario below to display the above category. Based on your skit, the rest of the class should be able to determine your substance abuse category.

2. Your skit should demonstrate:
• What addiction looks like;
• How it may affect possible transmission or re-infection of an STD/HIV

Scenario:

After your car accident 6 months ago, you were prescribed oxycontin for pain. You took your pills everyday for 4 months. When you went back to the doctor for a check-up, you lied and told him that you needed more pills because your pain was still severe, though you were not having had pain at all. After that prescription ran out, you decided to stop but experienced withdrawal. A few days later you stole the oxycodin pills from your partner's brother who has cancer.

SESSION HANDOUT # 2 of 2 (cont.)

RECREATIONAL/SOCIAL USE

Group Instructions:

1. Create a skit using the scenario below to display the above category. Based on your skit, the rest of the class should be able to determine your substance abuse category.

2. Your skit should demonstrate:
- What recreational/social use looks like;
- How it may affect possible transmission or re-infection of an STD/HIV

Scenario:

Every 1st Friday of the month there is a huge party at a local club. When you go with your friends, you tend to buy a few drinks for yourself and then drink whatever others purchase for you. By the time you head home you are usually pretty wasted. That is the only time you drink alcohol during the month.

FEMALE REPRODUCTIVE SYSTEM*

ABOUT THIS ACTIVITY

Time: 25-30 minutes

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

- Describe the stages of the female reproductive system;
- Identify different areas of the female reproductive system.

In This Activity You Will…

- Lead a discussion about the stages of female reproductive system (5 minutes)
- Ask participants to pair up and fill in blank diagrams (5 minutes)
- Conduct lecturette/discussion about the female reproductive system (15 - 20 minutes)

Materials:

- Handouts – Female Reproductive System
- Handout – Menstruation, Menopause, HIV (can be downloaded from http://www.hivlawandpolicy.org/resources/view/294)
- Handout – 4 Essential Stages of Female Reproduction
- Trainer Sheet - Definitions

Preparation:

- Print handouts

Instructions

1. Start off by asking participants: how many holes do we have down there (by down there, we mean female reproductive system)?

2. Talk about how many holes we have down there…vagina, urethra, and anus.

   Explain that the clitoris is not a hole. Nothing can go into it and nothing can come out of it. It is an area that is connected to lots of nerves which, when aroused, create sensation.

3. Pass out 4 Essential Stages of Female Reproduction handout. Explain to the group that the female body goes through 4 essential stages. Ask them what these changes are and what happens at each.

a. Puberty- age 8-13; develop breasts, hormones, pubic hair; menstruation begins

b. Reproduction – Puberty till age 45; pregnancy can happen

c. Perimenopause – age 40-60 (last 2 years or so); time right before menopause where body is getting low on hormone production, irregular periods, hot flashes, night sweats, mood swings, dry vagina and other side effects can occur.

d. Menopause – average age 45 or when full hysterectomy is performed; menstruation ends; pregnancy cannot occur; body stops producing estrogen

4. Ask the group to take a few minutes to complete the blank diagrams of the female reproductive system, on the Female Reproductive System handouts. Work in pairs.

5. Review with the group the picture and process of the female reproductive system. Pass out remaining handout.

* This module comes from the Lotus Women's Peer Education Training Manual, Center for Health Training and Women Organized to Respond to Life Threatening Diseases (WORLD), 2008.

FEMALE REPRODUCTIVE SYSTEM

Review Female Reproductive System

1. Most women have two ovaries; one on each side of the uterus and are connected by fallopian tubes.

2. Our ovaries contain a set number of eggs. Ovaries at birth contain 300,000-400,000 follicles, which are balls of cells with an immature egg in the center. This is the maximum number of follicles a female will ever have. However, only approximately 400 of these eggs will actually mature and ovulate while the rest degenerate.

3. One by one, the eggs in a woman's ovaries get used up. When there are no more eggs, she does not have a period. This is called menopause. Once they run out, we cannot make anymore. Men (most) on the other hand can produce sperm until they are very old. Women can also damage or loose our eggs over our lifetime by drinking, smoking, substance abuse, medications such HIV medications, stress, cancer treatments and other health issues.

4. For women on a normal cycle, each month ONE egg is released by one of the ovaries. As soon as the egg is released, a lining of tissue and blood is also formed in the uterus.

5. The purpose of the lining is so that the woman can hold the baby in her womb if she were to get pregnant.

6. Ovarian Hormones are also released when the eggs is released.

Estrogen – Prepares the body for pregnancy. Secreted by the follicle and causes the following changes:

- Uterine lining thickens (endometrial cells multiply and "proliferate")
- Cervical secretions become slippery and nourish the sperm
- Cervix softens, lifts and opens
- Resting body temperature is low

Progesterone – Sustains pregnancy. Secreted by the corpus luteum and causes the following changes:

- Uterine lining thickens (endometrial cells grow and store nutrients to offer an appropriate condition for implantation of fertilized egg)
- Cervical secretions thicken to keep bacteria and other sperm out
- Cervix firms, lowers and closes
- Resting body temperature is higher

7. The egg travels through the fallopian tube. The egg takes approximately 2 weeks to travel from the ovary to the uterus. This period is called ovulation.

8. In a woman (with a fairly regular menstrual cycle), ovulation occurs in approximately 14-15 days before her next menstrual period is due. Some women do not have a regular cycle due to various changes in their lives, including emotional stress, drug use, HIV, etc. If you have an irregular cycle, ovulation will also be irregular and unpredictable.

9. Ovulation is the time that a woman is most likely to get pregnant. You can get pregnant if you have sex during or near the time of ovulation.

10. During sex, sperm are released into the vagina. They travel up through the cervix, through the uterus, and out up to the tubes.

11. Around the time of ovulation, there is thin mucus in the cervix that helps the sperm move.

12. If a sperm meets an egg in the tube, fertilization (the joining of egg and sperm) can occur. The fertilized egg then moves through the tube into the uterus and

becomes attached there to grow into a fetus.

13. If the egg and the sperm do not meet during the ovulation period, the egg is absorbed into the body and the lining in the uterus break apart and come out of the vaginal canal. This is called menstruation. Cramps, changes in mood, breast tenderness, etc may also result during this period due to menstruation.

14. In her period a woman may notice clumps as well as blood. The clumps are not blood clots. They are pieces of the tissue that was in the uterus lining. It is very normal to see these clumps.

15. If a woman has her "tubes tied", the sperm and egg cannot join to form a fetus but she will continue to have her periods.

16. If a man has a vasectomy, he cannot impregnate (get a woman pregnant) BUT he can still transmit STDS and HIV through the semen. Vasectomy is a simple procedure. It makes men sterile by keeping sperm (the reproductive cells in men) out of semen — the fluid that spurts from the penis during sex.

    Sperm are made in the testes. They pass through two tubes called the vasa deferentia to other glands and mix with seminal fluids to form semen. Vasectomy blocks each vas deferens and keeps sperm out of the seminal fluid. The sperm are absorbed by the body instead of being ejaculated. Without sperm, your "cum" (ejaculate) cannot cause pregnancy.

    Vasectomy does not affect masculinity. And it will not affect your ability to get hard and stay hard. It also will not affect your sex organs, sexuality, and sexual pleasure. No glands or organs are removed or altered. Your hormones and sperm continue being produced. Your ejaculate will look just like it always did. And there will be about as much of it as before.

17. Remember that pre-ejaculation or pre-cum can get a woman pregnant as well as transmit STDS and HIV.

18. A woman cannot get pregnant if the semen/sperm enters the woman's body through the mouth during oral sex BUT she can get certain STDs in her mouth as we will talk about in the next section.

19. Some women because of complications, cancer, diseases or even naturally have less eggs or no eggs at all in their ovaries. They women reach menopause at a much earlier age then what the age an average woman does at 40-60 years of age.

20. Some women for health and personal reasons may have a surgical procedure called a hysterectomy. There are several types of hysterectomies.

21. A complete hysterectomy is the removal of the uterus, cervix, fallopian tubes and ovaries leads to menopause.

22. A partial hysterectomy is the removal of the uterus and the cervix. A woman will continue to ovulate but will have no menstrual periods.

23. An oophorectomy is the removal of the ovaries and is usually done in connection with a hysterectomy.

Summary

Wrap up by reminding the group that they don't have to remember all of the terms discussed, they can refer to their handouts. What's most important is that they have a basic understanding of what the parts are, what they do, and how to take care of them.

* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit. This module comes from the Lotus Women's Peer Education Training Manual, Center for Health Training and Women Organized to Respond to Life Threatening Diseases (WORLD), 2008.

FEMALE REPRODUCTIVE SYSTEM

TRAINTER GUIDE # 1 of 1

DEFINITIONS

Vagina: The canal in the female is used for 3 purposes. It is used for sex, birthing (baby comes out of this canal) and menstrual period is released from the body through this canal.

Clitoris: The center of sexual arousal for women. The area is made of many nerves and it is sensitive to stimulation for the women. The clitoris is not a hole or an opening but an area with nerves.

Uterus: The pear-shaped female organ, which houses the fertilized egg and the developing fetus (baby). The uterus is also known as the "womb".

Cervix: The cervix is the base of the uterus. It is located at the end of the vagina. In the cervix thin mucus forms that help sperm travel through for the fertilization of the egg. The cervix is very sensitive to infection. This is also the area which the doctor checks (for infections) when doing a pap smear. The younger we are, the more sensitive the cervix is to developing infections.

Ovaries: The primary organ of the reproductive system. We have two ovaries which are sexual glands that hold our eggs. The ovaries also produce the female hormones estrogen and progesterone. Hormones provide essential signals and functions for the body to operate properly.

Egg: The female reproductive cell released by the ovaries, which after fertilization (meeting with the sperm) develops into the beginning of human life (a baby).

Fallopian tube: Tubes or branches connected to the uterus. After the egg is released by the ovaries it moves through the fallopian tube and then goes to the uterus.

Urethra: A canal that transfers urine from the bladder to the outside.

The G-Spot (Gafenberg spot): An area that has brought much controversy. The G-spot is located on the front wall of the vagina. It is described as being about the size of a small bean during its unaroused state and growing to the size of a dime during arousal. Stimulation may lead to orgasm and sometimes resulting in the ejaculation of a clear fluid from the urethra.

Anus: The opening of the large intestine that carries waste to the outside.

FEMALE REPRODUCTIVE SYSTEM

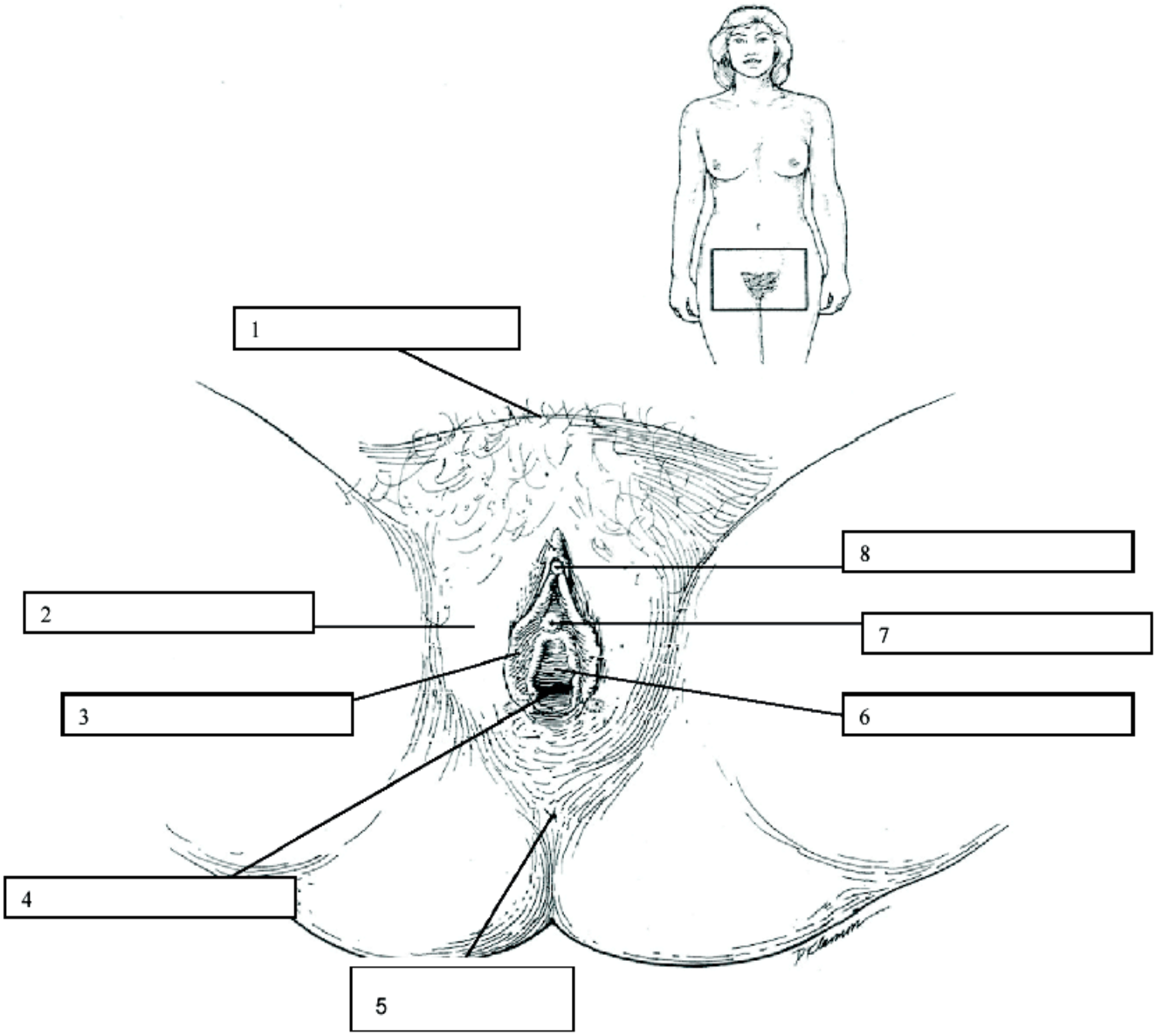
SESSION HANDOUT # 1 of 3

FEMALE REPRODUCTIVE SYSTEM

How many holes do we have down there (by down there, we mean female reproductive system)?

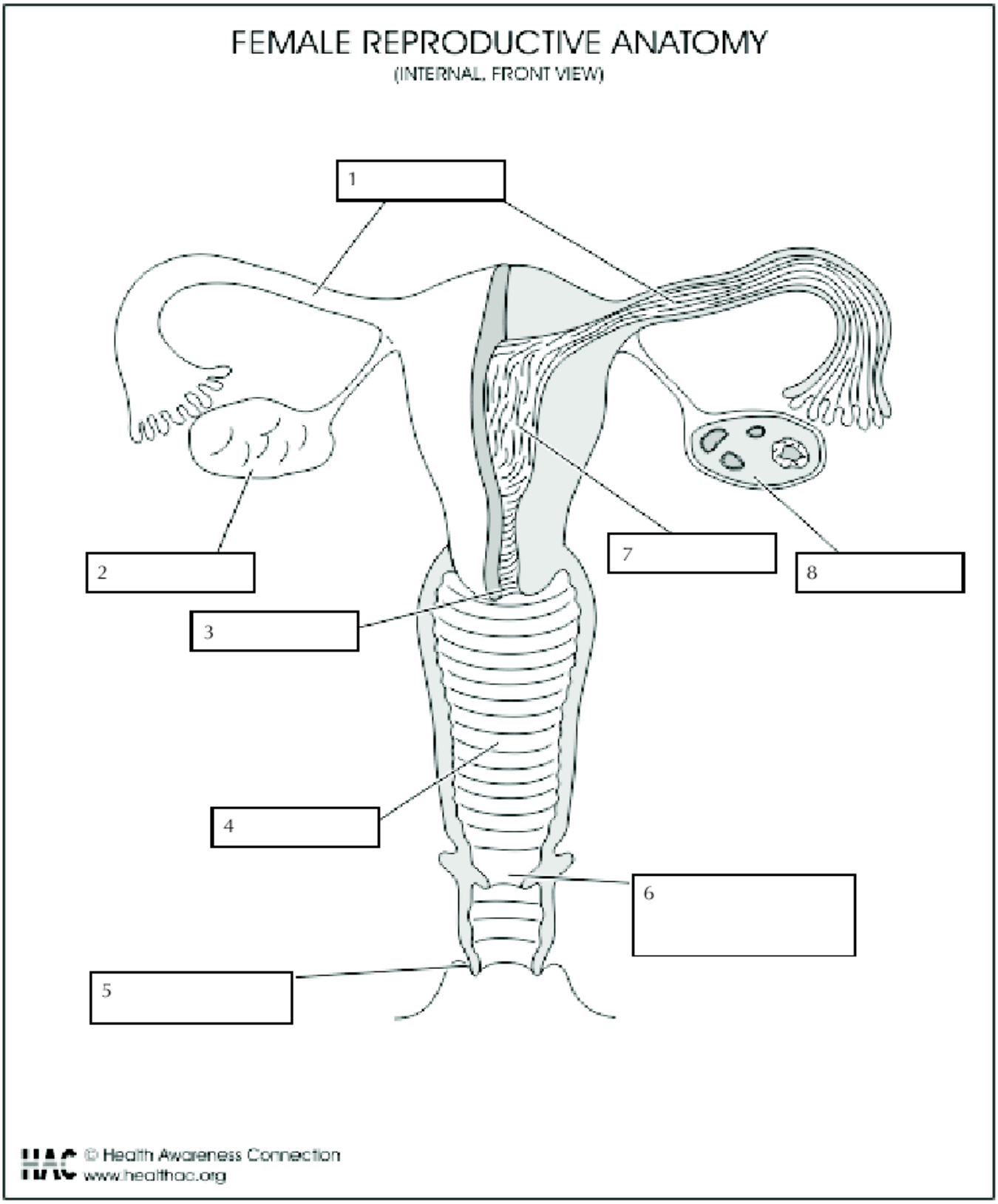
_____

Note: clitoris is not a hole. Nothing can go into it and nothing can come out of it. It is an area that is connected to lots of nerves which, when aroused, create sensation.



FEMALE REPRODUCTIVE SYSTEM

SESSION HANDOUT # 1 of 3 (cont.)



