Combination Prevention
A Facilitator’s Guide
Acknowledgements

The authors would like to thank Dr. John Waters for his guidance on the manual, Bennet Charles and Patricia Joseph for their efforts in organizing the first trial session in St. Lucia, and Alexandrina Wong for organizing the Antigua Workshop and all the participants for their invaluable insights, including Winfield Tannis-Abbot, Kizzy Ann Abraham, Duwayne Frederick, Orin Jerrick, H.N. Bethelmy, and Lorna Wilson.

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Caribbean Vulnerable Communities Coalition (CVC) is a coalition of community leaders and non-governmental agencies that are advocates and service providers, working with and on behalf of Caribbean populations who are especially vulnerable to HIV infection or often forgotten in access to treatment and healthcare programmes.

These groups include men who have sex with men (MSM), sex workers, people who use drugs, orphans and other children made vulnerable by HIV, migrant populations, persons in prison and ex-prisoners, and youth in especially difficult circumstances.

Throughout the Caribbean there is a critical need for effective prevention strategies that focus on populations with high incidence of new infections. Designing a package of interventions that matches the epidemiological profile of a target population involves careful planning and design. In order to address these issues, CVC has developed plans for three-day workshops for community-based organizations (CBOs) and health ministries working on HIV prevention in the Organization of Eastern Caribbean States (OECS).

The workshops will attempt to build the capacity of organizations to identify key populations affected by HIV/AIDS in OECS countries, to recognize specific vulnerabilities faced by those populations, and design combination prevention strategies which address the vulnerabilities directly.

The workshop was piloted in St. Lucia and Antigua, in late 2016. The participants will then go on to facilitate their own workshops throughout 2017. Each workshop should have between 15 and 20 participants, who are members of community-based organizations and health ministries.

This manual provides a plan to help trained facilitators deliver their workshops effectively. The modules are designed to build on each other as the workshop progresses, concluding with an activity in which participants apply the concepts in the design of new interventions.

In each module, facilitators can find the objectives, the methods used, and the recommended time and materials required for each activity, as well as a step-by-step guide to carrying them out. Facilitators are encouraged to adapt the activities as local conditions may require. The annex section contains materials that can be photocopied and distributed to participants.

Using this manual and their own prior knowledge, facilitators will be able to create a safe space to encourage participation and lead a workshop that is informative, collaborative and entertaining.
INTRODUCTION

MODULE 1.1: WORKSHOP INTRODUCTION

Activity Outline

1) Introductory remarks 15-20 minutes
- Welcome the participants, make sure everyone is comfortable and has everything they need.
- Briefly introduce yourself, your organization and the workshop.

2) Where do you stand Activity 15-20 minutes
- Ask participants to stand in a large clear space, such as the front of the room.
- Tell the participants that one side represents “coffee” and the other side “tea.”
- Have participants move to the either side, depending on their preference. They can indicate degree of preference by standing somewhere in the middle. Standing in the very centre of the room can indicate “neither” or “both equally.”
- Move from soft questions such as the one above, to questions relating to workshop participation, like “Do you prefer talking or listening?”, “Do you like working in small groups or big groups?” and moving on to questions about HIV prevention such as “Is preventing HIV more the responsibility of individuals or the state?”, “Are the biggest challenges you face in your work cultural or legal?”
- Participants can add their own questions if they wish.
- Alternatively, the bingo card activity may be chosen if participants have never met each other. (pg.30)

3) Presentation of Workshop Aims 45-60 minutes
- Ask participants why they are attending and what they hope to get from the workshop.
- Optionally, have participants write their hopes and worries on sticky notes and place them on a flip chart by category.
- Present the aims of the workshop, referring to the presentation provided.
- Be sure to address participants expectations.
- Go over the workshop schedule.
- Answer any questions that the participants may have.
- Have the participants fill out the Pre/Post Test on (pg 33).
- You can use this after the workshop to see how much the participants have gained from your workshop.
Module 1.2: Creating a Safe Space

Activity Outline

1) Establish a safe space 10-15 minutes
   - Ask the group what they know about safe spaces.
   - Provide information to fill gaps in participant knowledge.
   - Affirm your commitment to creating and maintaining a safe space by
     - Maintaining confidentiality
     - Enforcing a zero-tolerance policy on bullying and discrimination
   - Remember that there is a balance between creating a safe space and silencing opposing viewpoints. It’s normal for there to be criticism and conflicting opinions in a workshop. It is your job as a facilitator to mediate discussions, ensure that everyone can have their voices heard and express themselves productively, without letting arguments get out of hand

2) Comfort Zone Activity 10-15 minutes
   - Hand out comfort zone cards to all participants.
   - Explain that this is a tool for self-reflection as much as one for guiding discussion.
   - Ask about subjects such as:
     - Sexual health
     - Sexual assault
     - Personal stories about discrimination
   - Have participants write the subjects on their cards. They should write subjects they are comfortable with closer to the center, and subjects that they are less

Materials

- Comfort zone cards for each participant (pg. 34)
- Flip chart

Activity objective

- Create a safe space, create rules and set the tone for the workshop

Methodology

- Discussion
- Individual self-reflection activity/survey
- Group decision making

45-60 minutes

Energizers

Power and privilege role playing activity

Have participants take on roles of people in power such as a teacher and have them role play good and bad behavior.

TIPS

- Some people work best in small groups, whereas other people work better in large groups. During the piloting of this workshop, there was feedback that some participants would rather write their ideas anonymously and have the facilitator read them. It is important to stay flexible and modify activities and discussions to suit the needs of the participants.
Activity Outline

3) Ground Rules for Workshop 30 minutes
- Ask participants to suggest workshop rules.
- Be sure to get suggestions relating to:
  - How participants would like to be treated
  - What kind of language should be used
  - How differences in opinion should be handled
- The use of mobile phones/laptops
- Timeliness
- Discuss the rules with participants, get agreement that participants will follow them.
- Write the rules on a flip chart for easy reference.

Essential Information

What is a safe space?
A safe space is somewhere where everyone feels comfortable to express themselves freely and without fear of discrimination. A safe space will also ensure that the physical location is in a secure area and can be accessed without fear of violence and harassment. Finally, a safe space also has to take into account confidentiality issues. Some organizations will make stakeholders sign non-disclosure agreements.

Why is it important to establish a safe space?
In contexts where groups of people are marginalized and discriminated against, these people may not feel comfortable expressing themselves and talking openly. A safe space will encourage participants to engage in conversations and contribute to the workshop, creating a fuller experience for everyone.

Dealing with bullying

Abusive behavior can occur anywhere, even within groups of trained facilitators. If you find that someone is engaging in this type of behavior, you should:
- Step in immediately
- Draw attention to the behavior and demonstrate how it conflicts with the shared values or ground rules of the group
- Link the specific behavior to a broader context of human rights and dignity
- Ask the participants to avoid this type of behavior in the future
- Remember that these can be educational moments for growth and learning, instead of shaming and ostracizing members of the group
Activity Outline

1) How can we be better participants?
   - Invite participants to think of workshops, meetings or other situations in which either
     - Everyone could contribute and have their voices heard, or
     - They or someone else had their opinions and contributions sidelined, shut down or accepted in a
       superficial and patronizing way
   - Have participants write down notes on their experience(s).
   - Have participants work in pairs or small groups to share their experiences.
   - Bring the group together to draw out common themes and experiences. How can we use this informa-
     tion to create a better learning environment?

