



GUIDE FOR

Community Assessments on Women's Health Care



Parliamentarians
for Women's Health

Acknowledgments

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Preface

The *Guide for Community Assessments on Women's Health Care* is based on work undertaken by Parliamentarians for Women's Health, a collaboration of the International Center for Research on Women (ICRW), the Center for the Study of AIDS at the University of Pretoria (CSA), Realizing Rights: The Ethical Globalization Initiative (EGI), and International Community for Women Living with HIV/AIDS (ICW). This guide is one of several publications developed by the Parliamentarians for Women's Health project. It is based on the project's experience of organizing community assessments on women's health in Kenya and Namibia. HIV-positive women played a central role in organizing the community assessments, along with project staff, parliamentarians and civil society organizations.

The guide was developed as a resource for members of Parliament (MPs) and organizations who would like to do similar community assessments on women's health. It provides a step-by-step guide on how to organize the community assessment process.

Other publications in this series include:

- *Community Assessments of Women's Health Care: Namibia (June 2007)* – report on the field assessments
- *Community Assessments of Women's Health Care: Kenya (June 2007)* – report on the field assessments
- *Parliamentarians Use Local Assessments to Connect with their Communities: Assessments in Kenya and Namibia Arm MPs with Firsthand Knowledge of Women and AIDS (September 2007)*
- *Networking Proves Vital Strategy for Improving Women's Health Care: Case Study (September 2007)*
- *Workshops Bolster Parliamentarians as Leaders on Women's Health: Botswana and Namibia Workshops Facilitate Learning, Networking among MPs (September 2007)*
- *Parliamentarians for Women's Health: Project Paves the Way for Change (September 2007)*

Abbreviations

ART	Antiretroviral Treatment (or Therapy)
ARV	Antiretroviral
CA	Community Assessment
CD4	Glycoprotein on T cells that HIV binds to when it attacks the immune system
CBO	Community-based Organization
CL	Community Leader
CSO	Civil Society Organization
DOTS	Directly Observed Treatment, Short-course (treatment for tuberculosis)
FBO	Faith-based Organization
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender-based Violence
HBC	Home-based Care
IEC	Information Education and Communication
IGA	Income Generating Activities
MP	Member of Parliament
NGO	Nongovernmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PPTCT	Preventing Parent-to-Child Transmission
PTCT	Parent-to-Child Transmission
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counseling and Testing

CHAPTER A:

Introduction

What is this Guide?

This guide is a tool for civil society organizations and organizations of people living with HIV to improve women's access to health care among communities hard-hit by the AIDS epidemic. The guide is designed to help these organizations facilitate community assessments on women's health care, using participatory methods that involve not only members of the community, but also parliamentarians who may be sympathetic to but lack comprehensive knowledge and understanding of the plight of their women constituents who are struggling with the dual challenge of living with AIDS and having inadequate health care. Through the process of conducting the community assessment, both the service organizations and the parliamentarians emerge with better information about and a more comprehensive understanding of the issues women face, thus equipping them with the information they need to lobby and organize for change.

The guide provides information and practical tools on how to conduct community assessments on women's health. It includes lessons drawn from the Parliamentarians for Women's Health project's experience in conducting community assessments in Kenya and Namibia.

The guide consists of four chapters and an Annex:

Chapter	Contents
A	Introduction to the manual and the community assessment (CA) process
B	Step-by-step guide on how to plan and prepare for the CA process
C	Session-by-session guide on how to facilitate CA workshops for specific groups of community members, and a joint community workshop
D	Description of the techniques to facilitate and document the workshops
Annex	Fact Sheets. Energizer Games. Pictures.

Why was this Guide developed?

In 2006 the Parliamentarians for Women's Health project, in partnership with the parliamentarians, HIV-positive women and civil society organizations, organized community assessments in Kenya and Namibia to gather grassroots information and develop analysis on women's health care to support the related initiatives of MPs. The assessments consisted of several one-day workshops with different stakeholder groups, including HIV-positive women, non-positive women, service providers and community leaders, and gauged their opinions on women's priority health concerns, the gaps between needs and service delivery, and barriers to women's health care.

This activity was successful and produced a number of important results. It created:

- An opportunity for **MPs to develop firsthand knowledge** about the problems women face in accessing health care, including specific problems for women with HIV.
- An opportunity for **women to learn more about health issues**, including the importance of simple but potentially life-saving prevention measures, such as an annual pap smear.
- A platform for rural women to raise their concerns with MPs **and be listened to, so they could bring their voices and analysis to the national health care response.**
- **A new relationship between the MPs and rural women.** As a result of the community assessment process, the women began to see MPs as an advocate for their issues.
- A vehicle for empowerment, **strengthening the awareness, self-esteem and organizational strength of rural women, particularly women with HIV.**
- **A dialogue and mutual process of learning between HIV-positive women and MPs** to forge an ongoing relationship of joint advocacy and action.
- The formation of a working group of HIV-positive women **who monitor health services and work closely with MPs to lobby for ways to improve health services.**
- **A number of MP initiatives** to establish new parliamentary committees and develop new policies to address women's issues.
- A number of community initiatives by the participants **to plan and implement local actions for change to improve women's health care.**
- **A methodology** to collect data and analysis in other regions and on other topics (e.g., education). MPs currently are using this methodology in their work.

Given the success of the community assessment process, project staff sought to share its methodology and experience with MPs and organizations in other countries, with the hope that they might initiate similar community assessments on women's health issues.

Who is the Guide for?

The guide is for individuals and organizations that are working to improve women's health care. This group includes parliamentarians and organizations of people living with HIV, and those who are working on health and HIV/AIDS issues, women's rights and human rights.

How can the Guide be used?

This guide will help you plan and implement a participatory process to assess women's health needs and concerns at the community level. You can do this on a collaborative basis, working with HIV-positive women, civil society organizations and MPs. Chapter B shows you how to plan the process, and Chapter C details how to run the community workshops.

The guide is meant to support a participatory process – one in which participants share experiences and concerns; freely discuss sensitive issues such as sexual body parts, abortion and rape; and analyze and look for ways to improve health services. To implement the workshops described in the guide you need a certain level of facilitation skills to create an environment in which people feel free to express themselves. Facilitation tips are given in Chapter D.

The guide provides a standardized approach for running a series of day-long community workshops – one workshop for each of four different target groups – and then a final workshop bringing all the groups together. However, the guide is meant to be a flexible resource that can be adapted to suit your own circumstances and the groups with which you work.

The guide includes examples, presented in boxes, to illustrate how various techniques have been implemented.