FEMALE REPRODUCTIVE SYSTEM

SESSION HANDOUT # 2 of 3

4 ESSENTIAL STAGES OF FEMALE REPRODUCTION

1. Puberty
2. Reproduction
3. Perimenopause
4. Menopause

What Happens During the 4 Stages

1. Most women have two ovaries; one on each side of the uterus and are connected by fallopian tubes.
2. Our ovaries contain a set number of eggs. Ovaries at birth contain 300,000-400,000 follicles, which are balls of cells with an immature egg in the center. This is the maximum number of follicles a female will ever have. However, only approximately 400 of these eggs will actually mature and ovulate while the rest degenerate.
3. One by one, the eggs in a woman's ovaries get used up. When there are no more eggs, she does not have a period. This is called menopause. Once they run out, we cannot make anymore. Men (most) on the other hand can produce sperm until they are very old. Women can also damage or loose our eggs over our lifetime by drinking, smoking, substance abuse, medications such HIV medications, stress, cancer treatments and other health issues.
4. For women on a normal cycle, each month ONE egg is released by one of the ovaries. As soon as the egg is released, a lining of tissue and blood is also formed in the uterus.
5. The purpose of the lining is so that the woman can hold the baby in her womb if she were to get pregnant.
6. Ovarian Hormones are also released when the eggs is released:

Estrogen – Prepares the body for pregnancy. Secreted by the follicle and causes the following changes:

- Uterine lining thickens (endometrial cells multiply and "proliferate")
- Cervical secretions become slippery and nourish the sperm
- Cervix softens, lifts and opens
- Resting body temperature is low

FEMALE REPRODUCTIVE SYSTEM

SESSION HANDOUT # 2 of 3 (cont.)

4 ESSENTIAL STAGES OF FEMALE REPRODUCTION (CONT.)

Progesterone – Sustains pregnancy. Secreted by the corpus luteum and causes the following changes:

- Uterine lining thickens (endometrial cells grow and store nutrients to offer an appropriate condition for implantation of fertilized egg)
- Cervical secretions thicken to keep bacteria and other sperm out
- Cervix firms, lowers and closes
- Resting body temperature is higher

7. The egg travels through the fallopian tube. The egg takes approximately 2 weeks to travel from the ovary to the uterus. This period is called ovulation.

8. In a woman (with a fairly regular menstrual cycle), ovulation occurs in approximately 14-15 days before her next menstrual period is due. Some women do not have a regular cycle due to various changes in their lives, including emotional stress, drug use, HIV, etc. If you have an irregular cycle, ovulation will also be irregular and unpredictable.

9. Ovulation is the time that a woman is most likely to get pregnant. You can get pregnant if you have sex during or near the time of ovulation.

10. During sex, sperm are released into the vagina. They travel up through the cervix, through the uterus, and out up to the tubes.

11. Around the time of ovulation, there is thin mucus in the cervix that helps the sperm move.

12. If a sperm meets an egg in the tube, fertilization (the joining of egg and sperm) can occur. The fertilized egg then moves through the tube into the uterus and becomes attached there to grow into a fetus.

13. If the egg and the sperm do not meet during the ovulation period, the egg is absorbed into the body and the lining in the uterus break apart and come out of the vaginal canal. This is called menstruation. Cramps, changes in mood, breast tenderness, etc may also result during this period due to menstruation.

14. In her period a woman may notice clumps as well as blood. The clumps are not blood clots. They are pieces of the tissue that was in the uterus lining. It is very normal to see these clumps.

15. If a woman has her “tubes tied”, the sperm and egg cannot join to form a fetus but she will continue to have her periods.

4 ESSENTIAL STAGES OF FEMALE REPRODUCTION (CONT.)

16. If a man has a vasectomy, he cannot impregnate (get a woman pregnant) BUT he can still transmit STDS and HIV through the semen. Vasectomy is a simple procedure. It makes men sterile by keeping sperm (the reproductive cells in men) out of semen —the fluid that spurts from the penis during sex.

    Sperm are made in the testes. They pass through two tubes called the vasa deferentia to other glands and mix with seminal fluids to form semen. Vasectomy blocks each vas deferens and keeps sperm out of the seminal fluid. The sperm are absorbed by the body instead of being ejaculated. Without sperm, your "cum" (ejaculate) cannot cause pregnancy.

    Vasectomy does not affect masculinity. And it will not affect your ability to get hard and stay hard. It also will not affect your sex organs, sexuality, and sexual pleasure. No glands or organs are removed or altered. Your hormones and sperm continue being produced. Your ejaculate will look just like it always did. And there will be about as much of it as before.

17. Remember that pre-ejaculation or pre-cum can get a woman pregnant as well as transmit STDS and HIV.

18. A woman cannot get pregnant if the semen/sperm enters the woman's body through the mouth during oral sex BUT she can get certain STDs in her mouth, as we will talk about in the next section.

19. Some women because of complications, cancer, diseases or even naturally have less eggs or no eggs at all in their ovaries. They women reach menopause at a much earlier age then what the age an average woman does at 40-60 years of age.

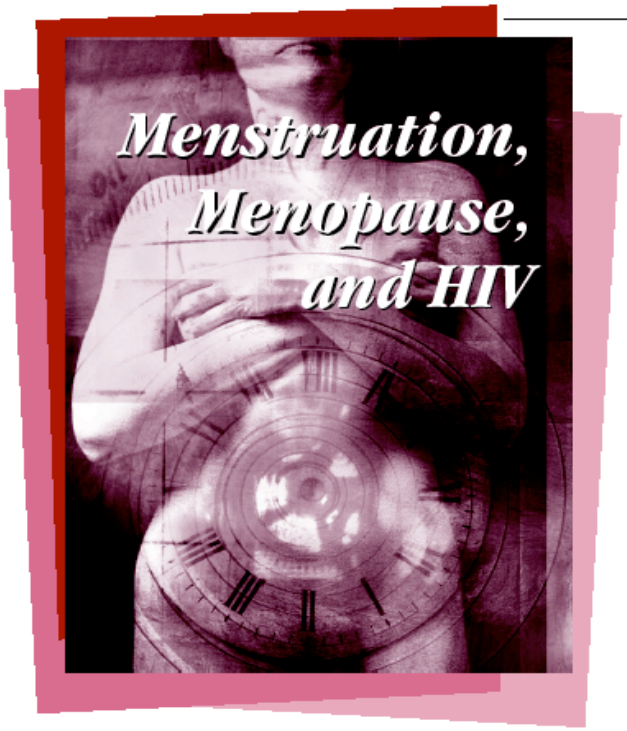
20. Some women for health and personal reasons may have a surgical procedure called a hysterectomy. There are several types of hysterectomies.

- A complete hysterectomy is the removal of the uterus, cervix, fallopian tubes and ovaries leads to menopause.

- A partial hysterectomy is the removal of the uterus and the cervix. A woman will continue to ovulate but will have no menstrual periods.

- An oophorectomy is the removal of the ovaries and is usually done in connection with a hysterectomy.

SESSION HANDOUT # 3 of 3



Anne Monroe, MD

There is a growing need for research about the effects of HIV on the menstrual cycle and menopause. HIV positive women and their care providers need to know what to expect at all life stages, and need strategies for optimal long-term care in the HAART era. Once the impact of HIV on menopause is better understood, clinical management can be individually tailored to avoid long-term complications such as osteoporosis and cardiovascular disease.

The Menstrual Cycle

There is a wide range of "normal" with regard to menstruation. A normal menstrual period ranges from two to six days, with an average length of four days. A mentrual cycle generally concludes in a period every 21 to 35 days, with an average loss of 40 mL of blood per period.

Normal menstruation is characterized by cyclic changes in the levels of hormones produced by the pituitary gland (luteinizing hormone [LH] and follicle stimulating hormone [FSH]) and by the ovaries (estrogen and progesterone). (See "HIV and Hormones" in the Summer 2004 issue of *BETA*.)

Menstrual irregularities are common in both HIV positive and HIV negative women. Amenorrhea is the absence of menstruation. Primary amenorrhea refers to a woman older than 16 years who has never menstruated, while secondary amenorrhea is the absence of menses for three to six months or longer in a woman who previously menstruated.

Menorrhagia refers to the loss of more than 80 mL of blood during each cycle of regular length, whereas dysfunctional uterine bleeding (DUB) is defined as loss of more than 80 mL of blood during irregular cycles; both menorrhagia and DUB may result in anemia, or reduced number of red blood cells. Dysmenorrhea refers to pain during menses, which may be a crampy discomfort with no underlying gynecologic condition, or may stem from endometriosis (growth of endometrium, or uterine lining tissue, outside of the uterus) or pelvic inflammatory disease (PID).

Many conditions can cause abnormal menstrual bleeding. Uterine fibroids may cause heavy or prolonged periods. Genital tract infections may cause abnormal bleeding, usually accompanied by other signs of infection, such as pain, vaginal discharge, or fever. Cancer in the genital tract (cervical cancer, endometrial cancer) may also cause bleeding. Other medical conditions, including thyroid abnormalities and low platelet counts, can interfere with regular menstrual cycles. Extreme

weight loss or being underweight can cause acquired gonadotropin releasing hormone deficiency, eliminating the stimulus for LH and FSH release and resulting in amenorrhea. Hormonal dysfunction that disrupts ovulation can also lead to abnormal bleeding, which may be more common in HIV positive women, although studies are inconclusive.

Use of drugs (including methadone) may interfere with hormonal regulation and cause abnormal bleeding. Some medications commonly used by HIV positive women, such as contraceptives and megestrol acetate (Megace), may also interfere with normal menstruation. Antiretroviral agents may also contribute to abnormal bleeding; for example, one case series reported heavy menstrual bleeding associated with full-dose ritonavir (Norvir) in a small sample of young women.

Menstrual Irregularities in Women with HIV

HIV positive women and their care providers should be aware of changes in the menstrual cycle that may be related to HIV and its treatment. Many studies have tried to sort out the effects of HIV on the menstrual cycle, with contradictory results. Much of the research on menstrual abnormalities in women with HIV/AIDS was conducted during the early years of the epidemic, when women more often had advanced disease accompanied by wasting. Menstrual irregularities in women on antiretroviral therapy with well-controlled HIV are less well understood.

In a study of the effect of HIV infection on menstrual cycle length, published in the May 2000 issue of the *Journal of Acquired Immune Deficiency Syndromes*, Sioban Harlow, PhD, and colleagues collected data from 802 HIV positive and 273 HIV negative women. The women completed monthly menstrual calendars and answered questions regarding antiretroviral therapy and recreational drug use. The researchers examined relationships between viral load and CD4 cell count and menstrual cycle length. Overall, HIV infection did not increase the likelihood of having a cycle longer than 40 days (i.e., a longer interval between periods). However, HIV positive women with more advanced immunosuppression (CD4 counts less than 200 cells/mm^3) were more likely to have long cycles. The researchers concluded that HIV serostatus had little effect on menstrual cycle length, and that other factors—for example, advanced disease, age, race, malnutrition, wasting, and substance use—were more important.

In an earlier study, Keith Chirgwin, MD, and colleagues evaluated 248 HIV positive and 82 demographically similar HIV negative women, and found that women with HIV were more likely to experience amenorrhea for more than three months and had intervals greater than six weeks between menstrual cycles. However, menstrual irregularities were not found to be significantly associated with HIV disease status in this study.

Tedd Ellerbrock, MD, and colleagues interviewed 197 HIV positive and 189 HIV negative women to assess the effect of HIV on menstruation. The researchers collected data retrospectively to identify trends in menstrual cycles over the previous year. The study found no major differences between the two groups, and no relationship between degree of immunosuppression and menstrual irregularities. However, the design of this study was not ideal, as it required that women recall characteristics

Tests for Diagnosing Menstrual Abnormalities

A full history and physical give the health-care practitioner clues to the underlying cause(s) of abnormal menstrual bleeding and directs all additional testing. These tests and screenings may include:

Blood tests

- Complete blood count (CBC) to screen for anemia, low platelet count
- Endocrine studies to check various hormone levels for abnormalities
- Coagulation studies to check blood clotting

Pelvic exam

- Collection of samples for sexually transmitted infection testing
- Pap smear to screen for cervical cancer
- Palpation of uterus and ovaries to check for abnormalities

Pelvic ultrasound (if indicated)

An ultrasound probe is inserted in the vagina to assess uterus size, presence of fibroids, thickness of the uterine lining, ovarian abnormalities, and presence of endometriosis.

Endometrial biopsy (if indicated)

A thin tube is inserted through the cervix into the uterus and samples from the endometrium (uterine lining) are collected to test for abnormalities, such as inflammation or cancer.

of their menstrual cycles for the entire year prior to the interview.

Wasting syndrome associated with HIV is known to affect the menstrual cycle, as also occurs in HIV negative women—such as athletes and malnourished women—who lose a significant percentage of body fat or lean body mass. For example, a small study by Steven Grinspoon, MD, and colleagues found that among 31 HIV positive women with varying degrees of wasting, 20% overall had experienced amenorrhea. Among the women with amenorrhea, muscle mass was significantly lower, as was the total level of estradiol (a form of estrogen). The study revealed a higher rate of amenorrhea in women with less than 90% of ideal body weight.

Menopause

Menopause is a natural, normal life stage. It is defined as the end of menses and is characterized by 12 months without a menstrual period. The hormonal changes associated with menopause include elevation of FSH and LH levels and decreased estrogen levels. In the United States, the final menstrual period occurs at an average age of 51 years. There is evidence supporting a younger age of menopause onset (48 years) in African-American women.

A diagnosis of menopause can be made in women over the age of 45 years who have stopped menstruating for at least one year. Menopause is a clinical diagnosis; no diagnostic tests are necessary. However, in younger women who stop menstruating and are not pregnant, hormone testing for premature ovarian failure should be performed.

Women beginning the menopausal transition (perimenopause) may have irregular cycles with either light or heavy bleeding. They may also experience hot flashes, a heat sensation that starts on the upper face or chest and can spread throughout the entire body. Hot flashes at night may be particularly troublesome if they disturb sleep. Another common symptom of menopause resulting from decreased estrogen production is vaginal thinning and dryness, which increase in prevalence as women age. Thinning of the vaginal wall may cause pain during sexual intercourse.

Other menopausal symptoms include breast pain or tenderness—more common during the early menopausal transition than in late menopause—and mood changes, such as depression. Other mood-related symptoms may include nervousness, irritability, and frequent mood fluctuations. Some women experience forgetfulness and impaired concentration. Long-term physiological changes associated with menopause include a higher risk of osteoporosis (bone thinning) and cardiovascular disease.

HIV and Menopause

As women with HIV live longer thanks to effective treatment, more research is needed on the interactions between HIV disease, antiretroviral therapy, and menopause. More than ever, HIV positive women need support and strategies for dealing with the changes of menopause. Considerable research has explored the relationship between menopause and HIV, but this too has yielded inconsistent results.

One large study examined the relationship between HIV disease and onset of menopause. Ellie Schoenbaum, MD, and colleagues examined the effects of HIV infection, HAART, street drug use, and immune status on age of onset of menopause. Their study group included 571 women, half of whom were HIV positive. Half the women in both the HIV positive and HIV negative groups used recreational drugs, and 90% were current or former smokers. About half were African-American, 40% were Latina, and 10% were white. In this population with high rates of drug use, the average age of menopause onset was 46 years in the HIV positive group and 47 years in the HIV negative group.

The likelihood of early menopause rose with increasing degree of immunosuppression. In women with CD4 counts less than 200 cells/mm^3, the mean age of onset of menopause was 42.5 years. Women with low levels of physical activity were also at risk for earlier onset of menopause. This study showed no association between low body mass index (BMI) or cigarette smoking and early onset of menopause, contrary to some other epidemiological studies. There was also no association observed in this study between HAART use and earlier onset of menopause.

Clearly, more research into the effect of HIV on onset of menopause is necessary. The HIV Menopause Clinic—the first of its kind in the U.S.—was founded by Susan Cu-Uvin, MD, director of the Miriam Hospital's Immunology Center in Providence, Rhode Island. The

Medications Used to Prevent or Reverse Osteoporosis

Bisphosphonates: alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva)

Selective estrogen receptor modulators (SERMs): raloxifene (Evista), tamoxifen (Nolvadex)

WOMEN AND HIV

clinic is currently collecting observational data as a first step toward large-scale research on menopause in HIV positive women.

In addition, numerous studies are underway to determine the effects of HIV infection and antiretroviral therapy on the risk of developing cardiovascular disease and osteoporosis. These effects may be compounded in HIV positive menopausal women on HAART.

Osteopenia and Osteoporosis

In the February 20, 2004, issue of *Acquired Immune Deficiency Syndromes*, Sara Dolan, NP, and colleagues report on a study comparing the risk of osteopenia—bone thinning, a precursor to osteoporosis (more severe bone atrophy)—in HIV positive and HIV negative women. They found that women with HIV were more likely to have osteopenia, even after controlling for age and BMI. Prior exposure to antiretroviral therapy did not appear to have any significant effect on bone density. The study also found that abnormal menstrual function was associated with lower bone density, and that women who maintained their baseline weight were more likely to maintain their bone mass, compared with those who had HIV-related wasting.

A study by Julia Arnsten, MD, and colleagues with the U.S. Menopause Study, published in the April 1, 2006, issue of *Clinical Infectious Diseases*, analyzed data from 263 HIV positive and 232 HIV negative women; the median age was 44, most were pre-menopausal, and roughly three-quarters were on HAART. Overall, the HIV positive women had lower bone mineral density (BMD) in their hips and lumbar spines: 27% of the HIV positive women had low BMD, versus 19% of the HIV negative participants.

Cardiovascular Risk

Post-menopausal women have an increased risk of cardiovascular disease as estrogen levels decrease. HIV positive people on antiretroviral therapy are also at increased risk of cardiovascular disease, as certain antiretroviral medications (especially protease inhibitors) can lead to elevations in low-density lipoprotein (LDL, or "bad") cholesterol and triglycerides. This side effect is quite common: multiple studies have shown that up to 20% of patients on HAART develop hyperlipidemia. Antiretroviral drugs may also cause insulin resistance and diabetes mellitus (impaired glucose tolerance), which in turn increase the risk of heart disease.

Management of Menopause

Although menopause is a natural process, many women seek medical assistance to manage the symptoms of menopause, both short-term symptoms such as hot flashes and vaginal dryness and more serious long-term complications such as elevated risk of osteoporosis and cardiovascular disease.

Not long ago, it was widely believed that hormone replacement therapy (HRT)—replacing estrogen, with or without the addition of progesterone—could safely alleviate

HEALTH SCREENING

Mammograms (breast cancer screening):
A mammogram is recommended every 1 to 2 years starting at age 40, then yearly after age 50. Monthly self-breast-exams are also advised.

Pap smears (cervical cancer screening):
HIV positive women should have two Pap smears during the first year following HIV diagnosis, then one per year thereafter.

Cholesterol checks:
For HIV positive people not on HAART, regular cholesterol checks should begin at age 45. Individuals at higher risk of heart disease (smokers, diabetics, or people with a family history of heart disease) should start cholesterol checks at age 20. Cholesterol should be checked before starting antiretroviral therapy, three to six months after starting therapy, and at least annually while on HAART.

Blood pressure checks:
Blood pressure checks are recommended at least once every two years.

menopausal symptoms while at the same time helping women avoid the detrimental long-term effects of reduced estrogen levels.

In recent years, however, data from large longitudinal studies have shown that the risks of HRT outweigh the benefits for many women. The Women's Health Initiative (WHI) is a group of studies designed to investigate long-term HRT. One study evaluated combined estrogen/progestin (synthetic progesterone) therapy versus placebo in more than 160,000 menopausal women, with an average follow-up period of more than five years.