Essential Information

What are participatory approaches to learning?
Participatory approaches to learning are approaches that encourage people to think for
themselves, contribute actively and work together to further their understanding. Participants
learn from each other instead of only receiving information from outside experts.

Why are participatory approaches important?
Participatory approaches encourage teamwork and cooperation. They can instill confidence in
participants and promote empowerment by giving everyone a voice. Participatory workshops are
also fun! Generally it is more interesting for participants to be involved in activities than for them
to simply listen to a presentation.

Parking Lot
- It is important to get a wide variety of comments, but sometimes conversations can move away from the
  main discussion topic. Keep a space, such as a blank flip chart, where you can write down subjects which will
  be addressed later if you need to cut discussions short. If sticky notes are available, participants can also write down
  their own off-topic questions to be put in the parking lot.
- Good facilitators can balance discussions so that everyone can share their ideas.
### Module 1.4: Checking Background Knowledge

#### Activity Outline

1) **Quiz**  
   - Hand quizzes out to participants and explain that this is less a test of knowledge than it is a tool to prompt discussion and encourage self-reflection.  
   - Quizzes to be filled individually.

2) **Discussion**  
   - Go over the questions one at a time. Prompt participants to provide answers.  
   - As a group, have participants discuss the questions and answers, being sure to mention:  
     - What information surprised them?  
     - What questions were easy?  
     - What subjects they are more and less familiar with?

After the discussion, collect the quizzes for review. These can be used to evaluate what basic review, if any, will be necessary.

#### Methodology

- Quiz
- Discussion

#### Materials

- Quiz handout (pg. 35-36)

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### Energizers

- The facilitator could change the format of the quiz to make it more interactive. For instance, having a group discussion or doing the exam in pairs could serve as an alternative.
## Optional Module: HIV/AIDS Refresher

### Activity objective
- Explain HIV/AIDS and treatment options

### Methodology
- Present HIV/AIDS and treatment options

### Materials
- Interactive video (link below)
- refresherhiv.ppt

#### Activity Outline

If the participants need a refresher on HIV/AIDS concepts, proceed with the following steps:

1) Present the interactive video. **3-5 minutes**

2) Present the PowerPoint with additional information. **5-10 minutes**

3) Refer back to the set of multiple choice questions and ask participants to answer questions again out loud. Ensure that the material is understood by the participants.

### Essential Information

**What is HIV?**
Human Immunodeficiency Virus (HIV) infects CD₄ cells of the body’s immune defense system.

**What is AIDS?**
Acquired Immunodeficiency Syndrome (AIDS) is an advanced stage of HIV infection where there is evidence of severe immune system depression. The progression will depend on the type of virus, and characteristics of the host such as age and genetics.

**How can you contract or transmit HIV?**
HIV is transmitted through body fluids. These include: vaginal secretion, semen, blood, and breast milk. Possible modes of transmission include sexual transmission, transmission through blood, and mother to child transmission (MTCT).

### Tips
Limit the use of scientific vocabulary in explanations. Participants need to understand how HIV is transmitted and treated in order to understand combination prevention methods.

### Resources:
AIDS - Everything you need to know.
Health Channel TV, December 4th 2012
www.youtube.com/watch?v=rV0ylICeg-E
COMBINATION PREVENTION

MODULE 2.2: WHAT IS COMBINATION PREVENTION?

Activity objective
- Describe the three types of combination prevention strategies.

Methodology
- Presentation
- Group discussion
- Illustrative case study/model

Materials
- Slideshow: combination.ppt
- Case study (page 49/50)

Activity Outline

1) Introduce biomedical, behavioral and structural interventions. 30 minutes
   - Explain the issues with current prevention methods.
   - Reinforce the idea that combination prevention is crucial to the success of HIV alleviation.
   - Give one example of a strategy for each intervention type.
   - Ask participants if they can come up with examples of strategies.
   - Refer to page 10 for examples of strategies.

3) Clarify the concepts using questions to make sure that the participants understand the material. For instance:
   - What are the differences between biomedical and behavioral interventions?
   - What are the different types of structural interventions?
   - Can an intervention be behavioral and biomedical at the same time?

4) Present and analyze a case study/model in the Caribbean as to illustrate combination prevention strategies in a real life setting. Case studies can be found on pages 49/50. 30 minutes

5) Invite participants to ask questions before continuing to the next session. 15 minutes

How to increase participation
- Use the questions and examples to prompt discussions.
- Have participants share their personal experiences and relate it to the material.

Resources:
Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioral and Structural Strategies to Reduce New HIV Infections - A UNAIDS Discussion Paper, September 2010
Essential Information

What is combination prevention?
A program that uses a mix of biomedical, behavioral, and structural interventions to create an effective and sustained reduction of HIV levels. It is based on an evidence gathering process which addresses the roles of gender inequality, gender-based violence, income inequality, stigma, discrimination, human rights violations and social marginalization.

Why choose combination prevention methods?
These methods operate on the levels of individuals, relationships, communities and societies, which enable members of key populations to reduce risky behavior and reduce vulnerabilities created by lack of knowledge, lack of quality service, inaccessibility (cost or location) and societal factors. Furthermore, combination prevention programs may benefit from synergies created from joined strategies.

What are the types of combination prevention strategies?
Biomedical intervention strategies aim to reduce exposure, transmission or infection.
Behavioral intervention strategies aim to promote individual risk reduction.
Structural intervention strategies take into account socio-cultural factors, economic factors, political factors and legal factors.

For example of combination prevention strategies, refer to page 10

TIPS
- Facilitators should have an extensive understanding of the material prior to teaching it. Some resources are provided on the previous page if needed.
- The illustrative case study should be analyzed with all the participants. It will serve as an example for the next activity. It will enable the participants to familiarize themselves with the process beforehand.
Examples of Biomedical Strategies
- Male and female condom provision
- Drug treatment including opioid substitution therapy, needle and syringe provision
- Male circumcision
- Biomedical prophylaxis
  - ARVs in PMTCT services,
  - post exposure prophylaxis, etc.
- Appropriate and accessible STI services, ART for prevention
- Blood safety, standard precautions in health care setting

Example of Behavioral Strategies
- HIV testing and risk reduction counseling
- Behaviour change communication to promote partner reduction, condom use, uptake of HIV testing and counseling, etc.
- HIV education
- Interpersonal communication, including peer education and persuasion
- Social marketing of prevention commodities
- Cash incentives for individual risk avoidance

Example of Structural Strategies

SOCIAL AND CULTURAL STRATEGIES
- Community dialog and mobilization, to demand services; for AIDS competence, etc.
- Stigma reduction programmes
- Advocacy and coalition building for social justice

POLITICAL, LEGAL AND ECONOMIC STRATEGIES
- Human rights programming
- Prevention diplomacy with leaders at all levels
- Community Microfinance/microcredit
- Training/advocacy with police, judges, etc.
- Policies re. access to condoms (schools, prisons etc.)