The Community Assessment Process

The community assessments on women's health care were designed to meet project objectives. One key objective was to provide parliamentarians with information on women's health concerns that they could use to lobby for changes in parliament. Instead of getting this information through reports, the MPs participated in the process of collecting the data firsthand. This direct exposure to the lives of their constituents was extremely effective in helping them understand the pressing need for change.

These visits got us out of our comfort zone. When we met grandparents looking after 15 grandchildren, we were devastated – deeply touched. How can you look into the eyes of a two-year-old who goes to bed without food, while you go to bed with a full tummy? You cannot not be affected by this. It is our people who are in deep poverty, challenging us to do something. I'll forget about what I read in the documents, but that kind of direct exposure to reality I will never forget. (MP, Namibia)

The core method was to **get the women talking and the MPs listening**. Normally, the interaction between MPs and women would be the other way around, so the methodology had to ensure these roles were reversed. This required a big shift in expectations for both parties and the use of participatory methodologies.

Getting MPs to listen to and learn from HIV-positive women was a breakthrough. The open atmosphere [of the workshops] helped to break the hierarchy – status differences were overcome. It got the MPs listening, and they discovered that the women had important stories to tell. The women at first couldn't believe that the MPs were listening and taking them seriously. A strong relationship of mutual respect emerged and this has become a critical hub of the project in Namibia. (Parliamentarian for Women's Health project staff)

Community Assessments Facilitate Greater Learning

The community assessment methodology drew on the methods of participatory learning and action (PLA), an approach that builds on local knowledge and experience. Community participants talk about their lives, concerns and priorities, and then identify, discuss and ultimately devise solutions for their own problems. The process helps both the community and the team facilitating the community assessment gain a deeper understanding of the issues.

Getting the women to talk openly about their health concerns and experiences meant **breaking through the taboos** around HIV, sexually transmitted infections (STIs), abortion, female genital mutilation, rape and sexual abuse. These are sensitive issues that women rarely talk about privately, much less publicly. The participatory learning tools were carefully chosen to help get these issues into the open. Body Mapping, for example, was used because of its capacity to encourage women to name the parts of their bodies, including sexual body parts. Once women started talking about the vagina, clitoris and other sexual body parts in explicit language, the ice was broken and they began to talk about health issues which affect the body, including STIs and violence. Getting the women to talk about these issues personally took careful facilitation and the creation of a comfortable and safe environment in which they could feel free to express themselves.

Another key feature of the community assessment approach was **collecting data from different stakeholders** – HIV-positive women, non-positive women, service providers and community leaders. After meeting separately to talk openly and clarify their own ideas, all peer groups came together for a joint meeting to share what they had discussed and work together to analyze and discuss how to solve the problems.

In summary, the community assessment approach used by the Parliamentarians for Women's Health project involved:

- Separate workshops with different stakeholder groups, **including HIV-positive women, HIV-negative and untested women, service providers and community leaders.**
- **A joint workshop with all stakeholder groups.**
- Use of different participatory methods **and the expertise of skilled facilitators to get participants talking openly, raising issues and analyzing their own experiences.**
- **Involvement of HIV-positive women** as key planners and facilitators of the process, and the parliamentarians as co-facilitators and active listeners.

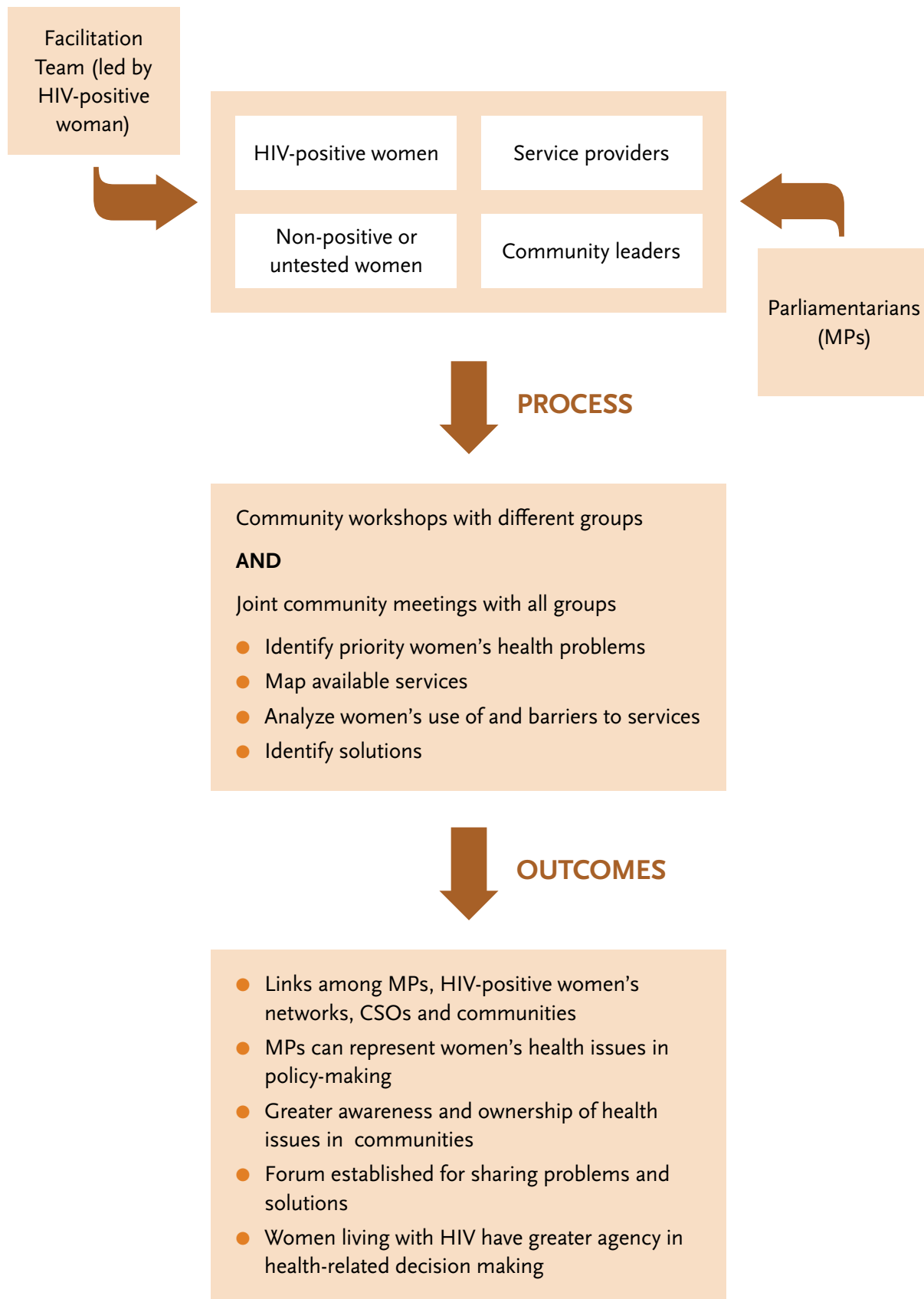
The process helped the community to:

- Identify and prioritize the main health problems women face.
- Map the services available in the community to address these problems.
- Define the crucial gaps in services.
- Analyze women's experience in using health services.
- Identify barriers to health services.
- Identify crucial problems that undermine women's health as well as possible solutions.