In 2002, the estrogen/progestin arm of the study was discontinued after it was shown that women receiving long-term combination HRT had an increased risk of cardiovascular disease, cerebrovascular disease (stroke), deep vein thrombosis (blood clots), and breast cancer. The study did, however, reveal some beneficial effects associated with HRT: decreased rates of bone fractures and colon cancer. The estrogen-only arm of the study (which included women who had received hysterectomies and therefore were not at risk for uterine cancer) was later stopped after data showed that estrogen replacement did not reduce the risk of heart attack and slightly raised the risk of stroke.

Symptom Management

Acute symptoms often improve spontaneously as the hormonal fluctuations of perimenopause and early menopause level out. Women with severe hot flashes may find relief through short-term, low-dose estrogen/progestin HRT.

Alternatives to HRT for hot flashes include using a selective seratonin reuptake inhibitor (SSRI) antidepressant, most commonly venlafaxine (Effexor). Some women use soy products or herbal remedies such as black cohosh (*Cimicifuga racemosa*) or evening primrose (*Oenothera biennis*)—which contain estrogen-like compounds known as phytoestrogens—to alleviate hot flashes, bloating, and mood swings. Dr. Cu-Uvin notes that there is conflicting evidence from clinical trials about the effectiveness of herbal therapies, but for her patients who wish to try soy products, she recommends 40–80 mg of isoflavones taken daily for up to six months. (It is essential, however, for an HIV positive woman to consult with her own health-care provider before beginning a supplement regimen, as some herbal and dietary supplements can interact with antiretroviral medications and other drugs.)

One solution for vaginal dryness and thinning is the use of topical estrogen creams or lubricants during sexual intercourse. There is also an estrogen-releasing silicone ring (Estring) that can be inserted in the vagina and worn for three months at a time to alleviate the symptoms of vaginal atrophy. Local administration of estrogen is not associated with the same risks as systemic HRT.

Avoiding Long-Term Complications

One of the beneficial effects of HRT demonstrated in the WHI study was a decrease in the risk of bone fractures. However, there are other interventions that can decrease

TESTS FOR WOMEN

Colorectal cancer screening:
Testing for colorectal cancer (colonoscopy or flexible sigmoidoscopy) should start at age 50. If colonoscopy results are normal, repeat every ten years; if sigmoidoscopy results are normal, repeat every 5 years.

Diabetes tests:
A blood sugar test screens for diabetes. Patients on HAART should have a blood sugar test one to three months after starting therapy and then at least every three to six months.

Osteoporosis screening:
A bone density test to screen for osteoporosis is recommended for all women at age 65. Women may need to be tested earlier if they weigh less than 154 pounds, take chronic steroid therapy, are white or Asian, or smoke. There are currently no changes to these recommendations based on HIV status or HAART use; patients on HAART should talk to their health-care providers to determine whether an earlier test is indicated.

Sexually transmitted infection screening:
HIV positive women with multiple sex partners are advised to receive biannual screenings for syphilis, gonorrhea, and chlamydia, as these infections may be more serious for people with immunosuppression.

the danger of osteopenia and osteoporosis without the risks associated with HRT. Adequate dietary intake of calcium and vitamin D is extremely important—postmenopausal women need 1500 mg of calcium daily in addition to 400 units of vitamin D (800 units for women over age 70). Weight-bearing exercise also helps maintain bone mass. In addition, several medications can prevent and even reverse osteoporosis (see sidebar, page 41).

Similarly, there are many ways to reduce the risk of cardiovascular disease. The first step is lifestyle modification, including exercising, eating a low-fat diet, and quitting smoking. Statins—drugs such as atorvastatin (Lipitor) and simvastatin (Zocor)—reduce LDL cholesterol and triglyceride levels and can help lower the risk of heart disease. Other strategies include diabetes management and, for some people (and under their doctor's orders), taking a daily aspirin.

Conclusion

Knowledge regarding the menstrual cycle and menopause in HIV positive women has advanced since the beginning of the epidemic, but much remains to be learned. As women live longer with HIV, it is increasingly important to determine optimal care for a healthy menopause.

As with many aspects of HIV care, management of menopausal symptoms and complications should be tailored to the individual patient. Dr. Cu-Uvin notes that many of her patients have refused even short-term HRT due to their fear of complications, but estrogen replacement remains a viable option for some women, and the absolute risk of complications such as heart attacks and strokes remains small.

Until more is known, HIV positive women are advised to receive the recommended regular health check-ups for their age group (see sidebar, pages 42–43). Women should also discuss bothersome menstrual irregularities or menopause symptoms with their health-care providers and together explore individualized management strategies.

Anne Monroe, MD, is a resident in Internal Medicine at Jackson Memorial Hospital in Miami, Florida. She has a longstanding interest in HIV clinical trials and women's health.

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Lifestyle Habits That Contribute to Optimal Health

- Eat a balanced diet with plenty of fruits, vegetables, and whole grains
- Get some exercise every day
- Sleep at least eight hours every night
- Avoid smoking and second-hand smoke
- Reduce alcohol intake

VIRAL HEPATITIS BINGO*

ABOUT THIS ACTIVITY

Time: 30 minutes

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

Review the basic Hepatitis A, B, and C information including prevention, transmission, testing, and treatment.

In This Activity You Will…

- Review basic information about Hepatitis A, B, C (5 minutes)
- Conduct the Hepatitis Bingo game (25 minutes)

Materials:

- Bingo cards
- Bingo Statements
- Marbles for markers
- Small prizes
- Handout – Hepatitis C Information Sheet

Preparation:

- Print handouts
- Prepare bingo cards

Instructions

1. Briefly give general information about Hepatitis.

- Hepatitis refers to inflammation of the liver. The liver acts as a filter for toxins in the body.

- There are different types of Hepatitis which can be caused by bacteria or viruses.

- The 3 we discuss regarding sexual health are caused by viruses and include Hepatitis A, B, and C.

- Hepatitis is not curable though in some instances it can self-resolve (go away on its own) or become undetectable with treatment.

- Discussing hepatitis with PLWHA is significant because it affects an already compromised immune system. Also Hepatitis A, B, and C can be transmitted through sexual activity and/or injecting drugs.

2. Distribute BINGO cards and marbles.

3. Ask participants if they remember how to win BINGO. The trainer will ask a question and if you think you have the correct answer then put a marble in the spot. The first person to get marbles diagonally, straight up or down, or across and say HEPATITIS wins.

4. Cover hepatitis information given on the Bingo Statements and answer any questions participants may have once there is a winner and before moving on to the next set of questions.

5. Depending upon time, allow for 2-3 rounds.

6. Distribute prizes to winners.

* This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

7. Make sure that participants fully grasp these points about Hepatitis:

- It's a blood-borne virus – has to get from an infected person's blood into someone else's bloodstream.
- Hepatitis C can be sexually transmitted.
- Treatment decisions are made on a case-by-case basis. It depends on many factors- the person's health, the 'strain' of virus, and their liver health. But EVERYONE is potentially a candidate for treatment.
- Everyone who is HIV+ should be tested and should know their Hep C status.

Summary

- It is important to understand the relationship between HIV and co-infection with Hepatitis A, B, and C.
- Hepatitis A and B have vaccines to prevent infection.
- Hepatitis B is transmitted similar to HIV.
- Hepatitis C is more virulent than HIV and is transmitted by exchange of blood.

* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit.This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

VIRAL HEPATITIS BINGO

TRAINTER GUIDE # 1 of 1

BINGO STATEMENTS

1. Hepatitis C is passed through what body fluid? (Blood)
   Or any fluids with blood in them, like…. (ask for examples)

2. Hepatitis affects what organ of the body? (Liver)

3. Inflammation of the liver is called _____? (Hepatitis)
   Just means" inflamed liver"- can be caused by too much alcohol, other illnesses, Tylenol + alcohol, etc
   Viral hepatitis – like A,B,C – are caused by a specific virus

4. The current medical treatment for HCV is _____ (Interferon and Ribavirin).
   Interferon causes flu-like symptoms because it's what our bodies produce to fight off illness- that's why we feel sick
   Almost everyone is potentially a candidate for treatment – decided on a case-by-case basis. People should know their status so they can decide.

5. Myth or Fact: HCV can live outside of the body longer than HIV can (Fact)
   About four times longer – that's what researchers say now

6. The best way to protect yourself against HCV is to _____. (avoid contact with blood, or body fluids that have blood in them)

7. What forms of Hepatitis are there vaccines for? (HAV or HBV)
   There is no vaccine for HCV.

8. Hepatitis B is transmitted by the same body fluids as HIV but there is one other one. What is the one fluid that transmits HBV and NOT HIV? (saliva)

9. What type of Hepatitis is passed through oral contact with feces? (Hepatitis A)
   What sexual activity can transmit HAV? (oral-anal)
   Who knows the slang term? (rimming, tossing the salad)

10. Tattooing with unsterilized equipment is considered (low, high, no) risk for HCV (HIGH)
    The artist should always use new ink and a new needle for each person

11. When a person has 2 diseases at the same time,(such as HCV and HIV) then we say that they are _____. (Co-infected)

VIRAL HEPATITIS BINGO

TRAINTER GUIDE # 1 of 1 (cont.)

BINGO STATEMENTS (CONT.)

12. The most common way that HCV is transmitted or passed. (Shared Injection Equipment)
    Includes shared works too. Ask for examples: cooker, cotton, water
    Accounts for about 60% of HCV cases in the U.S., if anyone asks

13. The final stage of liver disease that affects how blood flows in and out of the liver along with impairing normal liver functions. (CIRRHOSIS)
    People with advanced cirrhosis are not candidates for HCV treatment, but CAN be on maintenance therapy to help the liver function better.
    It's important for coinfected people to know about treatment options, and to be treated early on if they are candidates for treatment.

14. Transmission of HCV through blood transfusions and organ donations is pretty much unheard of in the U.S. since what year? (1992)

15. What test shows that you have a chronic HCV infection, or had it in the past and got over it? (HCV antibody test)
    The antibody test is like a footprint – you have the virus, or did in the past.
    PCR RNA test, or viral load. Tells how much virus is in your blood and whether you have chronic HCV.

16. There is ACUTE Hepatitis and CHRONIC Hepatitis. Which one means "sudden onset of illness; is of short duration and can be severe?" (Acute)
    Most people go on to have chronic HCV (80-85%)
    Can they pass it to others? YES!
    ¾ of infected people don't even know they have the HCV virus.
    Some people get rid of the virus on their own (like a cold) –about 15%

17. Using a (Condom) consistently and correctly will reduce a person's chance of getting a sexually transmitted disease.
    The CDC says about 15% of HCV cases are sexually transmitted.
    The best way to protect yourself against HCV is to avoid contact with blood, or body fluids that have blood in them.

18. Hepatitis B and C are treated by Interferon and Ribavirin. How long does most treatment for HCV last— 2 weeks to a month, 24 weeks to a year, or a lifetime? (24 weeks to a year)

19. Of all the people in NC who have HIV, what percentage also have HCV? (about 30%)
    And how many don't know it? About ¾ of them…
    Does everyone here know your HCV antibody status?
    The leading cause of death (about 1/3) for people with HIV disease is end-stage liver disease.
    People are living with HIV, but then dying of liver problems.

VIRAL HEPATITIS BINGO

TRAINTER GUIDE # 1 of 1 (cont.)

BINGO STATEMENTS (CONT.)

20. What substance could be most harmful to a person's liver? (alcohol)
    Like throwing lighter fluid on a fire – really flares up the liver.
    No safe level has been determined yet.
    Harm reduction model – reduce usage if not going to stop..

21. A side effect of interferon is depression. Therefore, in addition to seeing an infectious disease specialist, the patient may also have to see who? (a mental health professional, psychiatrist)
    Emphasize: It's caused by the medication, not because someone is a "weak" person

22. True or False. Vaccinations for Hepatitis A and B are recommended for someone who has HCV. (True)
    Avoiding other infections with the liver will help sustain it longer when treating HCV.

23. A mother can pass HBV to her child during birth, or after birth through what? (breast milk)

24. The CDC recommends that a person clean their works by using 3parts water, 3 parts bleach, and 3 parts water for a total of 4.5 minutes (30 seconds with each fluid) to kill HIV. Should a person clean their works for a longer or shorter period of time to kill HCV? (Longer; 2 minutes with each fluid)
    There aren't really definitive recommendations for this at this point in time. Better to use a clean needle every time.

25. Myth or Fact. It is possible for someone to be co-infected with Hepatitis A, B, and C. (Fact)

26. When a person is co-infected with Hepatitis C and HIV, then which of the two diseases usually progresses faster? (Hepatitis C)
    That's why it's especially important for people who are HIV+ to know their HCV status

VIRAL HEPATITIS BINGO

BINGO CARD

BINGO CARDS

Use the answers to the Bingo Statements to make your own Viral Hepatitis Bingo Cards. Below is an example of what the bingo cards should look like.

Condoms	Hepatitis	Co-infected	Breast Milk
Needle Stick	1992	Sex	HIV
Hepatitis E	Ribavirin & Interfereon	Free Space	Hepatitis A
False	Hepatitis C	Shared Injection Equipment	Blood

SESSION HANDOUT # 1 OF 1

HEPATITIS C INFORMATION SHEET

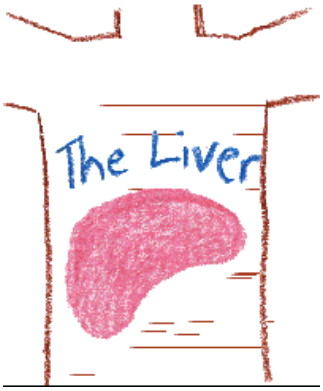
Hepatitis C is a liver disease caused by the Hepatitis C Virus (HCV). It has also been called non-A and non-B hepatitis. About 25,000 people are infected each year.

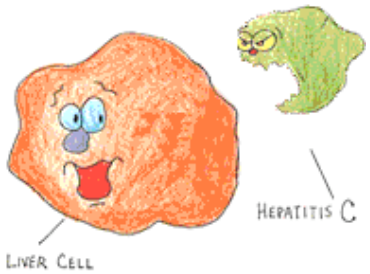
• About a quarter of people infected with HIV are also infected with HCV

• HCV progresses more rapidly to liver damage in HIV infected persons

• HCV can impact the management of HIV infection
Hep C is primarily spread by direct contact with human blood. Some ways it is transmitted is through:

- Contact with HCV-infected blood through sharing of needles or works that have not been properly cleaned between users. Injecting drug use is the most common risk factor for contracting Hep C at this time. Co-infection of HIV and HCV is common (50-90%) among HIV-infected IDUs.
- Sharing items such as razors or toothbrushes with someone infected with HCV since they may have had his or her blood on them
- Tatooing or body piercing with needles that have not been cleaned
- Blood, blood products or organs from donor whose blood contained HCV (before 1992- at this time risk is extremely low—less than 1 chance per million units transfused)
- If you were on long term kidney dialysis as you may have unknowingly shared supplies/ equipment that had someone else's blood on them
- Needlesticks/ contact with blood on the job (for healthcare workers)
- Hep C may be passed from an infected mother to her baby during birth
- Hep C may be transmitted sexually, but not that often.





HEPATITIS C INFORMATION SHEET (CONT.)

HCV Symptoms

Acute infection: (newly acquired)

- Often a person will have no symptoms. Some people with acute infection will have jaundice (yellowing of skin and eyes) or mild flu-like symptoms.

Chronic infection (persistant)

- 75-80% of people with acute Hep C will not be able to get rid of the virus after 6 months and will have chronic or long-term hep C.
- Most people with chronic HCV will have only mild to moderate liver disease.
- In some individuals, the damage is so great they have cirrhosis (scarring of the liver), liver failure or liver cancer and need a liver transplant. HIV-HCV co-infection has been shown to speed up to the progression to liver disease and there is an increased risk of scarring of the liver.
- Hep C is the leading cause of liver transplants

Treatment

- Treatment varies depending on the stage of illness at the time treatment is sought
- Some options include:

Treatment with interferon alone
Combination therapy with interferon and ribavarin
Protecting your liver by not drinking alcohol (it can do further damage)

(Adapted from the American Social Health Association & CDC)

MENTAL HEALTH*

ABOUT THIS ACTIVITY

Time: 35 minutes

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

- Recognize that stress, depression and anxiety may be common responses to dealing with HIV infection for many people;
- Recognize when a person needs more help than a peer educator can handle on their own;
- Recognize a mental health emergency and know how to get help in an emergency.

In This Activity You Will…

- Facilitate a discussion on coping with stress (5 minutes)
- Conduct "Helpful/Unhelpful Response" activity and process (15 minutes)
- Conduct Green, yellow and red light activity and process (15 minutes)

(continued next page)

Instructions

We all want to be as healthy as possible. As we have discussed in self-care, stress can affect our health. Similarly, when we feel sick or are in pain, it can affect our mood and make us anxious or depressed. Side effects from medication can also affect our state of mind. Mental health and physical health are closely related to one another.

1. We all have things that create stress in our lives. Ask group members to take a moment to think about this question:

- What is one thing you find stressful and how do you cope with it?
- What is one way that you deal with stress? [List coping strategies on the flip chart.]

2. Some stressors are small and easy to deal with while others are huge and can be overwhelming. HIV is a long term stressor that is difficult to live with. For some people HIV may be the most stressful thing in their lives, but other people living with HIV may have other things that stress them more, such as substance abuse, domestic violence, death of a loved one, or other serious problems.

- People living with HIV/AIDS often deal with emotional problems like depression and anxiety. In a survey at local infectious diseases clinics, 2/3 of PLWHAs self reported depression and/or anxiety symptoms.

- In the United States more than 17 million people every year are affected by depression.

3. Prepare to distribute cards and explain what participants will do.

- When someone is feeling depressed or anxious people want to help. Some of the things they say may be helpful, and others are not helpful.

- Here are some common responses. Please take a card. When you are ready, come up and stick the card up under the heading where you think it belongs – helpful or unhelpful.

* This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

ABOUT THIS ACTIVITY (CONT.)

Materials:

- Markers
- Flip chart
- Response cards
- Green, yellow & red cards
- Green-Yellow-Red light Situations
- Handout - Tips for Stress, Anxiety or Depression
- Handout – Mental Health Emergencies
- Handout - Symptoms of Clinical Depression
- Handout - Symptoms of Anxiety Disorders

Preparation:

- Print handouts
- Flipchart with two headings "Helpful Response" and "Unhelpful Response"
- Prepare individual cards, each with a different response

4. Read the responses and discuss some of them with the group.

5. If time permits ask group members to think of other helpful things they could say.

• What are some helpful things that you could say?

6. Sometimes problems are more complex.

• You might encounter a peer who needs more help than you can provide. Here are a few signs of more serious problems:
  Feeling depressed or anxious for more than two weeks
  Not keeping appointments
  Not getting out of bed
  Not eating, bathing, dressing
  Thoughts of hurting themselves or someone else

• If a peer expresses thoughts about suicide or homicide, DO NOT try to decide whether the person is "serious" or "just wants attention." If she or he says it, it IS serious.