INTERVENTION STRATEGIES ADDRESSING PHYSICAL ENVIRONMENT:
- Housing policy and standards
- Enhanced farming, other modes of subsistence, for food security
- Infrastructure development – transportation, communications

Resources: Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioral and Structural Strategies to Reduce New HIV Infections - A UNAIDS Discussion Paper, September 2010
Activity objective
- Analyze current models,
- Identify which prevention methods are being used

Methodology
- Post it activity
- Moving to intervention type activity

Materials
- Intervention type cards (pg. 37) cut out with tape on back
- Flip chart

Activity Outline
1) Project or draw diagram below:

- Distribute cards to participants, explaining that each one has a preventive strategy written on it. (Pg. 37)
- In groups or individually, the participants will identify if the interventions are biomedical, behavioral, structural or a combination of strategy types.
- Once they have identified the strategy, the participants will read out loud their strategy and explain their answer.
- Have participants write their own examples of interventions that they have been involved in or are familiar with, and post them on the diagram in the appropriate category, being sure to explain their answers.
- Participants will then stick the cards on the appropriate strategy.
- Invite all the participants provide their opinions. (Optional)

Materials
- Intervention type cards (pg. 37) cut out with tape on back
- Flip chart

Activity Outline
1) Project or draw diagram below:

- Distribute cards to participants, explaining that each one has a preventive strategy written on it. (Pg. 37)
- In groups or individually, the participants will identify if the interventions are biomedical, behavioral, structural or a combination of strategy types.
- Once they have identified the strategy, the participants will read out loud their strategy and explain their answer.
- Have participants write their own examples of interventions that they have been involved in or are familiar with, and post them on the diagram in the appropriate category, being sure to explain their answers.
- Participants will then stick the cards on the appropriate strategy.
- Invite all the participants provide their opinions. (Optional)

Energizers
If time is an issue or the participants are tired, the facilitator may read the strategies out loud or display them on a PowerPoint. Participants will then be asked to move to a part of the room corresponding with the intervention type. For instance, the back left corner of the room will be structural interventions, the middle of the room would be all three combined and so on.
Activity objective
• Identify intervention types and the challenges and efficiency levels of each one

Methodology
• Mini case studies

Materials
• Prepared models (pg 38/39)

Activity Outline

1) Participants will be given a sheet with situations written on them.

2) In small groups or individually, participants will have to answer the following questions:
- How does this make you feel?
- Have you ever encountered a situation like this? If so, what was it?
- What are the key vulnerability types and why? (biomedical, behavioral, or structural-social/cultural, political/economic/legal, physical environment)
- What could be done about these vulnerabilities?

3) Invite the participants to share their thoughts and opinions

This module should be used as to make sure that all the participants understand the material and are able to apply the concepts before moving on to the next section.

While participants are invited to share personal stories, this is strictly optional.
Activity Objective
- Get warmed up
- Review topics from day one
- Introduce topics for day

Methodology
- Presentation
- Quiz game
- Discussion

Materials
- None

Activity Outline
1) Greetings
- Welcome the participants, make sure everyone is comfortable and has everything they need.

2) Review
- Quiz participants on what they learned yesterday, using questions such as
  - What did we talk about yesterday?
  - Why should we establish a safe space?
  - Why is participation important?
  - What are the three types of combination prevention?
- Ask if anyone has additional questions or comments.

3) Introduce new topics
- Present the schedule for day two.

The facilitator should review materials for the day and the previous day as some participants might have some questions.
Activity Objective

- Identify subgroups and understand why this is important

Methodology

- Slideshow
- Discussion

Materials

- Slideshow: subgroups.ppt
- Flip chart
- Paper and pencils/pens

Activity Outline

1) Presentation 10 minutes
- Go over the slideshow
- Ask participants to name subgroups that they know of or work with on a daily basis.
- Take time to address any questions or comments from the participants.

2) Mindmap 15 minutes
- Draw a circle in the middle of a flip chart and take suggestions for one group to write inside it (MSM, sex workers, youth, etc.)
- Have participants list subgroups of the first group and create branches as they are listed.
3) Differences between subgroups 🕒 25 minutes
This exercise is optional.
- Write down two or three subgroups in the format below and ask participants to list differences and similarities between them in terms of behavior, society’s perceptions of them, economic status, etc.

**Essential Information**

**What are subgroups?**
Subgroups are members of populations who share similar traits or characteristics that are not shared by everyone in the larger group. For example, “migrant sex workers” are a subgroup of “sex workers”. Traits that differentiate subgroups could include race, age, gender, income level, and HIV status, among many more.

**Why are subgroups important?**
Subgroups may face particular structural and behavioral vulnerabilities that are different from those of the larger group. For example, migrant sex workers may be discriminated against due to their country of origin, and face additional challenges in obtaining services.

**Why do we focus on subgroups?**
Because vulnerabilities will vary greatly between subgroups, it is important to look closely at them when designing an intervention program. That way, interventions can be tailor-made to get to the heart of the issues that most affect HIV transmission within each subgroup.

**What happens if we ignore differences between subgroups?**
Lumping together individuals within larger groups can cause interventions to miss specific structural and behavioral vulnerabilities that are only experienced by a specific subgroup.

There may also be specific challenges in carrying out interventions with certain subgroups. For example, organizations may find it difficult to follow up with migrant sex workers who are highly mobile. Thinking about these issues during the design process can contribute to the success of an intervention.

If participants are not volunteering suggestions for the activity, ask questions such as how subgroups differ by income, age and other demographics.
Activity Objective

- Test knowledge of subgroups and vulnerabilities

Methodology

- Small group activity
- Discussion

Materials

- Subgroup matching cards (pg. 40-41)

20-30 minutes

Activity Outline

1) Subgroup-vulnerability matching activity

- Lay cards face down on the table in rows corresponding to type.

- Have a participant choose one card from the “subgroup” row, one from the “vulnerability” row, and one from the “subgroup type” row.

- Discuss with the group if these cards match. Make sure to get explanations as to why or why not. If not, the participant must turn the cards over again. If they do, the participant may keep the three cards.

- The participant with the most cards at the end of the activity wins.

The facilitator should emphasize that winning is not important and encourage participants to explain their response fully.
Activity Objective
- Relate the information on subgroups to personal knowledge

Methodology
- Small group activity
- Discussion

Materials
- Subgroup mapping activity sheet (pg. 42)

Activity Outline
1) Subgroup mapping activity

- Distribute mapping activity sheet (pg. 42)

- In small groups, have participants choose one subgroup from the list generated at the end of module 3.1, or from their own personal experience

- For each subgroup, the participants should list as many specific challenges and vulnerabilities as they can, and categorize them in terms of the combination prevention model (biomedical, behavioral, etc.)

- Encourage participants to come up with interventions that could address the specific challenges and vulnerabilities they have written down.

- Have the groups share their work with everyone and open the floor to discussion.