A community assessment facilitator should keep the following in mind:

- Put participants (especially women) into the driver's seat – enabling them to take over the process of analysis, map their own world, identify their own priorities and constraints, do their own problem solving and make their own decisions.
- Use a participatory approach to promote peer learning and two-way communication, rather than passive listening.
- Use the different groups and methods to cross-check and compare information and analysis.
- Be prepared to self-evaluate – facilitators should continuously assess their own behavior and learn from the workshops.
- Create a sense of ownership among all players of the analysis, strategies and plans to improve women's health.

Community Assessment Model



CHAPTER B:

Planning and Preparation

Introduction

This chapter shows you how to plan and prepare for the community workshops.

With planning and preparation, your workshops will start off on the right foot and you will be better prepared to cope with unplanned factors, for example, transportation problems, a team member's illness, inclement weather, etc.

Make a Checklist of Preparations

Make a list of all of the things that have to be done before the workshop starts. When you arrive at each site, go through the list with the local partners to check what has been done. If you arrive early enough, you can take care of anything that has been overlooked. The list below captures key items you should include.

- **Step 1: Build your team**
- **Step 2: Set objectives**
- **Step 3: Prepare a checklist of key questions**
- **Step 4: Select facilitator, recorder and logistics organizer**
- **Step 5: Select the field sites**
- **Step 6: Draw up a schedule**
- **Step 7: Identify local partner organizations**
- **Step 8: Invite participants and brief local gate keepers**

- **Step 9:** Find an appropriate venue
- **Step 10:** Plan for language issues
- **Step 11:** Plan your work as a team
- **Step 12:** Develop a team contract
- **Step 13:** Plan post-workshop follow up
- **Step 14:** Organize materials

Step 1: Build Your Team

Start off by bringing together organizations that would like to work together to plan and implement the community assessment process, and also initiate advocacy and actions based on the assessment's findings. This team could include organizations of people living with HIV and/or HIV-positive women as well as nongovernmental organizations involved in human rights, women's rights, HIV and AIDS, or health issues. This group of stakeholders would also include members of parliament (MPs) who are active on HIV and AIDS or women's issues (see box on next page).

HIV-positive women should play a lead role on the team and in all stages of the community assessment process: designing the process, implementing the field activities, analyzing the data and initiating follow-up advocacy.

During these initial planning meetings, find consensus on the assessment's objectives, scope and how the findings will be used. Help each group understand how they will benefit from the project and how they are expected to contribute.

These planning meetings will start the dialogue between the different groups involved in the community assessment, and build close working relations between HIV-positive women and the parliamentarians.

Involving Members of Parliament (MPs)

A major feature of the community assessment process is the involvement of MPs. By participating in the process, MPs will be more likely to:

- Listen to and learn from women as they explain their health problems;
- Develop a commitment to doing something about those problems; and
- Build a dialogue and links with HIV-positive women around these issues.

The MPs' participation also shows the community that their concerns are being heard and taken seriously. That said, having MPs present may dampen participation by other groups. Participants may be reluctant to share certain things if MPs are present; if MPs are poorly briefed, they may dominate the discussion or interfere with the process.

To get MPs on board initially, a key strategy is to approach those who already are committed to the issue of women's health – for instance, members of a parliamentary committee dealing with health and/or AIDS issues.

Once the MPs have agreed to participate in the community assessment, you will need to plan their involvement as carefully as everything else. Look for ways to maximize the advantages they bring, while controlling potential disadvantages. Help them understand the process and how they can make it work.

The MPs who participate may be familiar with participatory processes, but most will be used to delivering information through speeches, rather than asking questions and listening. If this is a new approach for them, help them understand it so they can participate effectively.

Meet with the MPs before the community assessment process begins to:

- Brief them about the community assessment process (its objectives, agenda/activities, “listening and learning” approach, timing, etc.);
- Give them a clear role in the workshops (for example, helping to gather and analyze data); and
- Discuss with them what happens after the workshops and how they might use what they learn from the process to make policy or other changes.

Providing MPs with instruction on their roles in the workshops will help ensure that they do not interfere with the workshop process.

MPs should understand that their role is to ask questions, listen and encourage discussion from participants. Explain to MPs that the goal is for the local community members to collectively identify and analyze the issues, and then consider what they can do to address them.

Ideally, the MPs should help facilitate discussion, but in our experience only a few MPs have the skills to manage this role effectively. If you want to involve the MPs in facilitation, protect the integrity of the process. Have them observe the process for the first two days. Then, if they seem to have the right skills, they can help lead one of the sessions as a co-facilitator – the other co-facilitator can take over if the MP gets off track.

Recommended sessions for MPs to facilitate include:

- Sessions with community leaders and service providers
- Sessions at the end of each day
- Site visits and transect walk around the community to observe the people, surroundings and resources

Step 2: Set Objectives

Develop clear objectives that define:

- What information you want to collect;
- What you want to do with the information and analysis produced in the workshops;
- What forms of action you would like to stimulate at the community level; and
- What impact you would like to create with the MP co-facilitators.

Sample Objectives

- Document women's concerns about their health problems and health services;
- Identify obstacles to women's effective use of health services;
- Help MPs acquire firsthand information about women's health problems through direct contact with HIV-positive women and other women at the community level; and
- Start the process of building dialogue among HIV-positive women, parliamentarians and civil society organizations.

Step 3: Prepare a Checklist of Key Questions

Once the objectives have been set, prepare a checklist of key questions that will help keep you focused on the issues to be explored and the information to be collected in the workshop sessions. One example of a checklist is given below.