• How could you still assist your peer?
  Find community resources, refer to physician or specialist.
  Accompany them to the emergency room or mental health center
  Call the crisis line
  Make sure they are not alone

7. Distribute colored cards. Explain the Green-Yellow-Red light activity.

• I am going to read some different situations. Each of you should hold up the color of card they think corresponds to the situation.
  A green light situation would be what you would consider normal levels of stress, anxiety, or depression.
  A yellow light situation is more serious and requires a referral.
  A red light situation indicates an emergency – take immediate action.

8. Discuss answers when participants have different interpretations of the situations.

TRAINING TIP

Participants may argue that they have been helped by being confronted, and told to get off their pity pot, or to count their blessings. If this comes up, explain that there are exceptions to every rule, but usually, a peer educator can be more effective using a supportive, non-judgmental response.

- It's ok to trust your instincts, and make an emergency referral in a borderline situation between yellow and red, when you have a strong "gut feeling" about it.

9. Wrap up and link to the next discussion.

- HIV, mental health issues, and substance abuse have a lot in common. In all three, adherence to treatment or programs can be challenging. There can be "stigma" around all three. People dealing with any of them may find it hard to ask for help, and feel very alone. As a peer educator you may be the first person a peer opens up to. You can't diagnose or treat, but you can make a big difference by providing non-judgmental listening, information and referrals.

- Thank you for participating in ways to recognize and respond to mental health challenges.

Summary

- Understanding your labs enables you to play an active and proactive role in your health care
- Use your new knowledge of lab tests and lab values to be a partner with your doctor
- Live smarter, healthier, and happier by being in control

* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit. This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

HELPFUL AND UNHELPFUL RESPONSES

Usually helpful

- I know you are hurting.
- You're not alone in this.
- I'm here for you.
- Do you want a hug?
- These feelings will pass; you'll get through this.
- I'm sorry you're in so much pain.
- If you need someone to talk to, I'm here for you.

Usually unhelpful

- It's all in your mind.
- No one ever said life was fair.
- There are a lot of people worse off than you.
- You should count your blessings.
- Stop your pity party
- Stop thinking about yourself and focus on your kids.
- You think you've got problems!
- Cheer up! Come on and give me a smile.

GREEN-YELLOW-RED LIGHT SITUATIONS

[Green means normal response to difficult things in life, yellow means referral is needed, and red means emergency referral. Some of these may vary depending on the context so it's ok if different group members have different opinions about them.]

- Your peer is feeling really blue on the anniversary of his partner's death [green]
- Your peer has a history of suicide attempts and is feeling REALLY blue today on the anniversary of his partner's death [yellow or red]
- Your peer is feeling unusually tense and angry today. [green]
- Your peer is so anxious and panicky lately that she can't eat and is losing a lot of weight [yellow]
- You call your peer to find out why he missed his appointment, and he says he just can't get out of bed.
- Your peer tells you wanted to tell you goodbye, because he plans to kill himself tonight. [red]
- Your peer says she can't come to her appointments anymore because she feels too panicky when she leaves her apartment. [yellow]
- Your peer says her meds have been making her feel moody and depressed [green to yellow]
- Your peer says she has had really bad insomnia for over two weeks. [yellow]
- Your peer is making plans to kill the person who infected her. [red]
- Your peer says "Nothing matters to me anymore. I wish I were dead." [probably red – peer educator may need to probe for more information to find out if actively suicidal]
- Your peer says he has been "cutting" himself to help him cope with all the emotional pain he is going through [yellow to red]

MENTAL HEALTH EMERGENCIES

- If a peer expresses thoughts about suicide or homicide or wanting to hurt themselves or others, DO NOT try to decide whether the person is "serious" or "just wants attention." If she or he says it, it IS serious.

- What can you do in an emergency? Depending on the situation and resources in your area, you could:
  - Ask members of your team to help you make an emergency referral.
  - Refer to physician or specialist.
  - Accompany your peer to the emergency room or mental health center
  - Call the crisis line
  - Call 911
  - Make sure they are not alone

TIPS FOR DEALING WITH STRESS, ANXIETY OR DEPRESSION (MILD)

- Talking to a trusted friend, family member or religious leader
- Exercising (Exercise has been found to be as effective as medications in treatment of depression)
- Helping others
- Keeping busy, finding something positive to do
- Writing in journals
- Take deep breaths
- Spend time in nature
- Relaxation, meditation
- Prayer
- Creative projects, arts, crafts, hobbies, or gardening
- Attending a support group meeting
- Attending religious services or other gatherings
- Add self-care tips that work well for you

_____
_____
_____
_____
_____

SYMPTOMS OF CLINICAL DEPRESSION

Not everyone experiences clinical depression in the same way. Different people have different symptoms. The National Mental Health Association recommends that you see a doctor or a qualified mental health professional if you experience five or more of these symptoms for longer than two weeks, or if the symptoms are severe enough to interfere with your daily routine.

- A persistent sad, anxious or "empty" mood
- Sleeping too little or sleeping too much
- Reduced appetite and weight loss, or increased appetite and weight gain
- Loss of interest or pleasure in activities once enjoyed
- Restlessness or irritability
- Persistent physical symptoms that don't respond to treatment [such as headaches, chronic pain, or constipation and other digestive disorders]
- Difficulty concentrating, remembering, or making decisions
- Fatigue or loss of energy
- Feeling guilty, hopeless or worthless
- Thoughts of death or suicide

SYMPTOMS OF ANXIETY DISORDERS

There are several types of anxiety disorders and not everyone experiences the same symptoms. An accurate diagnosis and treatment should be made by a qualified mental health provider.

- ☐ Excessive worry more days than not
- ☐ Inability to control the worry
- ☐ Restlessness, feeling keyed up or on edge
- ☐ Fatigue, feeling easily tired
- ☐ Irritability, or sudden anger outburst
- ☐ Muscle tension
- ☐ Trouble falling asleep or staying asleep
- ☐ Fatigue or loss of energy
- ☐ Repeated, unexpected "attacks" when you are suddenly overcome by intense fear or discomfort, for no apparent reason
- ☐ Repeated, distressing memories or dreams of a life-threatening event you experienced
- ☐ Feeling "on guard"
- ☐ Feeling detached from other people
- ☐ Intense, persistent fear of a social situation in which people might judge you
- ☐ Extreme anxiety with pounding heart, trembling or shaking, sweating, nausea or abdominal discomfort, fear of losing control
- ☐ Feeling worthless or guilty

OPPORTUNISTIC INFECTION EXERCISE*

ABOUT THIS ACTIVITY

Time: 30 minutes

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

- List 5 opportunistic infections and their primary symptoms.

In This Activity You Will…

- Ask participants to split into 3 groups and to list all OIs they can think of in 10 minutes including symptoms and whether or not is curable. (15 minutes)
- Review lists and correct any misinformation (10 minutes)
- Review handouts and summary points (5 minutes)

Materials:

- Newsprints - Opportunistic Infection (for each table group)
- Handout - Opportunistic Infection (can be downloaded from AIDSMeds)
- Flip chart and easel
- Markers
- Eraser

Preparation:

- Prepare 3 newsprints and post on wall in 3 separate areas
- Prepare handout

Instructions

1. Introduce session.
2. Ask participants the definition of an opportunistic infection.
3. Specify that not all lists agree on what is included as an Opportunistic Infection (OI).
4. Break the large group into three smaller groups.
5. Distribute newsprints and instruct each group to write down all the OIs that they can think of. Next they should list the symptoms.
6. Give the groups 10 minutes to do this.
7. Ask a group to present its list.
8. Ask a second group to read its list noting only information that was not already mentioned.
9. Repeat for third group.
10. Hand out OI information packet. Remind participants that this was just a brief overview/review and that more information is included in the AIDSMeds information packet. Remind participants that this is session was not intended for them to be able to diagnosis – but to merely be familiar with OIs.

Note: Hepatitis C is always an issue because some consider it a co-infection rather than an OI. We are flexible and usually include it because if we do not, someone will bring it up.

Summary

Wrap up session.

* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit. This module comes from the Comprehensive Peer Worker Training, Peer Advanced Competency Training (PACT) Project Harlem Hospital Center, Division of Infectious Diseases, 2008

OPPORTUNISTIC INFECTION EXERCISE

SESSION HANDOUT # 1 of 2

OPPORTUNISTIC INFECTIONS: NEWSPRINT

Opportunistic Infection	Symptoms

OPPORTUNISTIC INFECTION EXERCISE

SESSION HANDOUT # 2 of 2

OPPORTUNISTIC INFECTIONS

Opportunistic Infection	Symptoms
BACTERIAL INFECTIONS	
Bacterial Diarrhea- (Salmonellosis, Campylobacteriosis, Shigellosis)	severe diarrhea (including bloody diarrhea), fever, chills, abdominal pain, and occasionally vomiting
Bacterial Pneumonia	chills, shivering, chest pain, fever, rapid breathing, rapid heart rate, and wheezing
Mycobacterium Avium Complex (MAC)	fever, night sweats, chills, weight loss, muscle wasting, abdominal pain, fatigue, diarrhea, enlargement of the liver and spleen, as well as the lymph nodes
Mycobacterium Kansasii	breathing problems, fever, night sweats, chills, weight loss, muscle wasting, abdominal pain, fatigue, diarrhea, enlargement of the liver and spleen, as well as the lymph nodes
Syphilis & Neurosyphilis	primary syphilis: painless sore (called a “chancre”) that develops on the penis, vulva, or vagina. It can also develop on the cervix, tongue, lips, and other parts of the body. secondary syphilis: outbreak of small, pox-like lesions. they can appear anywhere on the body, but a rash and lesions on the palms and soles of the feet are classic symptoms of secondary syphilis
Tuberculosis (TB)	coughing, night sweats, chills, weight loss, fever, and fatigue

OPPORTUNISTIC INFECTION EXERCISE

TRAINERS GUIDE # 2 of 2 (cont.)

Opportunistic Infection	Symptoms
MALIGNANCIES (CANCERS)	
Human Papilloma Virus-(Genital Warts, Cervical Dysplasia & Cancer, Anal Dysplasia & Cancer)	may not cause any signs or symptoms; warts in or near the genital area can often be felt with a finger and are visible to the naked eye
Kaposi's Sarcoma (KS)	tumors or lesions; lesions in the gut, particularly in the large intestine and the colon, can cause diarrhea, cramping, and bleeding ; KS of the lungs (pulmonary KS) can cause severe breathing problems and discomfort
Lymphomas	enlarged spleen, liver obstruction, rectal pain, irregular heartbeat, digestive problems, internal bleeding, fever, unexplained weight loss, night sweats; lymphoma of the brain may cause problems focusing, paralysis affecting one side of the body, loss of ability to speak or understand language, confusion, sudden memory loss, and mania
VIRAL INFECTIONS	
Cytomegalovirus (CMV)	eye: floating spots before the eyes, hazy vision, blurred or missing areas of vision gut: diarrhea, loss of appetite, fever, blood in the stool, stomach cramps ,weight loss, painful swallowing , pain in center of the chest
Hepatitis C	fatigue, pains of the upper-right portion of the gut, nausea, decreased appetite, and muscle and joint pains.

OPPORTUNISTIC INFECTION EXERCISE

TRAINERS GUIDE # 2 of 2 (cont.)

Opportunistic Infection	Symptoms
VIRAL INFECTIONS (cont.)	
Herpes Simplex Virus (oral & genital herpes)	oral: sores around the mouth and nostrils genital: sores on the penis in males or near or in the vagina in women; can also cause sores near the anus; sometimes can cause pain when urinating or defecation.
Herpes Zoster Virus (shingles)	burning, sharp pain, tingling; some people experience severe itching or aching rather than pain; many people also feel tired and ill with fever, chills, headache, and upset stomach. After several days of these symptoms, a belt-like rash that extends from the midline of the body outward will develop. Within three days after the rash appears, the fluid-filled blisters will turn yellow, dry up, and crust over
Molluscum Contagiosum	itching or tenderness
Oral Hairy Leukoplakia (OHL)	usually does not cause serious symptoms
Progressive Multifocal Leukoencephalopathy (PML)	mental deterioration, vision loss, speech disturbances, ataxia (inability to coordinate movements), paralysis, and coma. In rare cases, seizures may occur.

OPPORTUNISTIC INFECTION EXERCISE

TRAINERS GUIDE # 2 of 2 (cont.)

Opportunistic Infection	Symptoms
FUNGAL INFECTIONS	
Aspergillosis	pain in the sinuses, nose, or ear canal; facial swelling; cough and difficulty breathing; chest pain, fever and night sweats.
Candidiasis (thrush, yeast infection)	oral candidiasis: burning pain in the mouth or throat, altered taste and difficulty swallowing vaginal candidiasis: thick white discharge resembling cottage cheese, itching and burning, rashes and tenderness esophageal candidiasis: chest pain, as well as pain and difficulty when swallowing. most people do not experience any symptoms of disease; when they do occur, they usually include fever, a productive cough, chills, headache, muscle aches, and sore throat.
Coccidioidomycosis	fever, fatigue, stiff neck, body aches, headaches (often severe), nausea/vomiting, and skin lesions, other important symptoms include confusion, muddled thinking and vision
Cryptococcal Meningitis	includes fever, weight loss, skin lesions, breathing difficulties, chest pain, nonproductive (dry) cough, anemia, enlargement of the liver, spleen, and lymph nodes problems, and possibly seizures
Histoplasmosis	watery diarrhea, abdominal pain, nausea, vomiting, weight loss, loss of appetite, dehydration, and passing gas

OPPORTUNISTIC INFECTION EXERCISE

TRAINERS GUIDE # 2 of 2 (cont.)

Opportunistic Infection	Symptoms
PROTOZOAL INFECTIONS	
Cryptosporidiosis	watery diarrhea, abdominal pain, weight loss, loss of appetite, dehydration, and passing gas
Isosporiasis	watery diarrhea , abdominal pain, weight loss, loss of appetite, dehydration, and passing gas
Microsporidiosis	watery diarrhea , abdominal pain, weight loss, loss of appetite, dehydration, and passing gas
Pneumocystis Pneumonia (PCP)	fever, dry cough that doesn't produce any phlegm (sputum); chest tightness and difficulty breathing; fatigue and night sweats
Toxoplasmosis	headache, fever, confusion, seizures, abnormal behavior, and coma
NEUROLOGICAL CONDITIONS	
AIDS Dementia Complex (ADC)	trouble learning new things, difficulty remembering things that happened in the past, changes in behavior, confusion, depression; if dementia progresses, it can cause speech problems, balance problems, vision problems, problems walking, loss of bladder control, mania or psychosis
Peripheral Neuropathy	usually occur in the feet and/or hands; numbness, insensitivity to pain or temperature, extreme sensitivity to touch , tingling, prickling, or burning sensation, sharp pain or cramping, loss of balance or coordination, loss of reflexes, muscle weakness, noticeable changes in the way you walk

OPPORTUNISTIC INFECTION EXERCISE

TRAINERS GUIDE # 2 of 2 (cont.)

Opportunistic Infection	Symptoms
OTHER CONDITIONS AND COMPLICATIONS	
Aphthous Ulcers (Canker Sores)	begins as a burning or tingling sensation, a red spot or bump usually forms, which develops into an open ulcer
Thrombocytopenia (low platelets)	many people do not have any symptoms; more advanced forms of thrombocytopenia can cause a number of bleeding problems
Wasting Syndrome	weight loss, especially muscle mass

OTHER INFECTIONS*

ABOUT THIS ACTIVITY

Time: 55 minutes

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

- Identify the risks associated with hepatitis B and C, as well as other STDs and what they mean for people with HIV infection;
- Identify other infectious diseases (TB, flu, etc.) and what they mean for people with HIV.

In This Activity You Will…

- Conduct a discussion on STDs and transmission (10 minutes)
- Facilitate the Bug Game (10 minutes)
- Conduct a discussion/lecture on Hepatitis C co-infection, TB and flu (35 minutes)

Materials:

- Flipchart
- Markers
- Handout - Don't Let These Bugs Get You!
- Answer Key – Answer to Bug Game
- Handout – Flu Information Sheet
- Handout – Hepatitis C Information Sheet
- Handout – Tuberculosis (TB) Information Sheet

Preparation:

- Prepare flipchart
- Print handouts

Instructions

1. Lead group into a brief discussion about other STDs.

   Next we're going to talk about infections and how they're related to HIV. We'll also review HIV and STD transmission. First, let's talk about other STDs that we've heard about. What are some of them?

2. As participants respond, write the STDs they list in three separate columns on a flipchart: bacterial, viral and parasitic. Fill in STDs that aren't mentioned. [Note to facilitator: see STD references in training resources.]

   Now let's talk a little how about how these STDs are transmitted. How can you get an STD?

3. Allow participants to answer. Responses should include the following:

- Through sex—vaginal, anal and oral, and sometimes through genital rubbing.
- Sharing body fluids like blood, semen and vaginal fluids.
- Some STDs (like syphilis, herpes and HIV) are passed from mother to baby during childbirth.
- HIV is passed person to person through infected blood, semen, vaginal fluids or breast milk.
- HIV and hepatitis C are passed by sharing needles with someone who is infected.

4. Refer to Bug Game handout. Facilitator should randomly select participants to answer questions. This will provide an opportunity for everyone to participant.

   Please take out the handout entitled, "Don't Let These Bugs Get

* This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

You!" We'll answer these clues together. There may be some members in the group that are more knowledgeable, but this is a way for all of us to learn something new. There is also no such thing as a stupid question.

5. Acknowledge how well participants worked together to answer the questions and move to hepatitis discussion.

You did a great job. If there are no more questions, we are going to talk a little about hepatitis C.

6. Facilitate discussion on co-infection with hepatitis C.

- What is hepatitis C?

7. Allow participants to respond. Responses should include:

- Hepatitis C is a liver disease caused by the hepatitis C Virus (HCV).

- It is also called non-A, non -B hepatitis. About 25,000 people are infected each year.

8. Introduce TB and Flu Information.

TB Lecture

Now we are going to talk about TB and flu. TB is short for a disease called tuberculosis and flu is short for influenza. Both can spread through the air when an infected person sneezes or coughs. Let's begin with TB.

In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. The bacteria become inactive, but remain alive in the body and can become active later. This is called latent TB infection. People with latent TB infection:

- Have no symptoms
- Don't feel sick
- Can't spread TB to others
- Usually have a positive skin test reaction
- Can develop TB disease later in life if they do not receive treatment for latent TB infection.

Many people who have latent TB infection never develop TB disease. But in other people, especially people who have weak immune systems, the bacteria become active and cause TB disease.

TB bacteria become active if the immune system can't stop them from growing. The active bacteria begin to multiply in the body and cause TB disease. Some people develop TB disease soon after becoming infected, before their immune system can fight the TB bacteria. Other people may get sick later, when their immune system becomes weak for some reason.

12. Ask participants what they know about TB.

- What are some of the symptoms of TB disease? [Note: Allow participants to respond. Symptoms include:]
  - A bad cough that lasts longer than 2 weeks
  - Pain in the chest
  - Coughing up blood or phlegm from deep inside the lungs
  - Weakness or fatigue
  - Weight loss
  - No appetite
  - Chills
  - Fever
  - Sweating at night

- How does HIV infection affect TB?