While the participants are engaged in group work, the facilitator should monitor their progress to ensure that everyone is contributing.
Activity Outline

1) Present a brief regional analysis of HIV/AIDS in OECS countries.  
   15 minutes

2) Project the following questions and have participants answer them individually  
   45 minutes
   - What are the main mode(s) of transmission of HIV in the area in which you work?
   - How could you classify the HIV epidemic scenario where you work - low, concentrated, 
     generalized, hyperendemic, or any other?
   - Are there certain locations and areas where risk behaviors are frequent and/or promoted?
   - Are there some populations to that are more vulnerable to HIV or which represent a high percent-
     age of new HIV infections?
   - What are the drivers (Eg: poverty, gender inequality, human rights violations) and risk factors that 
     increase an individual or group's vulnerability to becoming infected with HIV?

3) Optional discussion on human rights  
   30 minutes
   - Ask participants “What are human rights?”
   - Have participants write their answers on sticky notes
   - Read each answer aloud and place it on the flip chart
   - Try to decide with the group on broad topics and themes that cut across the different answers
   - Create a definition that the entire group can agree on
   - Ask the participants “What are some violations of human rights? What violations do you deal with 
     in your work? What can you do about them?”
**Essential Information**

**Why is it important to know your epidemic?**
In order to create interventions that are evidence based, one should know the essential characteristics of their crisis.

**What is the 90/90/90 program?**
It is a program that aims to increase “the proportion of people living with HIV who know their diagnosis, the proportion of people living with HIV receiving antiretroviral treatment, and the proportion of people on HIV treatment who have an undetectable viral load to 90%” This program implies a scale up scenario because in order to achieve this objective, an increase in investment is essential.

**What is the main challenge with the current strategy?**
The OECS countries do not have enough resources to sustain (or increase) intervention strategies. In addition, there has been a decrease in funding recently, and it is projected to continue decreasing over the next few years. Thus, the lack of resources combined with inadequate health care systems poses as a major challenge. The OECS countries will have to allocate funding efficiently as to maximize impact.

**What are the key trends in HIV testing?**
Testing among males is lower than in females in most countries with the exception of St. Kitts and Nevis where testing ratios are relatively equal.
Greater numbers of males testing positive for HIV than females across the OECS. Due to legal barriers, young people have significantly lower access to services.

**How are combination prevention strategies planned?**
Identify modes of transmission
Identify geographic patterns
Estimate the size of key populations
Document key structural factors that increase risky behavior

**Resources:**
TB and HIV Multi-country Concept
Note: Investing for Impact Against Tuberculosis and HIV. Global Fund Report, April 2015
Activity Outline

1) Warm up 15 minutes

- In plenary or in small groups organized by country, have groups go over their answers from the previous activity. Ask them to consider the following questions:
  - Is this information important? Why?
  - How would this information be used in planning an intervention?
  - Are they confident in their knowledge of the answers to these questions? Where do they get their information?
  - Have they collected reliable data or do they simply know through experience?

- Explain that while developing an evidence base through data is important, knowing how to interpret data and use anecdotal evidence are also important.

2) Graph Activity 30 minutes

In this activity, participants will get a chance to apply their knowledge of subgroups and combination prevention to data from around the Caribbean.

- Give participants the handouts (pgs. 41-45) with information on key populations.
- In small groups or individually, participants will have to analyze the graphs and answer the questions
- Follow the activity with a group discussion about their findings.
Activity Objectives

- Consider obstacles and assets required to overcome them

Methodology

- Group Discussion lead by the facilitator in a question/answer format

Materials

- Flip chart
- Assets activity sheet (pg. 48)

Activity Outline

1) Intervention Obstacles

- Prompt participants to list some common HIV interventions, and write them on your flip chart. Alternatively, use activities that have been mentioned before, such as during the post it activity.

- For each intervention, solicit social, cultural, economic, political, legal and infrastructural factors that could act as barriers to implementing them. This can be done in plenary or in groups where each group works on one intervention.

- Try to draw out the fact that these are structural problems, but must be considered separately from structural problems that increase vulnerability to contracting HIV.

- How could these obstacles be overcome?

2) Knowing your assets

- Ask the participants in plenary, small groups or individually:
  - What are assets?
  - What assets does your organization use most often?
  - What is the difference between tangible or physical assets (such as office equipment) and intangible assets (such as networks)?
  - What assets are most important?
Activity Outline

1) Allocating assets

- Use the case studies from page 48, and write them down the left side of the flip chart.

- On the right side of the flip chart, list assets that the participants have at their disposal.

- What resources (financial and otherwise) could be useful in creating each intervention? Which assets are most important?

- What assets are most difficult to acquire/maintain? What assets that are not currently available would be most useful?

- Alternatively, have small groups work on one intervention each using the case study handouts and write the assets themselves.

Essential Information

What is an asset?
In this case, an asset is a resource that can be used as to implement the strategy.

What are the types of assets that can be used to implement strategies and what are the benefits of using them?

- Social networks: KP communities can seek each other and create an online safe space.
- Entertainment entities: parties, shows, and other social venues can create a source of revenue for the LGBT community.
- Peer involvement: seek peers (members of the LGBT community) that can act as staff members or volunteers. Improves peer morale and possible increases their income.
- Allied providers: seek providers who are supportive. For example, patients might feel more at ease knowing that they will not be judged at an allied health care provider.

- If the participants need some guidance to come up with assets; provide the types of assets without discussing their potential benefits.
- Making the participants get up and write their own answers on the flip chart can serve as an energizer.
Activity Outline

1) Greetings
   - Welcome the participants, make sure everyone is comfortable and has everything they need.

2) Review
   - Quiz participants on what they learned yesterday, using questions such as
     - What did we talk about yesterday?
     - What are subgroups?
     - Why is it important to think about subgroups?
   - Ask if anyone has additional questions or comments.

3) Introduce new topics
   - Present the schedule for day three.

Energizers

The person to the facilitator's left says something that they will do or bring when they facilitate their own workshop. For example “When I facilitate my workshop, I will make sure everybody is comfortable.” The person on their left will have to repeat the first sentence and add one more thing that they will do or bring, such as “When I facilitate my workshop, I will make sure everyone is comfortable and bring plenty of things to write with.” The activity continues around the circle, with everybody saying what was said before and adding their own contribution. At the end, the facilitator should complete the circle by repeating what everyone has said, and then adding one last thing to do or bring.
Activity Outline

1) Case Studies

- Have the participants form small groups and distribute one case study to each group.

- Display the questions slide, write the questions on your flipchart or distribute the questions printout, so that all participants know what questions they are to answer.

- Give the participants time to read over the models carefully and answer the questions.

- Have each group present their answers in plenary, ensuring that other groups have a chance to ask questions and engage with each other on each topic.

- If the participants need a push to talk more, ask some follow up questions, such as:
  - What did you like about the project?
  - Where could the project be improved?
  - Does the project address problems that are common in your country?
  - What would need to be changed to implement this project in your country?
  - What obstacles might you have in implementing a project like this?
Activity Outline

1) Watching the video

- Inform the participants about the video that they are about to see: a 30-minute video on non-identifying MSM in Jamaica and the Dominican Republic, and the challenges faced in these situations. Warn the participants that the video they are about to see has some graphic scenes.