Key Questions

1. What do different stakeholder groups understand by the term "women's health"? What are their attitudes toward women's health and HIV-positive women's health?
2. What health issues do different stakeholders perceive to have the biggest impact on women in general, and women living with HIV in particular? What are some cultural practices (e.g., female genital cutting, polygamy, wife inheritance) and social and environmental factors (e.g., HIV-related stigma and discrimination; high incidence of gender-based violence, sexual crime, pollution) that have a negative impact on women's health?
3. What health services (e.g., care and support for women with HIV and AIDS or other long-term, chronic or life-threatening conditions) currently exist?
4. What are the gaps in health services, including reproductive health?
5. What are women's experiences of using these health services? Are HIV-positive women's experiences significantly different from the experiences of other women?
6. What barriers prevent women from using these services? Are they different for HIV-positive women and other women?
7. Which women's health issues need priority responses and what kinds of responses might be appropriate? How can MPs, civil society organizations and others raise these issues in parliament and other fora?

Step 4: Select the Facilitator, Recorder and Logistics Organizer

To conduct the workshops, you will need at least three people: a lead facilitator, a recorder and a logistics organizer. If you are working in a minority language, you also may need an interpreter.

Select appropriate team members to lead the different target groups. A woman should be the lead facilitator, because two out of the four target groups are women (HIV-positive women and negative/untested women).

At least one of the team members should be a woman living openly with HIV. This woman could be recruited from a national network of HIV-positive women. Having an HIV-positive woman who is open about her status and a skilled facilitator helps build the courage of female participants.

Other factors to consider when selecting team members include:

- Experience in using participatory methods and documentation;
- Proficiency in the local language or dialect; and
- Knowledge of the communities in which you are working.

Select facilitators with requisite experience that includes participatory methodologies and documentation and work in the HIV and AIDS, health or gender fields. Involve women living with HIV in the selection process.

MPs, especially those who have taken a strong interest in the process and have learned the necessary skills, should be included as facilitators when possible. You could train MPs in advance, or they could help as a fourth team member and learn facilitation skills through observation. At a later stage, they can help with some of the facilitation roles.

Consider two teams to coordinate the assessments, given that the process includes five major workshops (see Chapter C) as well as site visits. One team could be comprised of three women to facilitate the women's group workshops; the other team could be men and women who conduct the workshops with community leaders and service providers. Both teams would carry out site visits in addition to their respective workshops. The two teams would work together in conducting the final joint workshop.

Step 5: Select the Field Sites

It is important to choose diverse field sites for community assessments to get an overall picture of the various kinds of health problems women face. Sites you may want to consider could include:

- High HIV-prevalence areas or potentially high-risk sites, such as trucking routes or places with a highly mobile population or migrant labor force;
- A mix of rural and urban sites to compare health issues and access to health care services; and
- Areas with dominant cultural practices, which may have an impact on women's ability to access health care services.

Workshops are best organized around an MP's constituency, so consult with them when selecting the communities for the assessments. Choosing a field site also is influenced by what is practical. If you already know a particular community, you may decide to work there, because much of the background work (e.g., identifying local contacts, knowing which support groups and key actors are in the area, etc.) will already have been done. You already know the community and they trust you – this is a big start!

Select a site that is easily accessible for participants – walking distance if possible. In urban areas, somewhere central is probably best.

Step 6: Draw up a Schedule

Develop a schedule once you have decided on the sites for the community assessment process. The assessments will include five one-day workshops and site visits to health facilities.

In our experience, scheduling workshops for five consecutive days is exhausting. It is better to stagger the workshops and site visits over two weeks (i.e., two to three days in one week, use the weekend to debrief and recover, and two to three days at the start of the following week).

Step 7: Identify Local Partner Organizations

Use your contacts to select partner organizations (e.g., local support groups, nongovernmental organizations, community-based organizations, faith-based organizations, or a local clinic or district AIDS committee). These organizations often are the gatekeepers in getting access to the community and can help the workshops get off on the right foot.

Brief partners on the workshops' objectives and processes and solicit their ideas on possible venues, timing, how to invite the participants, etc. Provide each partner with a checklist of things to do in preparation for the workshops.

Staff from local partner organizations also may want to participate in the workshop as facilitators or translators. If they take on these roles, brief them on their responsibilities beforehand.

Step 8: Invite Participants and Brief Local Gatekeepers

The workshops include four groups of participants: (1) community leaders, (2) HIV-positive women, (3) HIV-negative and untested women, and (4) health care service providers. The discussion below gives some ideas for criteria to use when selecting workshop participants.

Community leaders include representatives of local nongovernmental, community-based and faith-based organizations, and traditional leaders and healers.

In the case of **HIV-positive women**, participants may be self-selected. HIV-positive women who choose to participate are usually those who feel more confident about discussing their status in public. Exercise careful consideration when inviting HIV-positive women and respect their confidentiality. Some HIV-positive women are not prepared to talk openly about their status.

When we organized community assessment workshops with HIV-positive women, we assumed that all members of support groups were openly living with HIV. We discovered that some of the women were unhappy that our process revealed their status. We “outed” them without knowing it. Be cautious. We should be careful not to put HIV-positive women at risk of being stigmatized. (Comments of a community assessment organizer for the Parliamentarian pilot project)

The community assessment process involves separate workshops with HIV-positive women and negative or untested women. In some situations it may be better to organize a single workshop that brings together HIV-positive and negative women. For instance, HIV-positive women who have not disclosed their status would likely avoid attending a meeting for HIV-positive women.

HIV-positive women’s groups should guide you on these decisions. They understand the sensitivities around this issue and how to handle it. Sometimes HIV-positive women from other villages who are living openly with HIV may be able to help others build up the courage to talk openly about their own status.

When inviting HIV-positive and negative women to the workshops, be sure to include young and older women as well as single and married women.

Health care workers include trained professionals who work in the health care economy, ranging from local clinics to hospitals. Be sure that you clarify what you mean by health care worker. In one workshop, we asked the local organizers to invite health care service providers, but instead we got people who were working in nongovernmental or community-based organizations providing home-based care and other AIDS services. Consequently, we did not get the views of nurses or others working in health care.

Some health care providers may find it difficult to talk openly about certain issues, particularly sensitive topics such as HIV. In one workshop, nurses did not want to be identified with their hospital when they discussed how they advised HIV-positive women about having children. The nurses said they covertly discuss this topic with their HIV-positive female patients because hospital staff normally discourage these women from having children. This made reporting difficult because the nurses did not agree to have their hospital affiliations documented.

There are other factors to consider when inviting participants. Limit the number of people who attend the workshops to keep them manageable – ideally, 15 to 20 participants; 30 participants at most. Send out the invitations well in advance of the workshops and send a reminder closer to the workshop date. Provide invitations to the partner organizations. In the invitation letters, clarify any logistical arrangements, such as reimbursing participants for transport costs. Also, be sure to explain that each workshop will last a full day, and participants are expected to stay for the duration.