OTHER INFECTIONS

People with latent TB infection and HIV infection are at very high risk of developing TB disease.

It is especially important for people with HIV infection to get tested for TB (each year) and to be sure to get treatment as soon as possible if they have latent TB infection to prevent them from developing TB disease. If they have TB disease, they must take medicine to cure the disease.

The treatment of TB

TB disease can be prevented and cured, even in people with HIV infection. It is very important that TB medications are taken correctly because, when taken correctly,:

- There are higher cure rates;
- It reduces the chance that the disease will be passed on to someone else;
- It reduced the chance the disease will come back;
- It reduces the chance that it will result in a resistant strain of TB.

The treatment can be a lengthy process, but it is very important for everyone to follow the treatment regimen correctly.

Flu Lecture

Another infection to be aware of is the flu. As was mentioned earlier, the flu is spread from person to person when the virus is sent into the air when an infected person coughs, sneezes, or talks. Unlike the common cold, the flu causes severe illness and life-threatening complications in some people.

Complications include bacterial pneumonia, dehydration and worsening of chronic conditions. Because people with HIV infection have a compromised immune system, it is important to get the flu vaccine each year to reduce or prevent getting the flu.

13. Distribute handouts on TB and Flu to participants at this time or refer to the participant notebook if placed in book prior to discussion.
These handouts provide an overview of TB and Flu and can be used as a reference. Are there other questions about hepatitis C, TB or Flu before we move on to our next section?

Summary

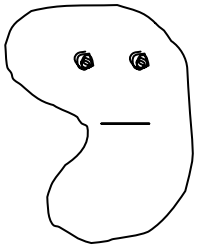
- It is important for peer educators to understand diseases related to HIV so they can give peers accurate information about them;
- It is important for peer educators to understand other diseases related to HIV so they can protect their own health.

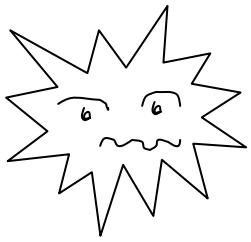
* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit.This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

OTHER INFECTIONS

TRAINER RESOURCE # 1 of 3

FLIPCHART FOR STD DISCUSSION





Bacterial—Curable with antibiotics	Viral—Not Curable but often manageable with medications or lifestyle changes	Parasitic—Curable with Antifungals, Creams, Ointments or Other Topical Treatments
(Bacteria—one-celled micro-creatures that can reproduce or multiply on their own.)	(Viruses—tiny particles that need the body's machinery, i.e., cells, nerves and tissues, to reproduce.)	(Parasites—organisms that must have a host to survive.)
° Syphilis (bad blood, chancres)	° Human Immunodeficiency Virus (HIV)	° Crabs
° Gonorrhea (the clap, drip)	° Hepatitis C	° Scabies (Mites)
° Chlamydia	° Hepatitis B	° Trichomoniasis (Trich, Trichomonads)
	° Hepatitis A	
	° Herpes	
	° Human Papillomavirus (HPV, genital warts, dysplasia)	
	° Molluscum contagiousum virus (MCV)	

OTHER INFECTIONS

TRAINER RESOURCE # 2 of 3

HOW STDS ARE TRANSMITTED

Anal Sex	Vaginal Sex	Oral Sex	Anal Sex	Mutual Masturbation	Genital to Genital Skin Contact
Majority of STDs	Majority of STDs	Gonorrhea Syphilis Herpes, Hepatitis B, HIV, Chlamydia (less likely) HPV (less likely)	Oral Herpes	Relatively safe provided no sexual fluids are exchanged and partners have no cuts, sores or lesions present on hands or genitals	Herpes HPV Molluscum Contagiosum (It is possible to pass these diseases to or from genital skin areas not covered by a latex condom)

Toilet Seats	Shared Clothing and Bedding	Towels, Swimming Pools, Shared Baths	Rimming	Perinatal Transmission
Crabs Scabies (unlikely but may be possible)	Crabs Scabies (unlikely but may be possible)	Mollluscum Contagiosum (MCV), Trichomoniasis (May be possible through towels and bathing suits, but has not been well documented and would be unusual) (less likely)	Chlamydia Gonorrhea Herpes Amoeba, Amebiasis Campylobacterio-sis, Giardiasis, Salmonella, Shilgellosis, Hepatitis A, Syphilis, HPV (less likely)	Chlamydia Gonorrhea, Herpes, Syphilis HIV, HPV, Streptococcus B, Hepatitis B and C' (Some of these are transmitted at delivery, some in utero, and some at either time. HCPs not sure how some are transmitted)

ANSWERS TO BUG GAME

1. Abstinence
2. HPV (genital warts), HIV, Hepatitis B, Genital Herpes
3. Human Papillomavirus
4. Yes
5. Blood, semen, pre-seminal fluid, vaginal fluids, and breast milk
6. False
7. Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
8. Yes, penicillin
9. Rashes, foul discharge, burning during urination, bumps, sores, blisters, tingling, bleeding between periods, swollen lymph glands
10. Scabies
11. No, other tests like a culture test or urine analysis are used to check for gonorrhea, chlamydia, and trichmoniasis; a visual exam can diagnosis herpes or genital warts
12. Yes
13. It's possible for all of them to be passed
14. Chlamydia
15. Yes

TUBERCULOSIS (TB) INFORMATION SHEET

TB is short for a disease called tuberculosis. TB is spread through the air from one person to another. The bacteria (or germs) are put into the air when a person with TB disease of the lungs or throat coughs or sneezes. People nearby may breathe in these bacteria and become infected. TB usually attacks the lungs, but may affect other parts of a person's body. Individuals who are in close contact with someone who is infected are at risk for developing TB.

TB is particularly dangerous for people infected with HIV, because it moves more quickly from TB infection to TB disease.

TB Infection

In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. The bacteria become inactive, but they remain alive in the body and can become active later. This is called latent TB infection. People with latent TB infection:

- have no symptoms
- don't feel sick
- can't spread TB to others
- usually have a positive skin test reaction
- can develop TB disease later in life if they do not receive treatment for latent TB infection

Many people who have latent TB infection never develop TB disease. In these people, the TB bacteria remain inactive for a lifetime without causing disease. But in other people, especially people who have weak immune systems, the bacteria become active and cause TB disease.

TB Disease

TB bacteria become active if the immune system can't stop them from growing. The active bacteria begin to multiply in the body and cause TB disease. Some people develop TB disease soon after becoming infected, before their immune system can fight the TB bacteria. Other people may get sick later, when their immune system becomes weak for some reason.

Symptoms

Symptoms of TB depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs. TB in the lungs may cause

- a bad cough that lasts longer than 2 weeks
- pain in the chest
- coughing up blood or sputum (phlegm from deep inside the lungs)

TUBERCULOSIS (TB) INFORMATION SHEET (CONT.)

Other symptoms of TB disease are:

- weakness or fatigue
- weight loss
- no appetite
- chills
- fever
- sweating at night

HIV infection affects TB in a couple of ways

A person can have latent TB infection for years without any signs of disease. But if that person's immune system gets weak, the infection can quickly turn into TB disease. Also, if a person who has a weak immune system spends time with someone with infectious TB, he or she may become infected with TB bacteria and quickly develop TB disease.

Because HIV infection weakens the immune system, people with latent TB infection and HIV infection are at very high risk of developing TB disease. All HIV-infected people should be given a TB skin test to find out if they have latent TB infection. If they have latent TB infection, they need treatment for latent TB infection as soon as possible to prevent them from developing TB disease. If they have TB disease, they must take medicine to cure the disease.

TB disease can be prevented and cured, even in people with HIV infection.

Treatment of TB

It is important that the TB medications are taken correctly.

When taken correctly:

- there are higher cure rates
- it reduces the chance that the disease will be passed on to someone else
- it reduces the chance that the disease will come back
- it reduces the chance that it will result in a resistant strain of TB

(Adapted from the CDC)

SESSION HANDOUT # 2 of 4

FLU INFORMATION SHEET

Influenza, commonly known as the flu, is a highly contagious viral infection found in the nose, throat and lungs (respiratory tract). It spreads when an infected person coughs, sneezes, or talks and the virus is sent into the air. Unlike the common cold, the flu causes severe illness and life-threatening complications in some people. Flu symptoms include fever, chills, muscle/joint pain and extreme fatigue.

According to the CDC, each year an estimated 10-20% of US citizens get the flu, and an average of 114,000 persons are hospitalized for flu-related complications. About 36,000 Americans die on average per year from the complications of flu. Complications include bacterial pneumonia, dehydration and worsening of chronic conditions such as diabetes, congestive heart failure, and asthma.
A flu vaccine is available each year and may be taken to reduce or prevent getting the flu.

(Adapted from the CDC)

OTHER INFECTIONS

DON'T LET THESE BUGS GET YOU

Don't Let These Bugs Get You!

1. What one word describes not having any sexual contact?

2. Name 4 STDs there are no cures for.

3. What does HPV stand for?

4. It is possible to have an STD and not know it. (T or F)

5. Name the 5 body fluids that spread HIV.

6. Once a person has an STD, s/he can't catch it again. (T or F)

7. What do the letters HIV and AIDS stand for?

8. Is there a cure for syphilis?

9. Name as many symptoms of STDs that you can think of…

10. What STD burrows underneath the skin and causes a rash?

11. Can a simple blood test show all the STDs?

12. Can men have a yeast infection?

13. What STDs can be passed from mother to child?

14. What STD is also known as the "Silent STD"?

15. Can a person have gonorrhea of the throat?

HEPATITIS C INFORMATION SHEET

Hepatitis C is a liver disease caused by the Hepatitis C Virus (HCV). It has also been called non-A and non-B hepatitis. About 25,000 people are infected each year.

- About a quarter of people infected with HIV are also infected with HCV.
- HCV progresses more rapidly to liver damage in HIV infected persons.
- HCV can impact the management of HIV infection.

Hep C is primarily spread by direct contact with human blood. Some ways it is transmitted is through:

- Contact with HCV-infected blood through sharing of needles or works that have not been properly cleaned between users. Injecting drug use is the most common risk factor for contracting Hep C at this time. Co-infection of HIV and HCV is common (50-90%) among HIV-infected IDUs.

- Sharing items such as razors or toothbrushes with someone infected with HCV since they may have had his or her blood on them.

- Tatooing or body piercing with needles that have not been cleaned.

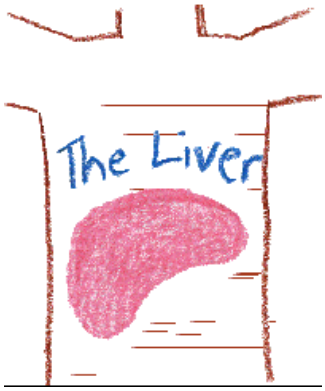
- Blood, blood products or organs from donor whose blood contained HCV (before 1992- at this time risk is extremely low—less than 1 chance per million units transfused).

- If you were on long term kidney dialysis as you may have unknowingly shared supplies/equipment that had someone else's blood on them.

- Needlesticks/ contact with blood on the job (for healthcare workers).

- Hep C may be passed from an infected mother to her baby during birth.

- Hep C may be transmitted sexually, but not that often.



HEPATITIS C INFORMATION SHEET (CONT.)

HCV Symptoms

Acute infection: (newly acquired)

- Often a person will have no symptoms. Some people with acute infection will have jaundice (yellowing of skin and eyes) or mild flu-like symptoms.

Chronic infection (persistant)

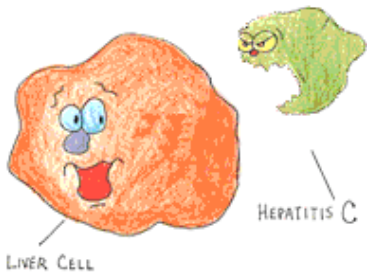
- 75-80% of people with acute Hep C will not be able to get rid of the virus after 6 months and will have chronic or long-term hep C.
- Most people with chronic HCV will have only mild to moderate liver disease.
- In some individuals, the damage is so great they have cirrhosis (scarring of the liver), liver failure or liver cancer and need a liver transplant. HIV-HCV co-infection has been shown to speed up to the progression to liver disease and there is an increased risk of scarring of the liver.
- Hep C is the leading cause of liver transplants

Treatment

- Treatment varies depending on the stage of illness at the time treatment is sought
- Some options include:

o Treatment with interferon alone
o Combination therapy with interferon and ribavarin
o Protecting your liver by not drinking alcohol (it can do further damage)

(Adapted from the American Social Health Association & CDC)



SEXUAL LIFE AFTER HIV DIAGNOSIS*

ABOUT THIS ACTIVITY

Time: 35 minutes

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

- Discuss the emotional impact of HIV and sexual life;
- Understand information and skills for assisting those who are HIV positive to regain the sex lives that they enjoyed prior to diagnosis;
- Assist peers and their partners in remaining safe sexually, while relieving some of the anxiety, fear, and negative feelings that often interfere during intimate sexual relations.

In This Activity You Will…

- Introduce the topic of sexual life after HIV diagnosis (5 minutes)
- Discuss the topic with group relating to their experiences (10 minutes)
- Do small group activity practicing how to talk to clients about sexual life (20 minutes)

(continued next page)

Instructions

1. Introduce the topic of sexual life after an HIV diagnosis .

A person's sexual life may be halted or changed by a positive HIV antibody test, or by the diagnosis of AIDS. Plans to marry, find a life partner or have children may change. These losses can be painful and intense, and feelings about them can be hard to share and difficult for others to grasp.

The stigma attached to HIV disease and AIDS, along with others' fears and misinformation about how a person can become infected or transmit HIV, only adds to the pain, isolation and worries of families. Some people choose secrecy with neighbors, friends, and even relatives, rather than risk rejection or discrimination. Other people choose to be open about their HIV status. Reactions can vary from understanding and overwhelming support to violent acts. These are difficult decisions and people may be isolated from others when they need them most.

2. Encourage the group to discuss some of their experiences and reactions about how HIV affects sexuality. [Note: trainer should encourage the group's experiences but be prepared to redirect people if participants get off track or the conversation goes on too long.]

What are some words you think of when you hear "sex after HIV"? [Note: allow a few responses and write on flipchart, then move to the next question.]

Think back to when you first learned you were HIV positive. What are some of the thoughts or experiences you had regarding sex and intimacy? [Answers may include the following:]

- Loss of libido
- Fear of infecting a partner
- Anxiety about disclosing status to a new potential sexual partner

Thank you for sharing such personal experiences. Now let's talk about how we can assist peers who are struggling with sexuality concerns.

* This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

SEXUAL LIFE AFTER HIV DIAGNOSIS

ABOUT THIS ACTIVITY (CONT.)

Materials:

- Flip chart
- Markers
- Method for breaking people into small groups (Topic cards)
- Cards – Sexual Life Topic Scenarios
- Trainer Notes – Sexual Life Topic Scenarios

Preparation:

- Prepare Sexual Life Topic Scenarios (should be printed, cut and laminated)
- Print/Cut topic cards

3. Give instructions for the activity.

   In a moment, we'll get into three groups of five. Each group will need to develop some responses for talking to peers about sexual life after HIV. We've prepared three areas to address, condom use and abstinence; unsafe sex; and talking about sex. In your small groups, discuss your scenario and develop some responses and questions for your peer. After 10 minutes, we'll report back on our topics.

4. Break large group into three smaller groups. Distribute topics.

5. After 10 minutes, call groups back together and allow each group to share their issue and report on the responses they developed.

Summary

- After all groups are finished, acknowledge the difficult nature of discussing sexual life with peers and process with the following questions:

  Talking about sex is difficult. Especially when it's someone you don't know very well.

  How comfortable are people with discussing these issues with peers?

  What are some of your success stories regarding good communication with sexual partners?

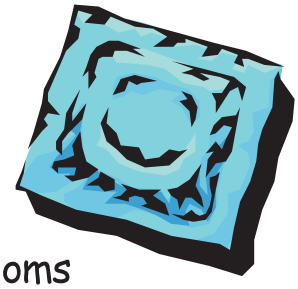
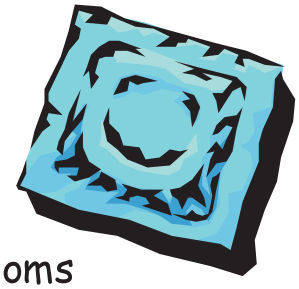
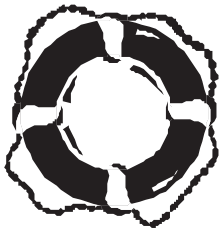
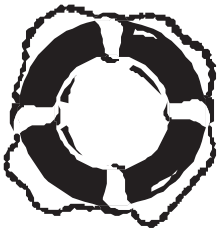
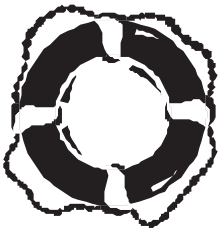
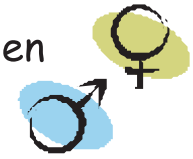
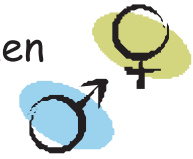
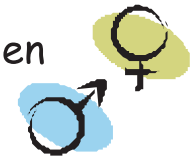
  What other questions do you have about sexual life after HIV?

- It is important to understand the emotional factors associated with HIV and sexual life;
- Peer educators are an excellent resource for helping newly diagnosed HIV positive peers process their concerns about regaining their sex lives.

* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit.This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

SEXUAL LIFE AFTER HIV DIAGNOSIS

TOPIC CARDS

 Condoms and Abstinence	 Condoms and Abstinence	 Condoms and Abstinence
Unsafe Sex 	Unsafe Sex 	Unsafe Sex 
Sex Talk: How & When 	Sex Talk: How & When 	Sex Talk: How & When 

SEXUAL LIFE AFTER HIV DIAGNOSIS

SESSION HANDOUT # 2 of 2

SEXUAL LIFE TOPIC SCENARIOS

Condoms and Abstinence

Your peer comes to you with questions about safer sex. As a group, come up with answers to the following questions posed by your peer.

- Is sex without condoms always unsafe?
- Does "unsafe" mean different things for HIV-negative and HIV-positive people?
- Should I just stop having sex?

Unsafe Sex

Your peer tells you that s/he has not been using condoms when having sex. As a group, come up with questions to discuss the circumstances involving unsafe sex.

Sex Talk: How and When?

Your peer comes to you with questions about how to talk to a new potential sex partner. As a group, help your peer develop strategies for talking to a new partner.

SEXUAL LIFE AFTER HIV DIAGNOSIS

TRAINTER RESOURCE # 1 of 1

SEXUAL LIFE TOPIC SCENARIOS

Condoms and Abstinence

Your peer comes to you with questions about safer sex. As a group, come up with answers to the following questions posed by your peer.

- Is sex without condoms always unsafe?
- Does "unsafe" mean different things for HIV-negative and HIV-positive people?
- Should I just stop having sex?

Possible answers:

Why might you choose abstinence or not having sex?

Emphasize that this is an individual choice but people who have been sexually active shouldn't feel that they must be abstinent just because they are infected with HIV.