- Distribute questionnaire forms or write questions on a flip chart and ensure that participants all have the materials to take notes.

- Quickly go over the questions with the group to ensure that everyone understands them, and so that they have an idea of themes to look out for in the video.

Before watching the video, give the participants a 5 minute break, if they need it, to make sure there will not be interruptions during the video.

Resources: MEN WITH NO IDENTITY
https://www.youtube.com/watch?v=Lq6YQsgYAqM
Activity Objective

- Share their ideas on MSM and HIV

Methodology

- Short presentations

Materials

- None

Activity Outline

1) Presentations

- Give each group a few minutes to share their ideas on the video.
- Have groups compare and contrast their perceptions and their proposed interventions, being careful to get the ideas of as many participants as possible.

2) Group Work

- Have the participants form small groups and go over their answers on the questionnaire.
- Together, the participants will have to come to conclusions about the challenges and vulnerabilities presented in the video and propose interventions that could address them.
- Participants should be able to link the vulnerabilities to their interventions: how exactly does the intervention address the specific vulnerabilities in the video?

In this activity, it is crucial that participants relate the video to their own experiences. The facilitator should ensure that participants talk about the differences and similarities to local circumstances.
3) Presenting Ideas

- Have the participants form small groups and go over their answers on the questionnaire.
- Together, the participants will have to come to conclusions about the challenges and vulnerabilities presented in the video and propose interventions that could address them.
- Participants should be able to link the vulnerabilities to their proposed interventions: how exactly does the intervention address the specific vulnerabilities in the video?
- Have participants talk about their ideas in plenary. What were some common

---

**Essential Information**

**Who are non-identifying MSM?**
Non-identifying MSM are men who have sex with men, but who don't identify as gay or bisexual. The men in the video operate "on the down low", keeping their sexual activity with men a secret from their friends, family, colleagues and the rest of society.

**Why is it important to talk about non-identifying MSM?**
These men are often overlooked by CBOs that focus on openly-identifying MSM. In addition, CBOs face additional challenges when dealing with the unique vulnerabilities of non-identifying MSM.

**What are the additional challenges in working with non-identifying MSM?**
Many MSM live in cultures that are not accepting of their identity. They face threats of violence and verbal abuse, the risk of losing their jobs, and the possibility of being ostracized by their family and friends. In many cases, the government will not support them, or worse, contribute to the violence and abuse. This drives many MSM underground, where CBOs will find them difficult to reach. In addition, non-identifying MSM can transmit HIV and other STIs to partners who are unaware of their other sexual activity.
Activity Objectives

- Allow participants to apply their knowledge

Methodology

- Intervention design

Materials

- Creating your intervention form (pg. 52)

Activity Outline

1) Planning activity 30 minutes

- Have participants form groups based on area of work.
- In their groups, participants should take a few minutes to look back over the previous activities.
- Have the participants choose a subgroup that they are familiar with, and talk about that group's vulnerabilities.
- Participants will then brainstorm intervention ideas, holding critiques and criticism until after a list has been generated.
- Have the groups choose an intervention, or combination of interventions that can address the groups vulnerabilities.
- Participants should fill out the intervention form, carefully considering each section.

   - Intervention planning form
     - Subgroup
     - Vulnerabilities
     - Intervention types
     - Challenges, Obstacles
     - How to overcome obstacles
     - Resources, materials
     - Timeline

2) Presentations 45 minutes

- Groups will present their ideas one at a time, going over their processes and sharing the details of their intervention planning form.
- Open up the floor for questions and discussions.

Tips

- When forming groups for this activity, it is recommended that participants be grouped by area of work.
- If this is not practical, the facilitator can use a brief activity such as choosing playing cards and putting participants with matching colors on the same teams.
- Participants can also choose their own groups, but the facilitator should attempt to ensure that no one feels excluded.
Activity Outline

1) Discussion 30 minutes
- Ask some questions about how the participants felt about the workshop.
- Give them time to talk about what they learned and how they will apply it to their work in the future.
- Have the participants fill out the Pre/Post Test on (pg. 33). You can use this after the workshop to see how much the participants have gained from your workshop.

2) Survey 5-10 minutes
- Hand out the survey and give participants.

3) Thanks and closing remarks 5-10 minutes
- In a circle, have each participant say something they appreciated about someone in the group. Encourage them to say something about someone who hasn’t been spoken about before.
- Take some time to thank the participants and address any final concerns.

Some participants will be happy to offer feedback verbally, while others may feel more comfortable writing something down anonymously. It is important to provide different feedback tools that allow all participants to share their opinions in a way that makes them feel comfortable.
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Combination! (Fruit salad)

This activity requires a group of 6 or more people with good mobility. Participants should sit on chairs in a circle, with one person standing in the middle. Each person should be assigned a type of intervention, and at least two participants must be given each type (e.g., 2 structural people, 2 biomedical people, and 2 behavioral people). The person in the middle will then describe an intervention, for example, “distributing condoms.” Participants whose intervention matches what the person in the middle said (in this case biomedical) must stand up and switch with another person who has the same type. While they are trying to switch, the person in the middle will try and take an empty chair and that person’s intervention type. The person who is left standing now must say the next intervention. At any time, the person in the middle may call “combination!” In which case all participants must switch.

Special action

The facilitator should describe a special action, such as touching their nose, sticking out their tongue or clapping their hands. If the facilitator does this action at any time during the workshop, all the participants must copy them. The last person to copy the facilitator must suffer a punishment (singing a song, telling a story, answering a question etc.) This activity is good when trying to ensure that everyone is paying attention.

Paper ball

In this activity, a paper ball is thrown amongst the participants. Each time a person catches the ball, they must talk about something (such as their reflections at the end of the day). They must then throw the ball to someone who has not caught it yet. For a fun bonus activity and to make sure participants are paying, have them briefly summarize what the last person, or the person 2 catches ago, said. For example, if the order is Charles, Janice, Miriam, Miriam would have to tell the group briefly about what Charles said.

Teachbacks

If there is time, participants can try and teach back some of the concepts to the class. They could lead a discussion, present some ideas, tell a relevant story, or lead a game or activity from the manual. This is a good tool if some participants are catching on faster than others. This way, participants can hone their facilitation skills, while ensuring that everyone is on the same page.
<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has attended a workshop on HIV/AIDS Before</td>
<td>Speaks 2 or more languages</td>
<td>Feels tired today</td>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works with young people</td>
<td>Works in the field of HIV/AIDS</td>
<td>Has a pet at home</td>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likes to dance</td>
<td>Had to travel more than one hour to get here today</td>
<td>Comes from another country</td>
<td>__________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

module 1.1 bingo cards
Module 1.1 Pre/post test

Instructions:

1) Answer each of the questions below with a few short sentences and to the best of your ability.
2) It is OK to answer I don't know or I am not sure. This is just to test the group’s knowledge, it is not to judge you or what you know specifically
3) Do not put your name on the test
4) Please write as clearly as possible.