The invitation letters can be used to introduce the facilitation team to local gatekeepers at district and village levels (e.g., district council, district AIDS committee, chiefs or headmen, village development committee, etc).

“In Namibia, the MPs encouraged us to use letters to introduce ourselves to stakeholders at different levels. It helps to have a letter from parliament to introduce the team and the purpose of your mission. When you walk into communities carrying these letters, you are immediately accepted. (Workshop organizer for the Parliamentarian pilot project)

Before sending out the invitations, decide with your partners what areas will be included. You may decide to invite people who live in a single village; or you may invite a representative group from several villages in a single constituency. A single village workshop is easier to manage because all participants have similar experiences and can talk about the same health institutions. A multi-village workshop is more difficult to manage and requires more extensive travel for participants, but has the advantage of providing a wider range of experiences and the chance to compare them.

Step 9: Find an Appropriate Venue

Select a meeting place with input from the partner organization. Find a place that is comfortable and safe for participants, and relatively free from noise and other distractions.

If possible, try to find a site with the following features:

- Large space for the plenary meetings and small groups;
- Comfortable chairs that can be moved easily;
- Clean facilities, clean toilets, potable water, and adequate ventilation and lighting; and
- Facilities for making tea, coffee and food.

Visit the site before the day of the workshop so you can make the necessary adjustments so it is suitable for your workshops. Keep in mind, however, that the local contact person often arranges the venue, so the first time you see the venue might be on the morning of the first workshop. This may require you to adjust your program to the facilities provided.

Be prepared to work in less than ideal circumstances. You will need to carefully consider what you need to take with you on the day, and come prepared for almost *any* eventuality. Bring money to purchase food locally. If you have to carry the food with you, take more than you think you need.

Step 10: Plan for Language Issues

It is best to conduct the workshops in the local language. If none of your team members can speak the local language, you will need a simultaneous translation, which could double the length of the workshop. You also will have to prepare translations of workshop instructions and handouts. You may need extra money in your budget to pay for translators.

Step 11: Plan Your Work as a Team

As part of your preparation, meet as a team and discuss the roles of different team members. Make sure that all team members understand their own roles and the roles of other team members and how they can support each other. There are three main roles within the team: facilitator, recorder and logistics organizer.

Role	Major Tasks
Facilitator	<ul style="list-style-type: none">● Introduce topics, ask open questions and follow-up questions to explore issues, rephrase responses, keep the discussion on track and encourage all participants to contribute.● Organize small group work and participatory activities, process group reports, and summarize the reports of each session.● Keep workshop on schedule and resolve any conflicts.
Recorder	<ul style="list-style-type: none">● Keep notes on all discussions and the level of participation.● Collect and organize flipchart products.● Make copies of body maps and community maps.● Take photos. (Ask permission before taking photos.)● Provide supportive feedback to the lead facilitator.
Logistics Organizer	<ul style="list-style-type: none">● Organize the registration of participants.● Record participants' ideas on flipchart.● Handle any external distractions that come up.● Manage the budget and materials.● Organize handouts for participants.● Book the workshop venue and arrange for access to it.● Organize transport for the team.● Arrange refreshments and lunches.● Provide transport allowances for participants who have traveled from a long distance.● Arrange the site visits.

The following tasks will be shared among the whole team:

- Arranging the translation of handouts and workshop materials into the local language.
- Writing flipchart presentations (e.g., small group tasks).
- Taping up blank flipcharts for recording.
- Organizing recorded flipchart notes (e.g., removing sheets from the easel, folding and labeling its contents).
- Preparing other materials (e.g., body mapping and community mapping).
- Arranging chairs for plenary sessions and small group work.
- Maintaining a clean and organized setting.

The role of the lead facilitator can be shared within the team. The team facilitation approach has the advantage of bringing in fresh energy at intervals and makes sessions more interesting for participants. If you choose to alternate facilitators, remember to also alternate responsibilities for recording notes and organizing logistics.

If possible, rehearse methods before the workshops to get feedback on how well you are doing.

Step 12: Develop a Team Contract

The team should consider the image they want to project to the communities with whom they are working. Obtain consensus on how you want to present yourselves. One way to monitor your own attitudes and behavior is to agree on a team contract that delineates how you are to work with the community and as a team. This contract would be agreed with the whole team, including the MPs. You should refer to it as needed when working in the field and with your team.

Sample Team Contract

We agree to:

- Work as a team and be supportive of each other.
- Be punctual and conscious of people's time.
- Be respectful to community members.
- See our main job as asking good questions, listening actively, rephrasing and encouraging everyone to participate.
- Encourage the shy and control the talkative without embarrassing them.
- Avoid being judgmental, reacting with surprise to what participants say and making fun of participants.
- Limit our own talk and encourage participants to avoid long speeches.
- Leave ourselves open to learning new things from participants.
- Answer participants' questions.
- Review our own performance and reports at the end of each day.
- Work together and avoid arguing among ourselves in front of participants.

Step 13: Plan Post Workshop Follow Up

Your planning also should include decisions on how to use the findings for action at the community and national level. The planning group should think about how to organize the next steps.

Parliamentarians for Women's Health Round Table

In follow up to community assessments, the project held a round table meeting of representatives who had participated in the process in different sites. Participants included the facilitator, recorder and logistics organizer, the MPs, representatives of the HIV-positive women's groups, and civil society organizations. During the round table, participants reviewed and compared the findings from different sites, agreed on priority health issues, gaps in services, and barriers to women's access to services, and recommended how to solve some of the problems raised.

Other forms of follow up include:

- MPs who participated in the field assessments conducted briefings for key parliamentary committees on assessment findings.
- MPs lobbied for the formation of new parliamentary committees to address some of the issues identified during the community assessment process.
- MPs made special efforts to involve HIV-positive women and nongovernmental organizations during the process of preparing new policies.
- MPs used the same participatory methods to conduct additional community assessment workshops in other parts of their countries.
- Key findings from the assessment were reported in the newspaper and radio.
- HIV-positive women formed a working group to monitor health services and work closely with MPs to lobby for ways to improve services.

Step 14: Organize Materials

One of your last steps to prepare for the workshops is to purchase and organize your materials (see box on next page).