They should choose abstinence because that's what they want.)

Unsafe Sex

Your peer tells you that s/he has not been using condoms when having sex. As a group, come up with questions to discuss the circumstances involving unsafe sex.

Possible answers:

What circumstances cause you to want unsafe sex?

When you have wanted to have unsafe sex and didn't, what stopped you?

Sex Talk: How and When?

Your peer comes to you with questions about how to talk to a new potential sex partner. As a group, help your peer develop strategies for talking to a new partner.

Possible answers:

What are some of your success stories regarding good communication with sexual partners?

What are your fears about discussing sex with your partner?

How can you practice talking about sex?

Continuing Education

SEXUALLY TRANSMITTED INFECTIONS EXERCISE*

ABOUT THIS ACTIVITY

Time: 20 minutes

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

- List 5 STIs and their primary symptoms.

In This Activity You Will…

- Discuss the difference between STI and STD (5 minutes).
- Ask participants to split into 3 groups and to list all the STIs they can think of in 5 minutes including symptoms and whether or not the STI is curable (5 minutes).
- Review lists and correct any misinformation (10 minutes).

Materials:

- Newsprint - 5 STIs (one for each table group)
- Handout - STIs answer
- Handout - STI definition
- Flip chart and easel
- Markers
- Eraser

Preparation:

- Prepare newsprints and post on wall in separate areas
- Prepare handout

Instructions

1. Introduce session.

2. Ask participants if they know the difference between STD and STI. Review the difference. "The concept of "disease," as in STD, implies a clear medical problem, usually some obvious signs or symptoms. But in truth several of the most common STDs have no signs or symptoms in the majority of persons infected. Or they have mild signs and symptoms that can be easily overlooked. So the sexually transmitted virus or bacteria can be described as creating "infection," which may or may not result in "disease." (From American Social Health Association website)

3. Ask participants to count off and break into 3 groups.

4. Instruct each group to go up to a newsprint and to write down all the STIs that they can think of. Next they should list the symptoms for the STI whether or not it is curable. They will get extra points if they can list any nicknames for the STI.

5. Give each group 10 minutes.

6. Ask a group to present its list.

7. Ask a second group to discuss its list, mentioning only items that do not appear on the first group's list.

8. Repeat for third group.

Summary

- Hand out STIs information packet. Remind participants that this was just a brief overview/review and that more information is included in the information packet.

- Wrap up session.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from the Comprehensive Peer Worker Training, Peer Advanced Competency Training (PACT) Project Harlem Hospital Center, Division of Infectious Diseases, 2008.

SEXUALLY TRANSMITTED INFECTIONS EXERCISE

SESSION NEWSPRINT

SEXUALLY TRANSMITTED INFECTIONS

STI	Symptoms	Curable?

SEXUALLY TRANSMITTED INFECTIONS EXERCISE

SESSION HANDOUT # 1 of 2

STI EXERCISE ANSWER SHEET

STI	Other Names	Symptoms	Curable?
Chanchroid		Ulcers, sores	Yes
Chlamydia		Generally asymptomatic	Yes
Crabs	Pubic lice	Itching	Yes
Gonorrhea	The clap, drip	Men: discharge; burning when peeing Women: often no symptoms; if symptoms, abnormal yellow discharge; burning when peeing (can lead to PID – see symptoms for PID)	Yes
Hepatitis B		Flu-like symptoms; Many people asymptomatic	No
Herpes		Mouth or genital sores	No
Human papillomavirus (HPV)	Genital warts	Generally asymptomatic	No
Lymphoma granuloma (LGV) (A strain of chlamydia)		Pimple on penis or vagina – can spread to groin area; swollen lymph glands	Yes
Molluscum contagiosum (MCV)		Lesions on thighs, buttocks, groin, lower abdomen, sometimes genital or anal region	Yes
Non-Gonococcal urethritis (NGU)		Men: discharge; burning when peeing; itching; underwear stain Women: discharge; burning when peeing; abdominal pain; abnormal vaginal bleeding	Yes
Pelvic Inflammatory Disease (PID)		Dull pain in lower abdomen; burning when peeing; nausea/ vomiting; abnormal vaginal bleeding; fevers/chills	Yes
Syphilis		Primary stage (10-90 days): chancre sore at site of infection Secondary stage (17 days to 6.5 months): rash on palms of hands and soles of feet Latent stage (2-30 years): no symptoms Tertiary/Late stage (2-30 years): small bumps, tumors on skin or other organs; blindness; insanity; paralysis	Yes
Vaginitis/ Trichomoniasis 1. bacterial vaginitis 2. yeast infection (not an STI) 3. trichomoniasis		1. Strong, fishy smell; discharge 2. thick cottage cheese-like discharge; pain; itching; burning 3. discharge; bad smell; itching; pain when peeing	Yes

STI EXERCISE ANSWER SHEET (CONT.)

STI	Curable?
Clamydia	yes
Gonorrhea	yes
Syphillis	yes
Trichomoniasis	yes
Vaginal infections	yes
Genital Herpes	Treatment but no cure
Genital Warts (HPV)	Treatment but no cure
Hepatitis B	Treatment but no cure
HIV/AIDS	Treatment but no cure

SEXUALLY TRANSMITTED INFECTIONS EXERCISE

SESSION HANDOUT # 2 of 2

STI DEFINITION

"The concept of "disease," as in STD, implies a clear medical problem, usually some obvious signs or symptoms. But in truth several of the most common STDs have no signs or symptoms in the majority of persons infected. Or they have mild signs and symptoms that can be easily overlooked. So the sexually transmitted virus or bacteria can be described as creating "infection," which may or may not result in "disease."

from the American Social Health Association www.ashastd.org

HIV AND ORAL HEALTH*

ABOUT THIS ACTIVITY

Time: 3 hours, 15 minutes

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

- Describe the life cycle of HIV and how HIV medications work.
- Describe good and poor oral hygiene habits.
- Describe the basic structures of oral health
- Identify oral manifestations of HIVTraining

Training Methods: Lecture, Small Group Activity, Game Trivia

In This Activity You Will…

- Review information on the HIV Life Cycle
- Review information on the Action of HIV Medication
- Review information on oral health hygiene practices, and oral manifestations of HIV disease
- Provide trainees with a scenario to work on communication and situational skills
- Have trainees play Jeopardy game to review all materials covered

Materials

- Handouts on HIV Life Cycle & HIV Medications
- Case Scenario
- Cards with Emotions
- Computer for PowerPoint
- Projector Screen
- Speakers to connect to computer

(continued next page)

Instructions

1. Start with an icebreaker –everyone will say their name and share one good and one bad oral health practice they may have.
2. Give handouts, slides and the case scenario to the participants. Start off by reading aloud (or have participant volunteer to read).
3. Inform the group that we will get back to discussing this scenario.
4. Review the information on the PowerPoint slides with the group.
   - If standalone training, review all three PowerPoints (in this order: 1. Interesting facts, 2. HIV 101, 3. HIV Oral Health)
   - If part of a larger HIV peer training curriculum, review PowerPoints on "Interesting Facts" and "HIV Oral Health" only.
5. Take a 15 minute break.
6. Reintroduce the case scenario to the group. Break the group into smaller groups and have each group answer one of the questions.
7. Ask the groups to report back to the larger group on their responses to the questions.
8. Allow groups to comment on each other's questions.
9. Non-verbal communication activity: each person picks up a card with an emotion on it and then tries to express the emotion non-verbally in front of the group.
10. Introduce Jeopardy game to participants and provide them with the instructions to play.
11. Play Jeopardy game to review materials covered.

Summary

Wrap up the session by reminding participants that while all this information is important, the general take-home messages are:
1) Knowing and practicing good oral hygiene is important
2) Getting dental care regularly is crucial
3) Good oral health is important for everyone regardless of HIV status, but peeople living with HIV need to be especially aware of the importance of oral health as part of their overall health.
While people face many challenges to getting dental care and practicing good oral health hygiene, peers can draw from their own personal experiences and use that to help them. Encourage participants to share what they learned today with others and, if they have any other questions, ask a dental provider.

* This oral health module was developed by the Health & Disability Working Group, Boston University School of Public Health, 2009. For more information, visit http://www.hdwg.org/echo. The HIV 101 portions of the module come from the Missouri People to People Training Manual, 2008.

ABOUT THIS ACTIVITY (CONT.)

Materials (cont.)

- Timer or watch with a second hand and calculator for jeopardy game
- Flipchart paper and markers
- Oral hygiene "products": regular and sugar-free gum with xylitol, hard-bristle and soft-bristle toothbrushes, floss, mouthwash, cigarette pack, bottle of rubbing alcohol, bag of candy, soda bottle
- PowerPoint Slides including:
  Interesting Oral Facts
  HIV 101
  HIV and Oral Health Review
  HIV and Oral Health Jeopardy Game

Preparation

- Have handouts printed in advance
- Prepare 10 cards with different emotions (angry, sad, unconcerned, suspicious, happy, shy, uncomfortable, tired, scared, surprised)
- Have oral hygiene products placed on a table where participants will be able to access them.
- It may be helpful to have two people facilitating the Jeopardy game –the game/slideshow operator and a scorekeeper who can also be the host.

TRAINING TIPS

- Be sure to review the PowerPoint slides and reference the slide notes when applicable
- It is important to do a test run of the slides and the Jeopardy game to become comfortable with operating the slide show view with all the multimedia and audio effects

HIV Oral Health Jeopardy Game Instructions

Important Note: Facilitator/Instructor should become familiar with how to run the PowerPoint game before trying with an actual group

1. Open the PowerPoint game and make sure to enable your macros; otherwise the game will not play correctly
2. If you wish to change a question, you can do so by editing the text in the slides. *Do not remove or replace text boxes or delete any shapes unless you are familiar with custom animation in PowerPoint.*
3. Depending on what version you have, you may need to keep score via pen and paper if the score box does not work in slideshow view
4. The facilitator will need to use the answer key to know the correct and incorrect responses.
5. You will need three teams to play the game.
6. Select a method (i.e. a coin toss) to determine which team will go first
7. Explain the rules of the game to the teams who will be playing (a-e, m):
   a. Team will select a question by the point system on the board
   b. Facilitator will click on the number/points team selected (IMPORTANT to click on the actual number and not just anywhere in the box)
   c. Facilitator will read the question out loud
   d. A team will have 20 seconds to answer the question
   e. If the team cannot answer the question in 20 seconds, another team will get a chance to answer the question to get the point. Whichever team says their team name first gets the next chance to answer the question.
   f. If the first team to answer a question does not get the right answer, another team can try to answer the question to get the points
   g. Once the right answer is given, facilitator will click on the "Score" icon at the bottom of the slide and this will bring you to the Score slide in which the facilitator will enter the points earned under the respective teams score board (Slide #2)
   h. Then the facilitator will click on the Category matrix icon on Slide #2 and that will bring you back to the Category matrix.

* This module is part of the online toolkit *Building Blocks to Peer Success*. For more information, visit http://www.hdwg.org/peer_center/training_toolkit. This module was developed as part of the SPNS Oral Health Initiative, 2009. For more information, visit http://www.hdwg.org/echo. The HIV 101 portions of the module come from the Missouri People to People Training Manual, 2008.

HIV Oral Health Jeopardy Game Instructions (cont.)

i. The points will disappear from the question board once they have been asked so you can keep track of which questions are still unanswered.
j. Repeat A-G until there are no questions remaining.
k. For the double Jeopardy questions, in order to get to the question, click on the arrow icon at the bottom right of the slide.
l. When there are no questions with points remaining, click on the Final Jeopardy icon on the question board slide and that will bring you to the final jeopardy question
m. The final Jeopardy question is open-ended. This allows teams to provide their own responses to a fair open-ended question and all the teams get the opportunity to get the question correct.
n. Final Jeopardy question rules include:
- The teams have to have the answer(s) ready by the end of the final Jeopardy song that will play or a set amount of time you determine
- The team must determine how many points they want the final Jeopardy question to be worth, with a maximum bet of their total score (i.e. 900 points).
- If a team does not get the right answer, the points they assigned or bet for the final Jeopardy question should be deducted from their total points.

8. When a team chooses a question, click on the number/points for which category box they chose. It is important to click on the number/points and not just anywhere in the box.
9. Read the question out loud.
10. Using a timer, give the team 20-30 seconds to respond.
11. If the team gets the right answer, click on the slide (anywhere except for the "Score" box) so it highlights the correct answer and depending on what version of the game you are using, a music clip will play.
12. Then click on the "Score" box, which will bring you to the slide where you can record the score in the team boxes.
13. Once you have recorded the score, click on the Jeopardy category matrix on that slide, which will bring you back to the categories.
14. If they get the wrong answer or do not respond after 20 seconds, open the question to the other 2 teams and whichever team says their team name first, gets a chance to answer the question.
15. If the team gets the right answer, repeat steps 11-13. If they get the wrong answer repeat step 14.
16. Continue steps 8-15 until there are no more points in the category matrix left.
17. At this point, indicate to the teams the final jeopardy question instructions in Step 7n and click on the Final Jeopardy box in the matrix. After reading aloud the question, click on the slide so the music will start playing.
18. If a team gets the right answer, the get to select the next question.
19. If all teams get the wrong answer or do not know the response to a question, the team who has most recently given the correct response on a question gets to go first.

HIV Oral Health Jeopardy Game Answer Key

HIV 101

100.
Which of the following products always contain fluoride?
A. Toothpaste
B. Floss
C. Water
▶ **D. None of the above**

200.
Why is fluoride important for oral health?
Fluoride helps bring minerals back into the tooth structure

300.
Which of the following is True?
A. Oral HPV will always result in oral warts.
B. HIV medications work by actively destroying the HIV virus
▶ **C. Anal sex has a higher risk of HIV transmission than oral sex**

400.
Describe the HIV Life Cycle using AFRITAB.
Attachment, Fusion, Reverse Transcriptase, Integration, Transcription, Assembly, Budding

500.
Name the following three structures.
A. Enamel. B. Dentin. C. Pulp

HIV & the Mouth

100.
_____ can cause "dry mouth" which contributes to _____ in HIV infected persons....
A. Dental cavities; oral herpes
B. Mouth rinse; healthy gums
▶ **C. HIV medications; dental cavities**

200.
Which statement about saliva is TRUE?
A. It mostly contains bacteria that's bad for your mouth.
▶ **B. It can act as a great lubricant for sex.**
C. It helps with swallowing food, not the digestion of food.

300.
A common fungal infection of the mouth seen in connection with HIV infection and it often includes white patches
Thrush (oral candidiasis)

400.
What are three ways to help manage dry mouth?
Appropriate answers include –**drink water; chew on sugarless gum; suck on sugarless gum; artificial saliva; avoid caffeine; avoid sodas and high sugar products**

500.
Why is it so important to treat oral health problems?
A. If you don't treat them, bad oral health can cause AIDS.
▶ **B. It can lead to trouble with eating, which can affect your overall health.**
C. When there is a problem, dental care is more important than HIV care.
D. All of the above.

HIV Oral Health Jeopardy Game Answer Key (cont.)

What's in the Mouth?

100.
Oral infections often occur when CD4 count is ____ and HIV viral load is _____.
A.CD4 Count is greater than 500 and Viral Load is less than 200
B. When Viral load is between 200 and 500
▶ **C. When CD4 count is less than 200 and Viral load is greater than 20,000**

200.
Pick a product and explain how it can reduce the build up of plaque?
•Flossing helps remove plaque by scraping plaque off in between the teeth
•Brushing the teeth helps remove plaque by brushing it off of the inner, outer and chewing surfaces of the teeth as well as the tongue
•Antiseptic mouth rinse helps reduce plaque by killing the bacteria that cause plaque
•Chewing on sugar free gum or candy helps to reduce plaque by stimulating saliva flow

300.
What is plaque and why is it a problem?
Plaque is a film on the teeth that attracts bacteria and can cause infections in your teeth and/or gums.

400.
Name two ways a dental rubber dam is used:
Appropriate responses include **by the dentists for fillings, helps isolate the teeth being worked on, oral sex for females, oral-anal sex, any other terms used to define these acts.**

500.
What is the most common malignancy associated with HIV that may present like this?
Kaposi's Sarcoma

Let's Talk Hygiene and Habits

100.
Brush me the right way. Which statement is True?
A. Hard bristles are better than soft bristles because they clean better.
▶ **B. Brush the tongue from back to front.**
C. Electric toothbrushes are not as good as regular toothbrushes.
D. Using someone else's toothbrush is okay if you boil in hot water first.

200.
Which is true about flossing?
A. Flossing is proven to be more important than brushing your teeth.
▶ **B. When first starting to floss, bleeding gums can be normal.**
C. The "C" effect is achieved by wedging the floss deep into your gums.

300.
Pick out all the products that are better for good oral hygiene.
soft bristle toothbrush, floss, sugar-free gum with xylitol, mouth rinse, diet soda, sugar-free candy

400.
Name 3 oral health habits that can lead to poor oral health
Smoking cigarettes; chewing tobacco; drug use; not brushing and/or flossing daily; eating and drinking sugary products; not going to the dentist for regular cleanings

500.
Demonstrate how you would examine your neck for swollen glands...What is a cause of swollen glands?
Infections, cancers, diseases of the immune system such as HIV/AIDS

HIV Oral Health Jeopardy Game Answer Key (cont.)

Peer Talk

100.
You are talking with a client about the importance of coming back for his next appointment and the client shrugs and says, "Well, the pain is gone, so why would I come back?" Provide two reasons why regular dental care is important for this individual?.
•There may be other problems/cavities that if not treated now will results it pain in the future.
•If he gets the dental care before there is pain, the procedures will be less invasive.
•By going to the dentist regularly, he can prevent further oral health problems in the future.
•His dental provider is part of his health care team and can help detect signs of HIV in or near the mouth.

200.
You want to ask a client about his current oral hygiene practices. Provide an example of an open-ended question you would ask the client.
Any question in which an open-ended response is possible and one-worded responses are avoided

300.
A client informs you that she does not want to inform her dentist of her HIV status because she is worried she will be treated differently. Why should her dentist know her HIV status?
A. As a courtesy, so the dental provider can know he /she is at risk of contracting HIV.
▶ **B. So the dental provider can monitor her lab values and look for any signs of infection in her mouth that may relate to her HIV status.**
C. Because it is required by law that patients need to tell their health care providers their HIV status.

400.
Your doctor asks you about any drug use in the past 30 days. You feel very uncomfortable answering the question. Demonstrate two forms of non-verbal communication that might express how uncomfortable you feel.
Looking away, folding the arms, raising the eyebrow, crossing the legs, moving away, and any other suggestive gestures using body language

500.
Your client makes the following comment: "I have dentures, so I don't have to worry about brushing my teeth and all that stuff." Provide three points of oral hygiene if someone has dentures.
1. brush the gums;
2. brush the tongue;
3. brush the dentures;
4. soak dentures overnight;
5. use special denture brush when brushing dentures

HIV Oral Health Jeopardy Game Answer Key (cont.)