Combination prevention relies on what? (You can choose more than one answer - for this question ONLY)
   a) Evidence-based interventions
   b) Strategic interventions
   c) Simultaneous use of behavioral, biomedical and structural strategies
   d) Focus on reducing individual risk

Identify the biomedical intervention.
   a) HIV counseling
   b) Peer education
   c) Distributing condoms
   d) Lobbying the government to change laws

What is the purpose of behavioral interventions?
   a) Reducing the risk, exposure and/or transmission of HIV infection
   b) Giving ARV medication to target groups
   c) Changing the values of a society that stigmatize members of key populations
   d) None of the above

Which of these is NOT an example of structural intervention?
   a) Support youth leadership
   b) Human rights programming
   c) HIV education and testing
   d) Community micro-finance: helping vulnerable groups get loans

Identify three subgroups of MSM or Sex Workers.

When designing an intervention, why would we look at subgroups? Why are they important?
Module 1.2 Comfort Zone Cards

Talking  
Listening

Talking  
Listening
1. The risk of HIV infection from blood donated by a family member or friend
   a) Is much lower than the risk from blood donated by the general public.
   b) Is about the same as the risk of getting HIV from a transfusion of blood from the general public.
   c) Is so low that testing of the blood is not required.
   d) Is not an issue because this type of donation is no longer an option in the United States.

2. Most teenagers with HIV become infected-
   a) From sharing needles and syringes or having sex with an HIV-infected partner.
   b) From blood transfusions.
   c) Through casual contact.
   d) Through piercing body parts and tattooing.

3. HIV may be spread from contaminated needles when-
   a) Piercing ears or other body parts.
   b) Injecting steroids.
   c) Injecting drugs.
   d) All of the above.

4. HIV prevention strategies women can use include-
   a) Using a latex condom.
   b) Not sharing needles with a person who has HIV.
   c) Not having sex with a person who has HIV.
   d) All of the above.

5. One HIV prevention strategy is the use of a condom that is-
   a) Latex
   b) Natural
   c) Organic
   d) Animal Skin

6. Someone who lives with a person who has AIDS should avoid contact with-
   a) The eating utensils he or she uses.
   b) His or her blood.
   c) The bathroom he or she uses.
   d) All of the above.

7. Correct and consistent use of latex condoms during sex greatly reduces the risk of-
   a) AZT
   b) HIV infection and other STDs
   c) Tuberculosis.
   d) Opportunistic infections.

8. HIV is-
   a) A fungus.
   b) A bacterium.
   c) A virus.
   d) An environmental pollutant.
9. People who are infected with HIV can infect others-
   a) Only after they have had a positive HIV-antibody test result.
   b) If they have symptoms of AIDS.
   c) After they become infected, even if they look and feel healthy.
   d) If they develop an opportunistic infection.

10. All of the following can be used as barriers against body fluids during oral sex on the vagina or anus EXCEPT-
    a) A water-based lubricant.
    b) A dental dam.
    c) Household plastic wrap.
    d) A latex condom cut to lay flat.

11. The most common reason for condom failure is-
    a) User error.
    b) Manufacturing defects.
    c) Improper size.
    d) Use of non-lubricated condoms

12. HIV can be spread through an infected person's-
    a) Urine
    b) Sweat
    c) Blood
    d) Tears

13. HIV infection can be spread during vaginal sex from-
    a) Man to woman
    b) Woman to woman
    c) Woman to man
    d) All of the above

14. Which of the following activities can put a person at risk for HIV infection?
    a) Giving or receiving a massage.
    b) Oral, anal or vaginal sex with an HIV infected partner.
    c) massaging one's own genitals.
    d) Dry kissing.

15. People who have AIDS get opportunistic infections because-
    a) When HIV enters the body, it mutates into the disease agents that cause infections such as Pneumocystic carinii pneumonia and cytomegalovirus infection (CMV).
    b) The drugs used to treat HIV cause infections.
    c) HIV weakens the immune system and makes it difficult to fight diseases.
    d) All of the above.
<table>
<thead>
<tr>
<th>Handing out condoms and lubricant at places where LGBT people converge</th>
<th>Teaching about sexual health to transgender sex workers and distributing condoms and lubricant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging in education programs that encourage youth to take the risk of HIV seriously</td>
<td>Starting a reproductive health campaign to (1) encourage lawmakers to increasing spending on family planning and (2) spread awareness of safer sex practices to youth</td>
</tr>
<tr>
<td>Working with government to draft legislation to help end discrimination against LGBT people</td>
<td>Helping to register migrant sex workers with local clinics and improve their access to health services</td>
</tr>
<tr>
<td>Helping to reduce stigmatization in health clinics, and encourages MSM sex workers to visit them for education, STI testing and general health checks</td>
<td>A social media campaign encouraging people who are sexually active to get tested for HIV</td>
</tr>
<tr>
<td>Case Study</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Bob (34) has a wife and 2 children. He also secretly has a boyfriend. He is worried that he might have HIV, but hasn't been tested because he is afraid that people will find out his secret.</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Maria (24) is an immigrant sex worker who faces difficulty obtaining health services because of discrimination at the clinic</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Tiffany (18) is living on the streets and doing drugs. She reuses needles and isn't aware of the risk</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Martin (28) is an incarcerated MSM. He has several partners, but doesn’t have access to condoms or lubricants</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Case Study</td>
<td>Question 1</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>David (14) has sex with older men for money. He knows that there is a risk of getting HIV/AIDS, but thinks that it will never happen to him.</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Shauna (16) engages in sex in return for drinks, money and food, but doesn’t consider herself a sex worker. She wants her partners to use protection, but hasn’t been able to convince them.</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Jacob (14) is kicked out of his home when his parents become aware that he is gay. He is not sure where to go or what to do.</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Benton (34) and Charles (30) are an MSM couple. They meet on the down low because they are afraid of getting hurt or killed. They want to find out more about HIV/AIDS, but are afraid for their safety and don’t know where to go.</td>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>Subgroup</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Non-identifying MSM</td>
<td>Difficulty finding and identifying individuals who are trying to keep their identities secret</td>
</tr>
<tr>
<td>Youth MSM</td>
<td>Lack of voice, not getting a “seat at the table”</td>
</tr>
<tr>
<td>Migrant MSM</td>
<td>Difficulty keeping track of individuals who are very mobile</td>
</tr>
<tr>
<td>MSM sex workers</td>
<td>Low rates of condom use</td>
</tr>
<tr>
<td>Incarcerated MSM</td>
<td>Lack of access to services</td>
</tr>
<tr>
<td>Group</td>
<td>Issue</td>
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<td>----------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>HIV-positive MSM</td>
<td>Lack of access to antiretrovirals</td>
</tr>
<tr>
<td>HIV-positive sex workers</td>
<td>Transmission of HIV to others</td>
</tr>
<tr>
<td>Transgender sex workers</td>
<td>Lack of knowledge about sexual health</td>
</tr>
<tr>
<td>Migrant sex-workers</td>
<td>Unsafe sex practices</td>
</tr>
<tr>
<td>Injection drug-using sex workers</td>
<td>Lack of clean needles/syringes</td>
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<tr>
<td>Intervention Options</td>
<td>Vulnerability Type</td>
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</table>
Risk Behaviours among People Living with HIV/AIDS