Checklist of Materials

- FLIPCHART PAPER. One ream is needed for a one-day workshop.
- MARKER PENS. Use dark colors (blue and black) for writing, and light colors (red and green) for emphasis and underlining. Have a marker in a dark color available for each participant. Estimated numbers for a one-week process: black (2 boxes), blue (2 boxes), red (1 box), green (1 box)
- NAME TAGS. You can use commercial name tags or simply cut A4-size paper into four pieces. Be sure to write the names with large letters to ensure that everyone can read them.
- MASKING TAPE and/or BLU-TAC to tape flipcharts on the wall. Take masking tape (or blu-tac) off the flipcharts before storing them to save you from unsticking them during report writing. Estimate: five rolls per week.
- STICKERS. Three different colored stickers recommended to add new information to the body maps.
- POST-IT NOTES or YELLOW CARDS.
- PENCILS and ERASERS.
- NOTEBOOKS for recording.

Resources for Trainers

- COMMUNITY ASSESSMENT MANUAL – Have a copy of this guide for all trainers.
- GAMES FOR TRAINING – See Annex B.
- SILHOUETTE PICTURES – See Annex C (to be used in Session 2).
- DEMONSTRATION BODY MAP – See Session 3.
- CHECKLIST OF POSSIBLE SERVICES – See Session 4.
- TOPIC CARDS – Health Services, Community, Household, Workplace – See Session 5.
- REGISTRATION FORMAT.
- EVALUATION FORMS – To be completed during Day Five.
- CHECKLIST FOR SITE VISIT.

Handouts – Translated into Local Languages

- COMMUNITY ASSESSMENT OBJECTIVES AND USE OF INFORMATION.
- WOMEN'S HEALTH FRAMEWORK – See Chapter C, Session 2.
- FACT SHEETS ON KEY HEALTH TOPICS – See Annex A.

Other Resources

- LAPTOP COMPUTER – Also take notebooks and writing materials in case there is no power in the venue. Never rely on objects that need electricity.
- CAMERA.
- DRUM OR BELL.

CHAPTER C:

Facilitating Community Assessment Workshops

Introduction

This chapter explains how to conduct both a one-day community workshop for each stakeholder group (the workshops are basically the same for all groups; variations are indicated in each session as appropriate) and a joint workshop at the end, where all four stakeholder groups meet together. In the final workshop (Day 5), the four groups share their findings, work together on problem solving and develop recommendations for action.

The agenda for the one-day workshop is as follows:

Session	Assessment Topic or Activity	Tool/Method	Group*
1	Introductions and Breaking the Ice	Group Discussion	All groups
2	Thinking about Women's Health	Life Cycle Exercise	All groups
3	Identifying Women's Health Problems	Body Mapping	All except community leaders
4	Identifying Health Services and Gaps	Community Mapping	All groups
5	Women's Experience of Health Services	Drama	Women's groups
6	Problem Analysis and Problem Solving	Group Discussion	All groups
7	Evaluation, Follow up and Closing	Cardstorm and Circle	All groups

*The community assessment on women's health includes four one-day workshops with each of the following stakeholder groups: HIV-positive women, HIV-negative and untested women, service providers, and community leaders. The final (5th) workshop brings all four groups together.

Additional Activities

- **COMMUNITY HEALTH WALK** – to explore health issues in a small community
- **SITE VISIT** – to look at services in health or other facilities serving women

Joint Workshop (Day 5)

Bring all the groups together to share their findings and do joint problem solving.

Pulling It All Together – The Round Table

- Review and compare findings from different sites.
- Agree on priority health issues, gaps in services and barriers to women’s access to services.
- Make recommendations on how to solve some of the problems raised.

The Full Package or Selected Activities

Using this full package of activities for a series of five workshops will provide participants a comprehensive understanding of women’s health needs. However, using just one or two of the activities during a visit also can yield valuable insight into women’s and other community members’ health issues.

Key Questions

Each workshop is aimed at finding answers to the following key questions:

1. What do different stakeholder groups understand by the term “women’s health”? What are their attitudes toward women’s health and HIV-positive women’s health?
2. What health issues are perceived to have the biggest impact on women in general, and on women living with HIV in particular? What cultural practices (e.g., female genital cutting, polygamy, wife inheritance) and social and environmental factors (such as HIV-related stigma and discrimination, gender-based violence, etc.) have a negative impact on women’s health?
3. What health services exist, including care and support for women with HIV and AIDS or other long-term, chronic or life-threatening conditions?
4. What are the gaps in services, including gaps in reproductive health and choices?
5. What are women’s experiences of using these health services? Are HIV-positive women’s experiences significantly different from the experiences of other women?
6. What barriers prevent women from using these services? Are these barriers different for HIV-positive women?
7. Which women’s health issues need priority responses and what kinds of responses might be most appropriate? How can these be taken forward by MPs, civil society organizations and others in parliament, or through other kinds of advocacy or lobbying?

One-Day Workshop

The Session Plans

Chapter C is the core of the guide. It consists of a number of session plans that include detailed, step-by-step descriptions of how to facilitate each session in the five workshops.

Each session plan is divided into the following parts:

Item	What It Means
Target Groups	Groups this session applies to.
Facilitator's Notes	A brief overview on the importance of the session and what happens during the session – the topic and methods used.
Things to Guard Against	Things that might go wrong during the session (e.g., weak response from participants) and how to avoid or manage them.
Objectives	What participants will learn or do during the session.
Time	Estimated time needed for the session. This may vary according to the size of the group and other factors.
Materials	Materials needed for this specific exercise. This list does not include general supplies such as flipchart paper, markers, masking tape/blu-tac.

STEPS

The activities involved in the session, described “step by step.” “STEPS” are the core of each session plan. This section includes information on:

- **Methods:** Description of the methods used within each session.
- **Group Work:** Description of group size and group tasks.
- **Questions:** Specific questions used to guide discussion (presented in *italics*).
- **Sample Responses:** Examples of outputs produced by groups or in response to questions – presented in **boxes**. These examples, taken from the Parliamentarians for Women's Health project experience, give you an idea of the kind of responses you might get from participants **but they are only examples – they are not meant to be the required output.**
- **Probing:** Additional questions to get more information and deepen the analysis.
- **Summaries:** Points to be emphasized at end of the session.

Session 1: Introductions and Breaking the Ice

Target Groups: ALL

Facilitator's Note: During this opening session you are trying to make everyone feel welcome and understand what you would like to achieve during the one-day workshop.

Things to guard against: Explain how the information from the session will be used – for instance, to help MPs make changes to improve health services and women's access to health; or help civil society or other organizations advocate around women's health issues. Explain what the workshop will do and what it will **not** do (e.g., the workshop will not pay people for their participation).