Random Facts

100.
How many Americans experience some anxiety and fear of the dentist?
1 million
15 million
▶ **30 million**

200.
Why are people with HIV more likely to have oral health problems?
Weakened immune system

300.
Oral Cancer. Which is true?
A.Only chewing tobacco puts you at high risk of getting oral cancer.
▶ **B. HIV does not cause oral cancer but can contribute to its progression.**
C. Smoking marijuana and smoking tobacco pose the same risk forgetting oral cancer.

400.
What is stigma? Provide an example of HIV/AIDS stigma in oral health care.
Any example where a person is prevented from receiving good oral health care because of their HIV status –i.e. dentist won't treat a person with HIV

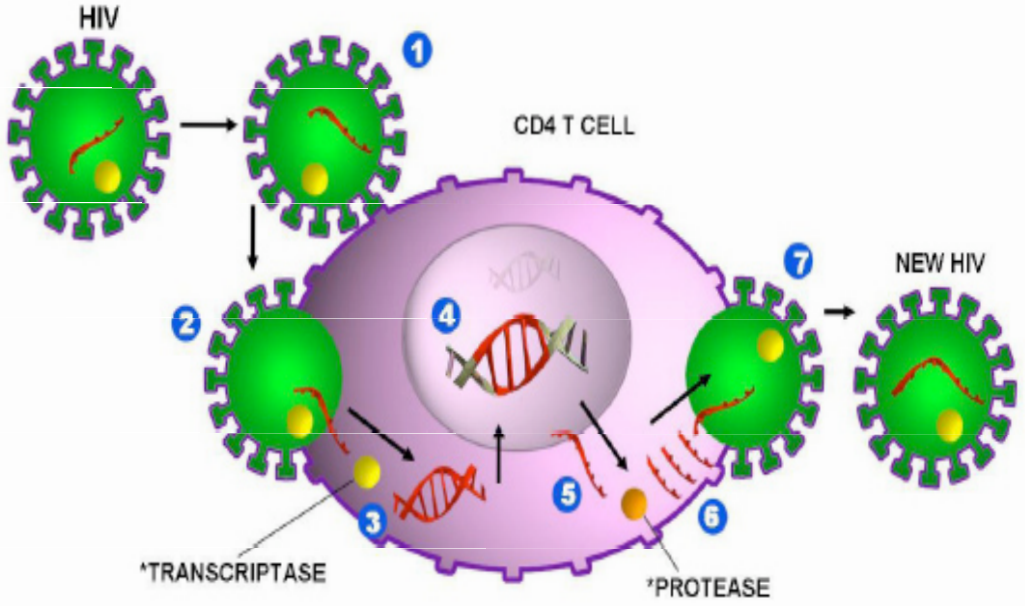
500.
Which of the following facts is FALSE?
A. Prince Charles has someone squeeze toothpaste on his toothbrush every day
B. In 1994, a prison inmate used tooth floss to escape from prison
C. In an average lifetime, a person produces 10,000 gallons of saliva.
▶ **D. The only cheese that is good for your teeth is feta cheese.**

Final Jeopardy

Identify four examples of how you as a peer could help someone with their oral health care needs?
Transportation, connecting with other social services, accompanying to dental visits, talking to them about their oral health care, explaining the importance of oral health care, describing your own experience with oral health care, appointment reminders, periodically calling them to stay in touch…

SESSION HANDOUT # 1 of 3

HIV Life Cycle - The Big Picture



Attachment

1. HIV binds to receptors on the CD4 T-cell.
   - A message is sent to the CD4 T-cell to let the virus in.

Fusion

2. Once bound, the virus is allowed to dump its contents into the CD4 T-cell.
   - Included in its contents are HIV RNA and reverse transcriptase.

Reverse Transcription

3. The HIV RNA is turned into double-stranded DNA within the CD4 T-cell.
   - The enzyme **reverse transcriptase* aids in this process.

Integration

4. Once the DNA is formed, it hides itself in the human DNA housed in the CD4T-cell nucleus.

Transcription

5. Copies of HIV DNA are made and released from the nucleus in small packages'.
   - Each of the small packages' contains information for creating a new HIV.

Assembly

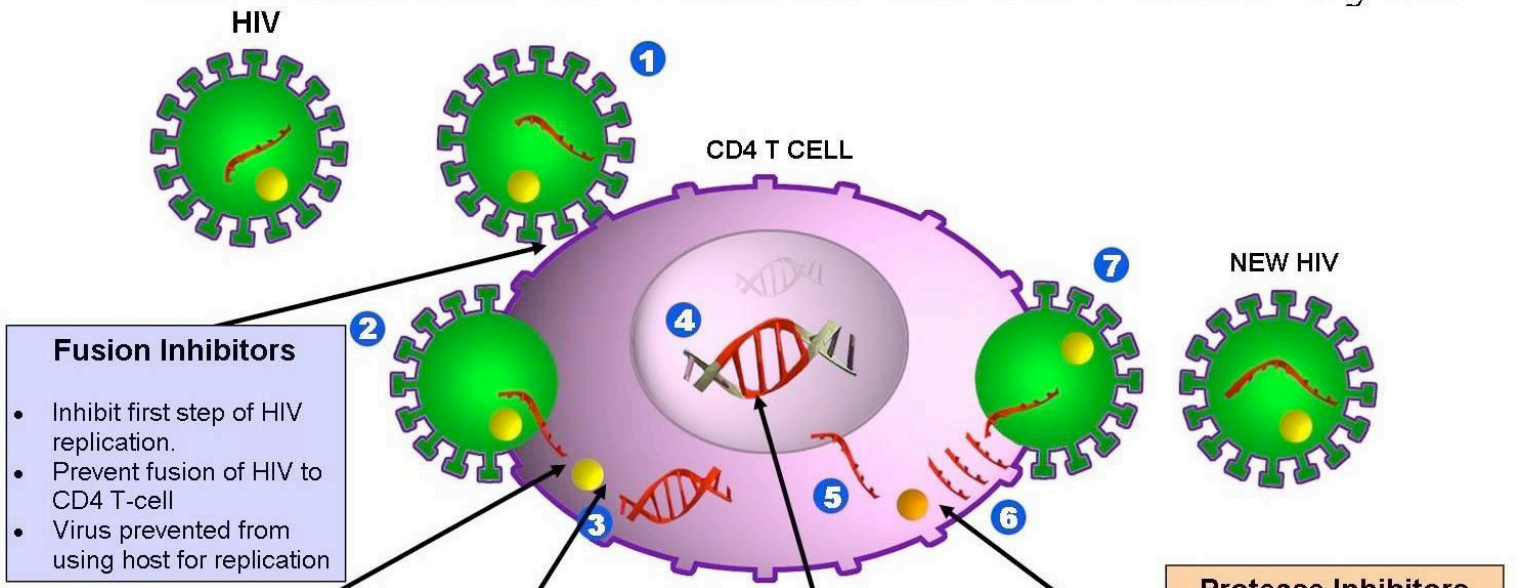
6. The **protease* enzyme in the cell combines the DNA 'packages' to create active virus.

Budding

7. Once the new HIV is formed, it pushes itself out of the CD4 T-cell
   - The virus steals part of the CD4 T-cell protective coating.

SESSION HANDOUT # 2 of 3

Medications at Work in the HIV Life Cycle



Fusion Inhibitors

- Inhibit first step of HIV replication.
- Prevent fusion of HIV to CD4 T-cell
- Virus prevented from using host for replication

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

- Inhibit reverse transcriptase—the enzyme responsible for turning HIV RNA into DNA
- Prevents virus from replicating

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

- Inhibit reverse transcriptase. This drug binds to the enzyme at a different place than the NNRTIs.
- Prevents virus from replicating

Integrase Inhibitors

- Blocks viral DNA and keeps HIV from binding to the host cell DNA
- Prevents virus from replicating

Protease Inhibitors

- Prevents the piecing together of HIV DNA into small 'packages'
- Prevents the formation of new HIV

Attachment	Fusion	Reverse Transcription	Integration	Transcription	Assembly	Budding
1	2	3	4	5	6	7

SESSION HANDOUT # 3 of 3

CASE SCENARIO: SANDRA

The dental team introduces a new client and her situation to you. They want you to help with getting her into dental care more regularly since she misses a lot of appointments and seems reluctant to complete her treatments. Sandra is 35 years old and in need of a lot of dental work, including some surgery to remove some teeth. She is a single mom who just got her life back together after being homeless and abusing alcohol and drugs for many years. It was during this time that she contracted HIV through what she believes was unprotected sex. During this period in her life, she rarely sought dental care, and if she did, it was only for when she had pain. And as soon as the pain was gone, she saw no need to go back to the dentist. She is juggling two jobs and dealing with a legal issue to regain full custody of her daughter. Sandra seems very self-conscious when she speaks to anyone, and she always covers her mouth, as she has some decayed and discolored teeth. She has expressed before an interest to go back to school to get her Associate's Degree and a better paying job, but in her opinion she doesn't have the "smarts" or the time to think about school. She smokes about a pack a day to help calm her nerves even though she wants to quit. As you go to approach her outside, in front of the waiting room to the dental clinic, she is smoking a cigarette sitting on the steps with her legs crossed and she does not make eye contact with you.

1. What are some of the biggest challenges Sandra faces to getting regular dental care?

2. Before you start talking with Sandra, what do you notice about her nonverbal communication (body language)? What does her body language suggest? How might this affect the way you approach her?

3. What are some ways you can start a conversation with Sandra?

4. Using open-ended style questions, list three questions that you would like to ask Sandra to learn more about her situation?

5. Sandra informs you that she doesn't want the surgery because she doesn't want them pulling out her teeth and making her look ugly. She doesn't want to go to work with missing teeth. How can you respond?

6. Identify three ways you specifically can help Sandra with getting the dental treatment she needs?

Continuing Education

HIV/AIDS AND PEOPLE OVER 50*

ABOUT THIS ACTIVITY

Time: 30 minutes

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

- Discuss 2 current issues among people over 50 with HIV/AIDS and the implications for access to care and treatment.

In This Activity You Will…

- Ask participants to read statements found in their fortune cookies and then discuss the information with the class. (30 minutes).

Materials:

- Handout – Fortune cookie statements
- Fortune cookies with statements inside
- Flip chart and easel
- Markers
- Eraser

Preparation:

- Prep fortune cookies

Instructions

1. Introduce session. Ask the group – do people over 50 have sex? Who is included in the group of people over 50? (this group includes those infected after 50 as well as those infected and living with HIV for many years who are now over 50).

2. Explain that we are going to have a group discussion about HIV in people over 50.

3. Explain that each table has fortune cookies with information on HIV and People over 50.

4. The facilitator will ask for a volunteer who will pick a fortune cookie and read what is inside.

5. The participant will comment on the statement and then facilitator will respond.

Note: Collect the fortune cookies as each statement is discussed

Summary

Ask participants for feedback on the session and wrap up.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from the Comprehensive Peer Worker Training, Peer Advanced Competency Training (PACT) Project Harlem Hospital Center, Division of Infectious Diseases, 2008.

HIV/AIDS AND PEOPLE OVER 50

SESSION HANDOUT

FORTUNE COOKIE STATEMENTS

15% of AIDS cases occur in people over 50.

The number of cases is expected to increase, as people of all ages survive longer due to combination therapy.

Older people with HIV/AIDS are often invisible, isolated and ignored.

Despite myths and stereotypes, many seniors are sexually active and some are drug users, therefore their behaviors can put them at risk for HIV infection.

Healthcare and service providers and older adults themselves do not realize seniors are at the same risk as other populations. This may lead to misdiagnosis.

AIDS has been increasing twice as rapidly for people over 50 as for people under 50.

Professionals are often reluctant to discuss or question matters of sexuality with aging clients.

Rates of HIV infection are especially difficult to determine because older people are not routinely tested.

Most older persons are diagnosed with HIV at a late stage and often become ill with AIDS related complications and die sooner than their younger counterparts: these deaths can be attributed to original misdiagnoses and immune systems that naturally weaken with age.

HIV/AIDS educational programs are not targeted to older individuals.

Seniors are unlikely to consistently use condoms during sex because of a generational mind set and unfamiliarity with AIDS and STD prevention matters.

Older people with HIV/AIDS face a double stigma: ageism and HIV/AIDS.

While men who have sex with men form the largest group of AIDS cases in the over 50 population, the number of cases in women infected heterosexually have been rising a higher rate and compromise, a greater percentage increases into the 60's and older population.

Because of the stigma, it can be difficult for seniors - women in particular, to disclose their HIV status to family, friends and their community.

SESSION HANDOUT (cont.)

FORTUNE COOKIE STATEMENTS (CONT.)

For older women, there are special considerations: after menopause, condom use for birth control becomes unimportant and normal aging changes such as decrease in vaginal lubrication and the thinning of the walls in the vagina can put them at higher risk during sexual intercourse.

Due to the general lack of awareness of HIV/AIDS in older adults, this segment of the population for the most part has been omitted from research, clinical trials. education programs and intervention efforts.

Specific programs must be implemented for older adults who need to be informed about transmission and prevention of HIV Outreach should include workshops and training's devoted to HIV/AIDS information "safer sex" negotiation skills- all in relationship to aging.

The over 50 population often does not identify with the average younger peer and may not be open to advice the younger population.

With the availability of Viagra, sex among seniors has increased.

Some people over 50 are at risk due to sharing needles used for insulin when they are diabetic.

SPECIAL POPULATIONS*

ABOUT THIS ACTIVITY

Time: 30 minutes

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

- Understand the risk and challenges that special populations have with regard to living with HIV/AIDS.
- Understand what ethnic groups are affected in this pandemic which is increasingly becoming problematic and why they are facing such challenges.
- Understand reported health statistics for MSM's, Women, Youth, Children the Aging populations and the barriers to care living with HIV/AIDS.
- Understand the critical issues and risks factors for HIV/AIDS special populations as they relate to HIV/AIDS treatment, adherence and care.

In This Activity You Will…

- Share epi-data on HIVs impact on different populations (10 minutes).
- Lead a group discussion about HIV/AIDS risk factors and issues different populations (10 minutes).
- Lead a group discussion to summarize (10 minutes).

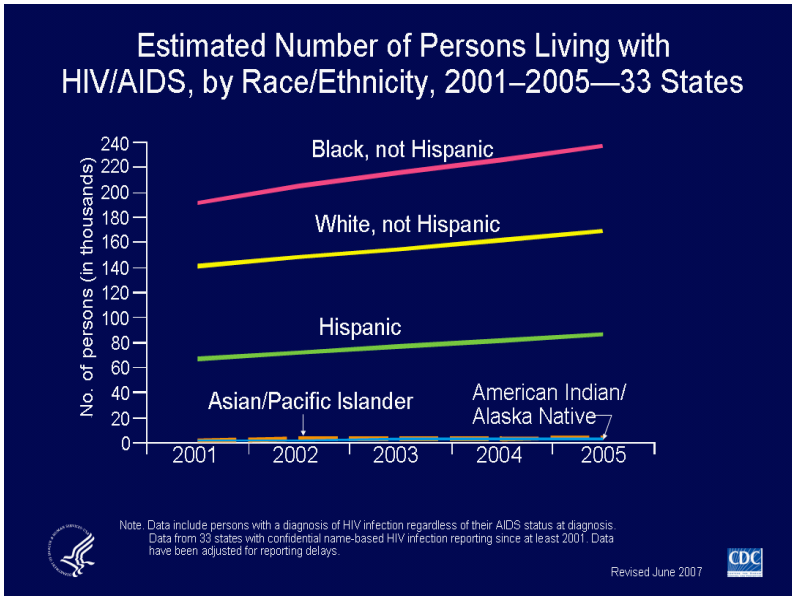
(continued next page)

Instructions

1. Participants will follow power point presentation on Special Populations using presenter slide notes.

Special Populations - Overview

- Rates of HIV/AIDS are highest and growing in the African American population
- Overall survival rates have improved over the last 10 years
- Unique considerations require attention to improve HIV/AIDS management among African Americans and Hispanics.



Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 2005

* This module comes from the Missouri People to People Training Manual, 2008.

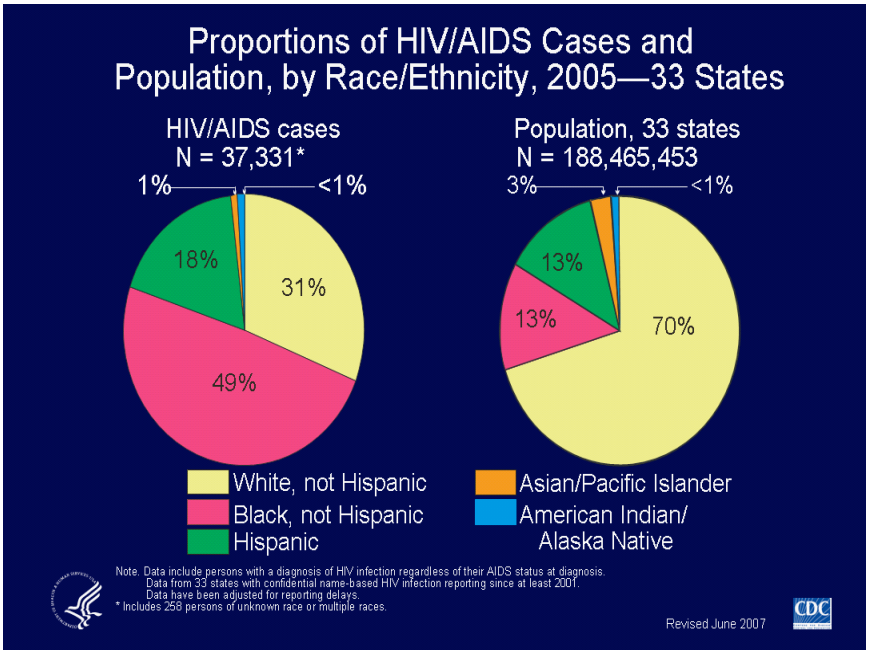
SPECIAL POPULATIONS

ABOUT THIS ACTIVITY (CONT.)