<table>
<thead>
<tr>
<th>Risk</th>
<th>No. of Persons (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex with Sex workers</td>
<td>4279 (13.4%)</td>
</tr>
<tr>
<td>Crack, Cocaine use</td>
<td>1,301 (4.08%)</td>
</tr>
<tr>
<td>STI History</td>
<td>10,183 (35.6%)</td>
</tr>
<tr>
<td>IV Drug Use</td>
<td>180 (0.57%)</td>
</tr>
<tr>
<td>Multiple Sexual Partners/contacts</td>
<td>3,665 (11.5%)</td>
</tr>
<tr>
<td>No high risk behavior</td>
<td>5,321 (19.6%)</td>
</tr>
</tbody>
</table>

This table was taken from the 2013 Ministry of Health, Jamaica National HIV/STI Programme Annual HIV Epidemiological Profile. The numbers on the right represent the percentage of the total infected population that engage in the behaviours listed on the left.

1) What behaviours/subgroups do you believe are missing?
2) Should these other subgroups be included? Why/why not?
3) Can you think of any reasons that these subgroups would not be included - by the agency not asking or by the groups not self-identifying?
4) What kind of obstacles would there be in trying to get these subgroups included?
5) How could you ensure that these subgroups are counted in future work?
The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have stated that male circumcision, when carried out by well-trained professionals in a clean environment, can significantly reduce the risk of men becoming infected by a female partner. The table below comes from _______________.

1) What kind of intervention is male circumcision?
2) Would a program offering free male circumcision be effective in St. Vincent?
3) What kind of factors might contribute to a man not wanting to get circumcised?
4) What factors would be necessary in order to successfully implement a male circumcision program in St. Vincent?
5) If a program was successful at getting more men circumcised in St. Vincent, what factors would have an impact on the program’s ability to reduce HIV transmission?

<table>
<thead>
<tr>
<th>Circumcised</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20.3</td>
</tr>
<tr>
<td>No</td>
<td>79.7</td>
</tr>
</tbody>
</table>

Rates of circumcision (N=74)
## Reasons for not obtaining an HIV test

<table>
<thead>
<tr>
<th>Reason</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of confidentiality</td>
<td>36.1</td>
</tr>
<tr>
<td>Know people who work at testing facility</td>
<td>14.6</td>
</tr>
<tr>
<td>No reason or unsure why</td>
<td>22.7</td>
</tr>
<tr>
<td>Do not want a test</td>
<td>8.8</td>
</tr>
<tr>
<td>Too expensive</td>
<td>1.7</td>
</tr>
<tr>
<td>Too far away</td>
<td>0.8</td>
</tr>
</tbody>
</table>

In Antigua, over 50% of the respondents who said they did not want to get HIV tested gave “lack of confidentiality” or “know people who works at the testing facility” as their reason for not getting tested. In Grenada, 42% of respondents mentioned their concerns about confidentiality, while 33% were concerned about “having to answer personal questions”

1) How are these factors related?
2) Have you ever met people with similar concerns?
3) Why might people feel this way? Could their concerns be justified?
4) How could you encourage people with these concerns to get tested?
5) How could you increase the chances that the client’s information and identity will remain secure and confidential?

## Perceptions on HIV testing that inhibit access in Grenada

<table>
<thead>
<tr>
<th>Perception</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns of confidentiality</td>
<td>42</td>
</tr>
<tr>
<td>Having to answer personal questions</td>
<td>33</td>
</tr>
<tr>
<td>Concerns of availability of treatment if test is positive</td>
<td>38</td>
</tr>
</tbody>
</table>
In St. Kitts, patients with HIV have received different levels of care at health facilities. The table below shows some of the different experiences that people living with HIV have had at health facilities. During a discussion with 40 police officers in St. Kitts, some said that homosexuals should not have any rights and that the police should not protect them.

1) What do you see that is positive in these numbers? What is negative?
2) Does this information surprise you? Why or why not?
3) Do you think the problems here are more biomedical, behavioural or structural?
4) How can these problems be addressed? What kind of interventions would be needed?
5) What obstacles would there be in trying to address these problems?

<table>
<thead>
<tr>
<th>Observed behaviour</th>
<th>Proportion of medical staff (%) (n=99)</th>
<th>Proportion of all facility staff (%) (n=307)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unwilling to care for HIV positive patient</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Providing poorer quality of care to HIV positive patient</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Disclosing a patient’s HIV status without patient consent</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Facility staff providing extra support or care for people living with, or thought to be living with HIV</td>
<td>45</td>
<td>36</td>
</tr>
</tbody>
</table>
In many OECS countries, some sexual practices are not talked about publicly, or occur on the down-low. Participants in a study in Antigua estimated that as many as 50 to 60% of MSM were down-low or did not self-identify. In the study above (Caribbean Men's Internet Survey) a high number of MSM reported that few or no people knew of their attraction to men.

Have you ever seen evidence of certain sexual behaviour being hidden?
Are there any other types of sexual behaviour that might be kept quiet or engaged in on the down-low?
Why might some people keep their sexual behaviour secret?
How could this affect interventions and service delivery?
What could be done to mediate these negative effects or encourage people to be open about their sexual behaviour?

### Level of Outness to Family, Friends, and Colleagues from Work and School

<table>
<thead>
<tr>
<th>Who knows you are attracted to men?</th>
<th>% All or almost all</th>
<th>% More than half</th>
<th>% Less than half</th>
<th>% Few than half</th>
<th>% None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>27</td>
<td>8</td>
<td>7</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Friends</td>
<td>29</td>
<td>16</td>
<td>9</td>
<td>28</td>
<td>19</td>
</tr>
<tr>
<td>Work colleagues</td>
<td>18</td>
<td>10</td>
<td>7</td>
<td>20</td>
<td>45</td>
</tr>
<tr>
<td>People at school</td>
<td>14</td>
<td>9</td>
<td>7</td>
<td>25</td>
<td>45</td>
</tr>
</tbody>
</table>

In many OECS countries, some sexual practices are not talked about publicly, or occur on the down-low. Participants in a study in Antigua estimated that as many as 50 to 60% of MSM were down-low or did not self-identify. In the study above (Caribbean Men's Internet Survey) a high number of MSM reported that few or no people knew of their attraction to men.
1. Support existing social networks and reinforce those existing safe spaces, including both virtual spaces and physical safe spaces as venues for health information and health services.

2. Support LGBTI parties and shows as venues for health messaging and health services while also serving as social venues, outlets for creativity, and as a source of revenue for LGBTI communities.

3. Create structured mentorship programs, where every client is matched with a peer mentor and a peer service provider, and then support is provided to all to identify and build capacities for increased access to health services and health promotion.


5. Strengthen regional networks of MSM and transgender people, and programs working with MSM and transgender people, to share capacities and information, including about HIV treatment care and prevention.

6. Pilot community research, community-based needs assessments, and programme intake to truly hear what people say are their needs and design interventions to meet those goals.