Objectives:

- Break the ice, put participants at ease and get them talking.
- Underscore the importance of the workshop and how participants will benefit.
- Respond to participants' expectations and correct any false expectations.
- Agree on basic rules for the one-day workshop and how to enforce them.

Time: 30 minutes

Materials: Registration sheet. Name tags.

Steps:

1 ARRIVAL ACTIVITY (Registration and Rhyming Name Tags): As participants arrive, ask them to write their name on the registration sheet and make "rhyming" name tags – their own name plus an adjective starting with the same letter, e.g., **Crazy Christine**, **Magical Mary**, **Sexy Sara**. If they are illiterate, help write the names. This activity involves everyone when they first arrive, creates some fun and helps to build a relaxed atmosphere.

2 WARM-UP AND INTRODUCTIONS (10 minutes): Organize a warm-up game to break the ice, get participants interacting, and prepare for introductions and expectations. See Annex B for possible warm-up games.

Warm-up Game – "Fire! Fire!" Ask participants to stand up and walk in any direction. When you call "Fire! Fire!" and a number, participants get into groups of that number. Call out two to start with, then three, then four, then two. When you back to having pairs, ask each pair to do two tasks–

- Find out two things about each other (e.g., three grandchildren and likes to dance).*
- What do you expect to learn or do during the workshop?*

Introductions: Bring the group back together in a circle and ask each person to introduce his/her partner – rhyming name and two things. As part of these introductions, introduce yourself, the recorder and the logistics organizer, and ask the MPs to introduce themselves, using the rhyming names.

3 EXPECTATIONS (10 minutes): Go around the circle and ask each person to give his/her expectations from the workshop.

Note: This round of expectations can be repetitive, but it also can bring out important information and identify expectations that the workshop won't address. For example, in one pilot workshop many participants talked about "the sickness," rather than AIDS. This showed there was a taboo about speaking about AIDS and, because many people talked about it, it showed that AIDS was a big problem in the community.

Possible expectations might include such things as wanting to access a certain health service (which would highlight that service as a priority), or wanting to learn a particular set of skills (e.g., home-based care skills). While the workshop is not going to provide those outcomes, it is useful to know of these expectations.

Some participants may expect to be paid for attending the meeting or financial support for their projects. This exercise gives you an opportunity to explain:

- a) What will be provided, e.g., reimbursement of travel expenses.
- b) What won't be provided, e.g., funding for local projects.

This information also should be provided in the invitation to the workshop.

4 OBJECTIVES (5 minutes): Explain the objectives for the workshop (see below for example).

Our aim is to find out more about women's health problems and concerns so we can determine the best way to improve health services. The MPs (or civil society organizations) will listen and learn from you to get a better understanding about the gaps in women's health services and your ideas on how to improve them. Then, they can use this information to improve services or lobby for changes in laws.

During the discussions today we would like to learn more about:

- Your experience and concerns in getting health care for yourselves and your families.
- The health services in your area and what works/what doesn't.
- The problems facing women in accessing health care and how to improve things.

Feel free to talk about anything you think will help us get a better understanding about women's health. If you prefer not to talk on some issues, this is okay too.

The workshop will run until [pick an appropriate time] in the afternoon. Lunch and tea will be provided at breaks. Please stay until the end of the meeting – we need your full contribution.

We will meet with and get opinions from different groups in the community, including HIV-positive women, other women, community leaders and health workers. On the fifth day, we plan to bring all these groups together for a joint meeting to share what we have learned and generate ideas on how to improve things. We hope you will be able to come.

5 GROUND RULES (5 minutes): Say – “We would like to hear everyone's ideas and have a good meeting. What rules should we use in working together today?” Give an example of one rule (e.g., listen to and respect each other's views), and then ask for other rules. Record suggestions on a flipchart.

If the group doesn't mention “CONFIDENTIALITY,” add it to the list and explain: “You might want to share personal stories during the workshop, but your stories should NOT be shared with anyone else after the workshop is over.”

Examples of Meeting Rules

- Encourage everyone to participate to the extent that they feel comfortable.
- Listen to each other and respect each other's views.
- Don't interrupt when a person is speaking.
- Don't hold "side meetings" – keep the focus on a single meeting.
- Keep things confidential.
- Turn off cell phones.

Once the list is completed, say, *"These will be our rules for the rest of the day, so that we have a good meeting."*

Then ask, *"How can we enforce these rules?"* Agree on a funny word or animal noise, e.g. **"ouch!"** or **"ajukuja!"** Anyone who notices a rule is being broken says **"ouch!"** loudly. Everyone joins in until you have everyone's attention again, can remind the group of the rule, and can go back to the person who has been interrupted. *"Ouch!"* works quite well – it's funny enough to make a point without upsetting people.

Note: One fun way of breaking down status differences with parliamentarians present during the workshop is to make two sets of name tags – a) name tags starting with "Honorable" and last names and the word "MP," and b) Rhyming Name using their first name. Hand out the "Honorable" name tags when they first arrive. Then during the Introductions (Step Two) ask the MPs to hand over these name tags and say, *"For the rest of the workshop we will get rid of the "HONORABLE" and we have given you new names,"* and then hand them the second set of name tags.

Session 2: Thinking about Women's Health

Target Groups: ALL

Facilitator's Note: This is a short session designed to help participants understand the meaning of "women's health" in preparation for later discussions. The aim is to help participants think about specific women's health issues.

Objectives:

- Help participants understand that:
 - Women's health is more than just a list of diseases or physical health. It also includes mental, psychological and spiritual health.
 - Social, cultural and environmental factors (e.g., gender-based violence, reproductive health issues and excessive workloads) affect women's health and their ability to access health care services.
 - Illnesses and health problems affect women differently than men due to their lack of access to and control over household resources, heavy workload, lack of access to health services, etc.
- Help participants identify a few health issues specific to women.
- Help participants understand the importance of talking about women's health.

Time: 20 minutes

Materials: Silhouette pictures – grandmother, grandfather, mother, father, teenage girl, teenage boy, baby (Annex C).

Steps:

1 **LIFE CYCLE EXERCISE (15 minutes):** Post the silhouette pictures on the wall and lead the following discussion–

a) “What diseases or health problems do men and women have at different stages?”

Stage	Male	Female
Childhood	Malaria. Diarrhea. Colds. Flu. Pneumonia. Malnutrition. Worms. Measles. Chickenpox.	
Adolescence	Sexually transmitted infections. Alcohol abuse.	Sexually transmitted infections. Menstrual pains. Pregnancy. Abortion.
Middle Age	HIV and AIDS. TB. Cancer. Alcohol abuse.	HIV and AIDS. TB. Pregnancy complications. Stress. High blood pressure.
Old Age	Heart disease. Cancer. Poor vision. Feet swelling.	High blood pressure. Back pain. Depression.