Materials:

- Laptop
- Projector with screen or blank white wall
- Centers for Disease Control Fact sheets – Reference www.cdc.gov/hiv/topics/surveillance/basic

Preparation: None



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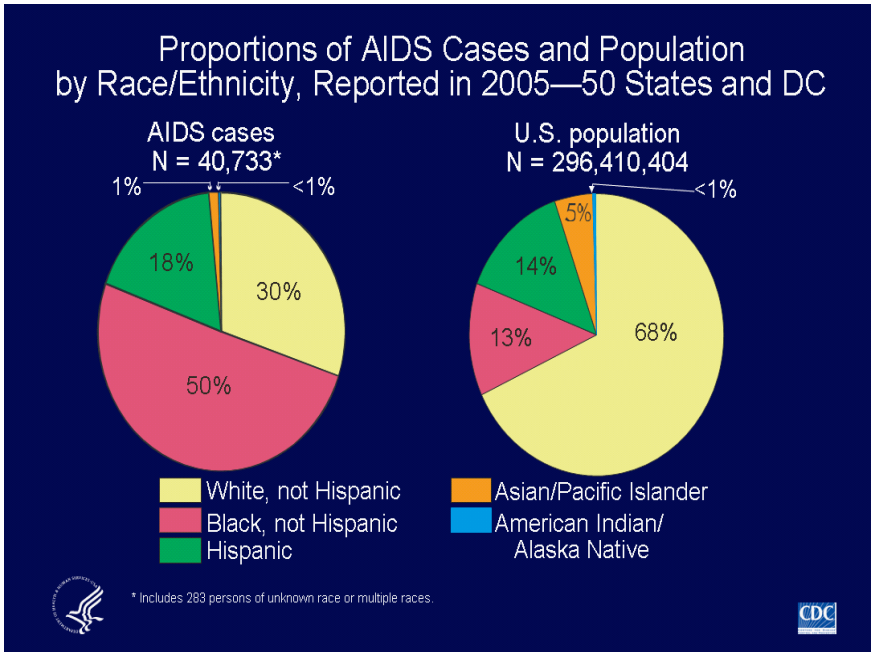

Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 2005

SPECIAL POPULATIONS

Facilitator Notes

- Blacks account for 13 percent of the U.S. population but constituted 49 percent of the adult and adolescent AIDS cases reported in 2005.*

- More than half 20,187 (50%) of new HIV cases reported in the U.S. of the estimated 40,608 in 2005 were in African Americans.**

- The rate for AIDS diagnoses for black adults and adolescents was 10 times the rate for whites and nearly 3 times the rate for Hispanics.

*Includes 33 states with long-term confidential name-based HIV reporting.

**Includes 50 states and the District of Columbia.

Hispanics & HIV/AIDS

- Hispanics account for 13 percent of the U.S. population but constituted 18 percent of new AIDS cases reported in 2005.
- At the end of 2005, estimated that 19 percent living with AIDS in the U.S. were Hispanic.

**Includes 50 states and the District of Columbia.

- Mobility, lack of knowledge about HIV transmission.
- Cultural and language barriers complicate relationships with medical providers.
- Social economic barriers for Hispanic migrant farm workers where median education level is sixth grade, access to health care is difficult.
- Hispanics who are not citizens of the U.S. may not access care for fear of immigration authorities.

Men of Color Who Have Sex with Men & HIV/AIDS

- HIV incidence has been highest among men who have sex with men (MSM).
- MSM men of color represented 39 percent of an estimated 207,810 HIV/AIDS cases reported in the U.S. in 2005.
- Men of color also accounted for 39 percent of reported HIV/AIDS cases related to MSM/Injection drug use.
- MSM of color face many types of Stigma for being:
  a minority
  an MSM and
  HIV positive
- MSM's fear condemnation from many sectors:
  Family
  Community
  Service providers

MSM & HIV/AIDS

- Estimated Number of AIDS Cases by MSM Exposure Category and Race/Ethnicity, 2005 (N=207,810)
  1% Asian/Pacific Islanders
  1% American Indian/Alaska Native
  50% White
  32% Black
  16% Hispanic

Includes 33 states with long-term confidential name-based HIV reporting.

Women

- Women with AIDS made up an increasing part of the epidemic. In 1992, women accounted for an estimated 14% of adults and adolescents living with AIDS in the 50 states and the District of Columbia. By the end of 2005, this proportion had grown to 23%.
- Of 40,608 AIDS diagnoses in the 50 states and the District of Columbia, 10,774 (26%) were for women.
- Of the 126,964 women living with HIV/AIDS, 64% were black, 19% were white, 15% were Hispanic, 1% were Asian or Pacific Islander, and less than 1% were American Indian or Alaska Native.
- Social and medical aspects of HIV tied together (care of

SPECIAL POPULATIONS

children and household – tend to put yourself last)
- 1 in 4 women eligible for HAART - are on the regimen

Women-Pregnancy

- Transmission rate (with treatment) from mother to infant is as low as 2% with some studies showing a zero transmission rate.
- Transmission rate (without treatment) is a one in four chance of passing the virus on to babies.
- Still 90% of pregnancies in HIV-infected women are unplanned.
- Risk increase with vaginal versus cesarean delivery, mothers with high viral loads, and mothers who breastfeed increases – 28%.
- All babies receive treatment from 3 to 6 months.

Youth

- An estimated one-fourth of HIV infections occur among ages 21 and younger
- In 2005, 2,283 estimated AIDS cases among people ages 15 to 24
- Given the average time from HIV infection to progression to AIDS, poor access to HIV testing, and lack of HIV reporting systems surveillance data do not reveal the scope of the epidemic among adolescents
- Barriers are:
  limited understanding of HIV disease;
  links between the disease and behaviors;
  feelings of invincibility;
  lack of youth friendly counseling and testing facilities;
  fear of being tested and of receiving the test result; and consent and confidentiality concerns

Children

- New infections of children are rare where antiretroviral medications and good medical care for pregnant women are available.
- According to U.S. health statistics, age 13 or younger is counted as a child.
- The cumulative estimated number of AIDS cases through 2005 is 9,112 .
- Children's immune systems are still developing; CD4 cell counts and viral load counts are higher and infant's viral load usually declines until age 4 or 5 then stabilizes.
- Children respond differently to ARVs and have larger increases in CD4 cell counts and they recover more of their immune response than adults.
- There are approximately 12 ARVs approved for use by children.

Aging

- Nearly 27% of people living with AIDS in the U.S. are 50 or older.
- Numbers of cases, will increase as people of all ages survive longer due to triple-combination drug therapy and other treatment advances.
- Despite myths and stereotypes, many seniors are sexually active, and some are drug users.
- Health care and service providers – and older adults do not realize they are at risk as other age populations; often are reluctant to discuss or question matters of sexuality with aging patients/clients.
- Older adults are not routinely tested.
- Seniors are unlikely to consistently use condoms during sex due to generational mindset and unfamiliarity with HIV/STD prevention methods.

Substance Abuse

- The spread of HIV disease in the U.S. is fueled by use of illicit drugs, direct transmission – sharing needles, indirect transmission - sexual contact with HIV-positive injection drug users.
- Non-injected drugs increases risk for HIV because of

its effect on decision making and sexual risk taking.
- Without treatment for drug problems, substance abusers have difficulty adhering to therapies and accessing care.
- In 2004, estimates of new AIDS cases through IDU exposure were:
  21.5% Adolescents and adults
  19.2% Men
  27.8% Women

Mental Health with HIV/AIDS

Common psychological disorders - Men and Women:

- Depression- Low self esteem, anxiety, forgetfulness, sleep disturbances, changes in appetite, weight loss or gain, decreased libido, sense of hopelessness
- Anxiety-Sense of numbness, emotional detachment, or a dazed state
  Types of anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and phobias
- Dementia (AIDS Dementia Complex or ADV) common among people with advanced HIV-Problems thinking clearly, lack of concentration, loss of memory, social withdrawal, sluggish thinking, short attention span, poor coordination, impaired judgment, vision problems and altered personality

Power point Slides

Critical Issues & Risk Factors for HIV/AIDS in Special Populations

Risk Factors often overlap for Special Populations (such groups included in this list are women, children, youth, persons with sexuality and gender differences, substance use and mental health challenges).

Psychosocial Issues:

- Poverty
  Poorer than the general population
  Live below the poverty line
  Homelessness
- High risk heterosexual contact
  Relationship inequality (age, power)
  Fear of abuse or partner leaving
  MSM (unprotected sex and STD's increase risk)
  Denial or unaware of risk (monogamy, marriage, bi-sexuality)
- Underestimate their risk
- Overestimate how safe their partners are
  Sexually Transmitted Diseases
  Substance abuse
  Social discrimination and cultural issues (stigma may inhibit accessing health care and testing)
  Mental Health (Depression, Anxiety, Dementia (AIDS Dementia Complex or ADV)
- Health Disparities
  Limited healthcare
  No health care (minorities less likely to receive care)
  Poor access (i.e. rural area, transportation, resources)
  Provider insensitivity
  Provider lack of cultural competency
  Provider lack of knowledge
- Racial and Ethnic Minorities Healthcare
  Less likely to receive combination therapy
  Less likely to receive drugs to address opportunistic infections
  Less likely to be admitted to the hospital when presented to the emergency department
  Less frequently monitored by a health care provider on a regular basis
  Test late in the disease process
  Minorities experience poorer health outcomes
  Receive lower quality health care than whites do, even

when insurance status, income, age, and severity of conditions are compared

Special Populations

Of all the forms of inequality, injustice in health is the most shocking and the most inhumane. - Dr. Rev. Martin Luther King Jr.

Discussion Questions:

- Do you see the need for the HIV/AIDS community and our government to promote programs that focus on Special Populations due to the higher incidence of infection?
- What do you feel will happen if these programs are not funded and/or promoted?
- Is there validity in promoting HIV/AIDS programs in the specific communities to target special populations?

Summary

There are many critical issues and risk factors that we've discussed that contribute to the increase of HIV/AIDS despite the numerous Prevention and Intervention programs offered, it is the burden of society as a whole to continue to define strategies and methods to meet this pandemic.

We are our brother's keeper and as Dr. King's quote says – *"Of all the forms of inequality, injustice in health is the most shocking and the most inhumane."* We must continue to demand equality and justice in our healthcare system.

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1. Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 2005

2. U.S. Census Bureau, 2004, CDC and Prevention (CDC). HIV/AIDS Surveillance Report 2004

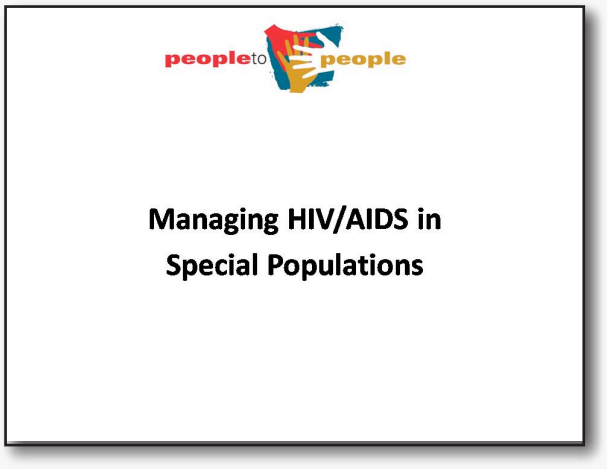
3. Shapiro, et al. 1999. Variations in the care of HIV-infected adults in the US. JAMA, 281:24(June):2305-2315

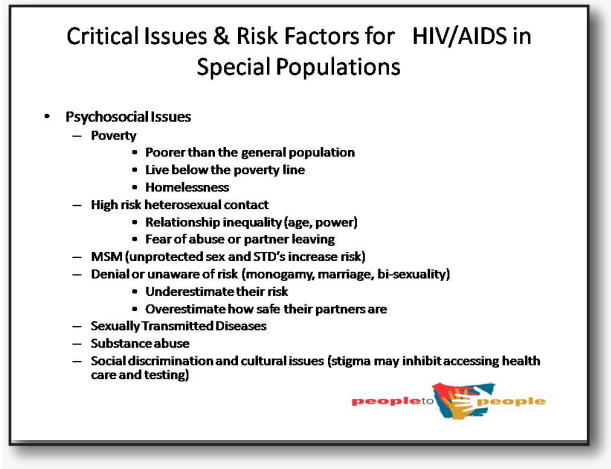
4. MMWR. Late versus early testing of HIV-16 sites, United States, 2000-2003. June 27, 2003/Vol.52/No.25.

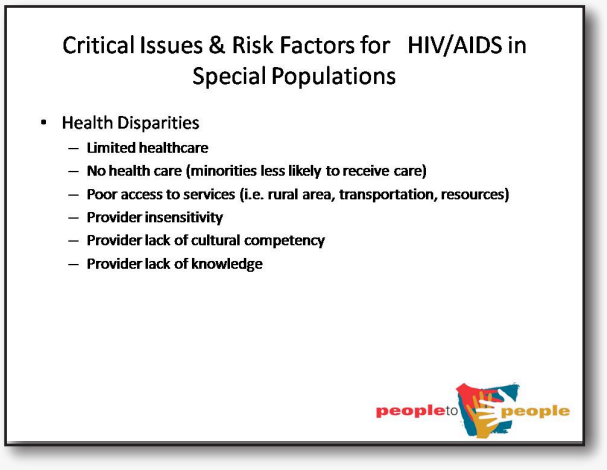
* This module is part of the online toolkit *Building Blocks to Peer Success.* For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from the Missouri People to People Training Manual, 2008.

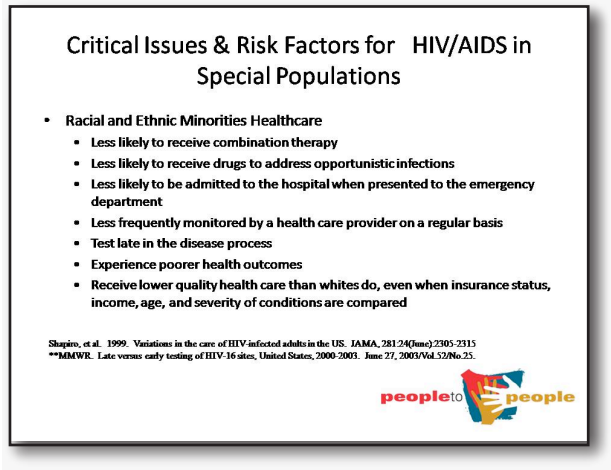
SPECIAL POPULATIONS

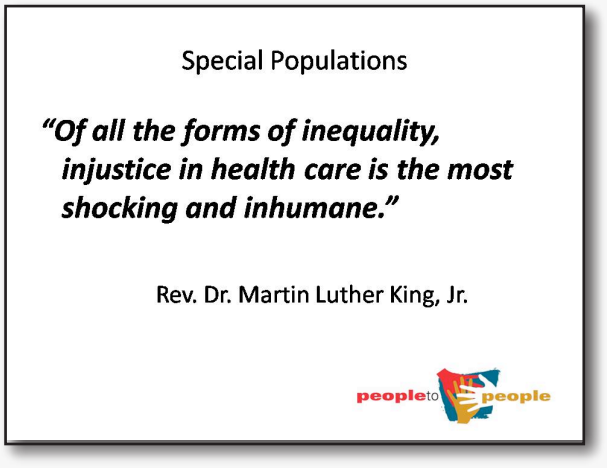
SESSION POWERPOINT











Continuing Education

WORKING WITH THE TRANSGENDERED COMMUNITY*

ABOUT THIS ACTIVITY

Time: 95 minutes

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

- Discuss 2 current issues among transgendered people with HIV/AIDS and the implications for access to care and treatment.

In This Activity You Will…

- Ask participants to split into 2 groups and to work on brainstorming stereotypes about trans-folk and people who are HIV+ (10 minutes).
- Lead a discussion in which the class compares and contrasts the two lists (20 minutes).
- Lead a discussion about barriers for trans-folk (20 minutes).
- Review definitions related to transgender populations (15 minutes).
- Ask the group to come up with possible solutions to the Barrier (20 minutes).
- Discuss "best practices" when interacting with the transgendered population (10 minute).

(continued next page)

Instructions

1. Introduce session and explain that we will be discussing working with TransFolk. Remind participants about the session on Delivering Cultural Competent HealthCare. Highlight that we will be dealing with the same issues: how do we treat someone who comes through the door of our agency with respect so that they will return for services and therefore improve their health?

2. Acknowledge that this topic is rarely discussed and we are only exposed to stereotypes on Jerry Springer etc. Gender Roles start at birth with questions about if it is a boy or a girl and clothing only in certain colors.

3. Ask participants to split into two groups and to write on newsprints that are on the wall. Ask them to write stereotypes about the group listed on their paper: Transgender people or People living with HIV/AIDS. Give the group about 10 minutes.

4. Once the newsprints are filled out, ask participants to take their seats and lead a discussion comparing and contrasting the lists.

5. Discuss Barriers to Care as they arise and write them on the Barriers newsprint.

6. Summarize by reminding participants that ideas about TransFolk are given to us by media stereotypes and lack of education.

7. Review Definitions handout.

8. Discuss the Barriers to Care and ask the class to come up with Solutions and Interventions to address the barriers. List these on the flipchart. Focus especially on solutions that the peers that the peers can do.

* This module comes from the Comprehensive Peer Worker Training, Peer Advanced Competency Training (PACT) Project Harlem Hospital Center, Division of Infectious Diseases, 2008.

WORKING WITH THE TRANSGENDERED COMMUNITY

ABOUT THIS ACTIVITY (CONT.)

Materials:

- Handout – TransFold Increased Risk
- Handout – Definitions
- Miscellaneous handouts on current issues in the Transgendered Community
- Flipchart sheets with each of the following written on them:
  - Transgender People
  - People Living with HIV//AIDS
  - Barriers to Care
  - Solutions and Interventions
- Flip chart and easel
- Markers
- Eraser

Preparation:

- Prepare handouts
- Prepare flipcharts

9. Distribute the handouts on current issues in the Transgendered community.

10. Remember that it is okay to ask someone what they would like to be called but do not make the person into your teacher. That is not their role. If you would not ask a non-trans person the question, then don't ask a transperson.

11. Useful phrases are "What do you call yourself? or Is there a name you would like me to call you in this office but not outsider? What people do you have sex with?"

Summary

Wrap up by reminding participants that our goal is to give the best possible services to anyone who comes through our door. You might not need this information but you might be someone's best advocate.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit.
This module comes from the Comprehensive Peer Worker Training, Peer Advanced Competency Training (PACT) Project Harlem Hospital Center, Division of Infectious Diseases, 2008.

WORKING WITH THE TRANSGENDERED COMMUNITY

SESSION HANDOUT # 1 of 2

WHY MIGHT TRANSFOLK HAVE INCREASED RISK FOR HIV?

Agency and societal policies – bathrooms, forms that list only male or female

CDC counts an HIV+ Transperson as "MSM" so that determines funding levels. There is little prevention targeting transfolk.

Stigma and low self-esteem lead to the person being less likely to take care of self

Higher rates of drug and alcohol use so sex may be under the influence and safer sex not practiced

Difficult to find a job due to prejudice.

Survival sex to make money or to pay for surgery

May use street hormones since the person may not want to have a mental health diagnosis which is needed to get the hormones.

Some transwomen say that sexwork is affirming of their new gender or can provide a sense of community

Using silicone from hardware store or street hormones because they are cheaper. Leads to needle sharing at hormone or silicone parties or also general health risks because of quality of the product.

Fear of discrimination leads to avoiding health care providers. When the person is diagnosed, they might be at a later stage of HIV infection: lower T cell count, higher viral load.

WORKING WITH THE TRANSGENDERED COMMUNITY

SESSION HANDOUT # 2 of 2

DEFINITIONS

Sex

Body parts you are born with – male/female/intersex (hermaphrodite)

Gender

Boy/girl/man/woman/transW/transM/gender/queer

Orientation

Straight/gay/bi/hetero/homo/

Gender identity

Interpretation of own gender, sense of self about own male/femaleness – may not be visible to others!

Transgender

Umbrella term like Christian or Person of Color. Transgender can include transsexuals although they identify as straight while they dress in clothing of the other gender