7. Deliberately work across class lines, engaging middle class LGBTI communities to share resources and efforts to engage, listen to, and support LGBTI people in economically disadvantaged communities.
MODEL: Empowerment and Education through the Avancemos Project

One of the most successful HIV education and prevention programs in the region called the Avancemos Project was developed and implemented by COIN, 20 years ago, in the Dominican Republic. They used peer-to-peer education methods to reach marginalized groups. The project carried out STI/HIV prevention programs with sex workers, their clients, and the owners and tenants of places where sex work was performed. The project was led by a group that trained and supervised a large number of peer educators, selected based on their lifestyle and culture so it would correspond with the project’s target population. Those educators, known as “health messengers” were trained in several areas: STI/HIV prevention, the use of educational techniques, and data collection and management. One of their strategies was to use “provocative theatre”, performed in brothels and bars, to raise clients’ awareness of the dangers of having unprotected sex. The idea is that direct, face-to-face interventions spread and multiply the healthcare knowledge among key populations, thus promoting change in risky behavior practices. Most project actions are aimed toward helping sex workers to take care of their own lives. They learn about STI/HIV prevention methods as well as techniques in condom negotiation in both their personal and commercial relationships. An associated element of the project is social marketing of condoms, which are sold by the Messenger Network representatives in all businesses where the project exists. The Avancemos Project’s success was clear early on and its success has influenced interventions for vulnerable populations in the country ever since. In 1996, for example, 72% of sex workers interviewed reported that their main source of information concerning STIs/AIDS was via the project’s health messengers.

MODEL: Peer education based on positive sexuality and self-determination

COIN developed and led a peer-education model in Jamaica and the Dominican Republic to address gaps in traditional peer-education programs. Among the gaps are that, in COIN’s view, such programs have underestimated the difficulty people have in following risk-reduction strategies because not enough attention has been paid to psychological, relationship, cultural, and situational influences that surround and form the content of human sexual behavior. The organization also believes that most programs have failed to promote long-term sexual health care. COIN’s new model for transgender people, sex workers and MSM moves away from providing steps to behavior change, and instead is based on the principles of positive sexuality, self-determination, independence, and fairness. In the first phase of the pilot, in 2011, a total of 20 peers were taken through a selection of 15 modules in two countries. Initial evaluations indicate that this program is a promising rights-based intervention that is responsive to vulnerable populations and able to reduce HIV/STI transmission.
MODEL: Adaptation of the 100% condom program in the Dominican Republic
In the Dominican Republic, the government worked with NGOs to adapt Thailand’s 100% Condom Program. The program helped to reduce HIV rates among female sex workers from an average of 9% in 2000 to 2.7% in 2007. The Population Council found that the program was successful because NGOs in the country had done many peer-led sex worker interventions before, used of community solidarity and empowerment approaches to support the program, and had community members help in developing programs and policies. A review of the program published in the American Journal of Public Health in 2006 said: “Interventions that combine community solidarity and government policy show positive initial effects on HIV and STI risk reduction among female sex workers.” The Thai model, which was mostly run by the government, was seen by some activists as a way to criminalize sex workers by punishing those who did not get HIV tests. The Dominican Republic, by working together with NGOs to create their plans, avoided these problems.

MODEL: Reaching sex workers where they work
The Jamaican National AIDS Program has found that it is difficult to carry out HIV programs in brothels. It is easier in clubs, because owners can say that they don’t know what their employees do in their own time in the back of the club, and they are not so afraid of the law. But brothel and massage parlour owners can easily be arrested for owning a brothel, so they may not want to talk to health workers. The owners often don’t let health workers into their buildings. These differences can mean problems in getting HIV and information and prevention tools to sex workers in brothels and massage parlours. Also, sex workers in massage parlours often do not see themselves as sex workers and don’t want to talk to outsiders. In order to reach this sub-group, the Sex Work Association of Jamaica (SWAJ) has used a different approach. They call massage parlours listed in the classified ads pretending to be looking for work. They then get to know the sex workers and the owners, so that they can bring the programs in more easily.

MODEL: Police training
Twenty police officers from different units and areas took part in two 2-day workshops with members of Sex Work Association of Jamaica (SWAJ). For the police, the workshops were part of their community work. The trainings helped to make a safe space for police and sex workers to talk together. They talked about issues such as sexual diversity, sexual orientation, human rights, and stigma and discrimination. SWAJ got feedback from the police after the training and found that they had changed the way they thought about sex workers and were much more open to finding ways to protect them from violence. They had learnt about the daily life and experiences of sex workers and had been given a chance to share their own experiences as police. They were also able to give advice to sex workers on laws and procedures they are required to follow and gave tips to sex workers about safety. When PANCAP/CVC-COIN interviewed two participants after the training, police said that the process was as an “eye opener” and saw their relationship with SWAJ as a “long term partnership”. They wanted to expand the program to more police units and regions of Jamaica.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>How did the video make you feel?</td>
<td></td>
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<tr>
<td>Who is the target subgroup in this video?</td>
<td></td>
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<tr>
<td>Have you worked with this subgroup before? If so, how did your experiences compare to what you saw in the video?</td>
<td></td>
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<tr>
<td>What other groups of people are at risk in these situations?</td>
<td></td>
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<tr>
<td>What are the key challenges in DR and Jamaica that the video presents?</td>
<td></td>
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<tr>
<td>What category do these challenges fall into? (biomedical, behavioral, etc.)</td>
<td></td>
</tr>
<tr>
<td>How do the challenges addressed in the video compare to the situation in your country? How are they similar? How are they different?</td>
<td></td>
</tr>
<tr>
<td>What strategies could be used to address the key challenges presented in the video?</td>
<td></td>
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<tr>
<td>What types of prevention strategy (biomedical, behavioral, etc.) would be most useful? Briefly, how would you implement the intervention?</td>
<td></td>
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<tr>
<td>Which stakeholders need to be involved in the solution and what roles will they play?</td>
<td></td>
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<tr>
<td>What possible challenges will be faced when implementing the strategy?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>What subgroup will you target?</td>
<td></td>
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<tr>
<td>What specific vulnerabilities does your subgroup face?</td>
<td></td>
</tr>
<tr>
<td>How will you address your subgroup’s specific vulnerabilities?</td>
<td></td>
</tr>
<tr>
<td>What intervention types will you use?</td>
<td></td>
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<tr>
<td>What challenges will you face?</td>
<td></td>
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<tr>
<td>How will you overcome the challenges?</td>
<td></td>
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<tr>
<td>What resources and assets will you require?</td>
<td></td>
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<tr>
<td>Who are the actors you will rely on and what will their roles be in the intervention?</td>
<td></td>
</tr>
<tr>
<td>What is your timeline for your intervention?</td>
<td></td>
</tr>
</tbody>
</table>
Module 6.2 : Final Survey

What did you like most about this workshop?

What did you like least about this workshop?

How would you improve on the content or delivery of the workshop in the future?

Would you like to see more or less time spent on any one module? Are there other subjects you would like to see added?

How will you apply what we have done to your own work?

Do you have any other comments, questions or concerns?

__________________________________________________________________________________________