Then probe:

- “What problems do women have because of their **heavy workload**?”
- “What problems do women have related to **having sex and having children**?”
- “What problems do women face as a result of **violence**?”

Examples of women’s health problems related to these three issues:

Stress. Depression. Violence. Teenage pregnancy. Fistula.

Note: Don’t worry about getting a complete list at this point. The aim is simply to get participants thinking about women’s health problems. Participants will produce a more detailed list in the next session.

b) Select a few general health problems (e.g., diarrhea) and ask–

“How do these health problems affect men and women differently?”

Example: Does diarrhea have a bigger impact on women than men – why?

Example of Health Impacts on Women:

Diarrhea in the family – increased workload, more washing, more time fetching water, women have to take children to clinic, women have to work even when they are sick.

Why are women affected more than men? Women have to do all the housework and care for the children and anyone sick in the house. When women get sick themselves, there is no one to care for them.

2 SUMMARIZE: Explain what was learned from the discussion (see example below):

WOMEN'S HEALTH FRAMEWORK

Women's health includes:

- a) **Physical health**, including sexual and reproductive health
- b) **Mental health**
- c) **Emotional well-being** (feeling good about oneself, living free of fear)
- d) **Spiritual well-being**

In our discussions we looked at **health issues that are specific to women**. Many of these issues are related to women having or not having children, and women's relations with men (e.g., violence and its effects on women).

We also noted that women's health issues are different from men's for a variety of reasons.

To maintain good health, women need to be able to get:

- a) Diagnosis and treatment of illnesses, including sexually transmitted infections and reproductive health problems.
- b) Care and support services (from the clinic and at home).
- c) Psychosocial support and counseling.
- d) Information about all health issues.
- e) Information, advice and counseling related to having children/family planning.
- f) Freedom to decide whether, when and how many children to have.
- g) Adequate standard of nutrition.
- h) Clean water and sanitation.

Women's health is affected by a number of factors in the home, community and workplace:

- a) **Environmental and social factors** (violence, lack of clean water and sanitation, lack of year-round access to food, etc.)
- b) **Cultural factors** (female genital cutting, polygamy, violence, attitudes toward health care, such as suspicion of western medicine and reliance on traditional healers).
- c) **Political factors** (low status of women, lack of representation in decision making, war/conflict, lack of access to education and information, high rate of unemployment, lack of laws to protect women from violence, etc.)

Women's health is important, but it is not given sufficient attention in our society. This is why we are focusing on this issue.

Session 3: Identifying Women’s Health Problems

Target Groups: ALL – except community leaders

Facilitator’s Note: This session uses a technique called “Body Mapping.” Participants make a life-size outline of a body by getting one participant to lie down on top of flipchart sheets taped together and getting another participant to trace around her. This outline becomes a focus for discussion on women’s body parts, including sexual anatomy, and related health issues – all of which are recorded on the picture.

This exercise is used to get participants talking about women’s health, including sexual and reproductive health. Naming the body parts helps to get people talking about these often taboo subjects. This discussion helps reveal what people know about their bodies, and at the same time to identify important health issues.

Body mapping is a good starter activity because it shifts control away from the facilitators to the participants who take the lead in making the body map, adding the body parts and health problems, and deciding on the priority issues.

Body mapping is usually done in gender-segregated groups, making it easier for women and men to talk freely. The drawings provide a non-threatening way to start a discussion about sensitive topics such as sexual anatomy. It may be possible, however, with the service providers, to do this exercise as a mixed group.

Things to Guard Against:

During this exercise let participants take control. Hand over the marker pens and let them do the recording on the body map. They will show and explain how they view the body, its parts and diseases. If you try to control this activity too much, you will stop them from telling their story. If one or two participants are dominating, ask them to hand the markers over to the other participants.

At the start, participants may be shy about naming sexual body parts. However, it is important that the participants DO name the body parts (including genitalia) themselves, and not have the facilitator do it for them. This might take a lot of prompting and encouragement by you, even to the point of putting your finger on the relevant parts and asking, “What do we have here?” Once participants have gotten over any embarrassment, the process usually goes smoothly.

Some body maps may trigger traumatic memories for some participants. You need to be prepared to manage these strong feelings. See suggestions in Chapter D.

Objectives:

- Identify common health problems and concerns faced by women.
- Agree on which of these health concerns are priorities.
- Explore local perceptions, myths and understandings of diseases.
- Help participants talk about sexual and reproductive health issues comfortably.

Time: 1 hour

Materials:

- Stickers (3 different colors)
- One marker for each participant. Pencils and erasers
- Fact Sheets on key diseases – symptoms, causes, treatment

Preparation:

- Tape six flipchart sheets together to make a large sheet of paper.
- Make a body map showing the major organs as a demonstration tool used during Step 6 (Questions and Answers) in case participants' body map is incorrect.

Steps:

1 INTRODUCTION: Say – “*We are going to make a map of the woman’s body. Then we will mark the parts of the body and talk about how women’s bodies are affected by different health issues.*”

2 DRAWING THE BODY AND ITS PARTS (15 minutes): Put the large sheet on the floor and ask one volunteer to lie down on it. Ask another participant to draw an outline of her body, using a marker.

Then ask participants to mark parts of the body – a) those that are visible, and b) those that are covered by clothes (sexual anatomy). Get them to use the local names for each part.

3 MAPPING HEALTH PROBLEMS AFFECTING WOMEN (15 minutes): Ask – “*What health problems affect women and which body parts are affected?*” As each problem is mentioned, record it on a colored sticker and tape it on the part of the body affected. For example if they mention “cancer in the vagina” (cervical cancer), tape the sticker on the vagina.

Encourage the group to mention not only general diseases but also other issues affecting women’s health, for instance:

- Problems related to women’s heavy workload (e.g., back pain);
- Problems related to having children or preventing pregnancy; or
- Problems related to men’s violence

Note: This probing to produce a full list of women’s health problems is very important. Use the following checklist to help.

Examples of health problems faced by women:

- Malnutrition. Lack of food and safe water.
- HIV and AIDS. Sexually transmitted infections. High blood pressure. Hypertension. Diabetes. Malaria. Diarrhea.
- Cervical cancer. Vaginal infections. Fistula. Breast cancer.
- Problems getting information/counseling to have children, or not have children. Teenage pregnancy. Difficulties getting abortions. Poorly performed abortions. Ectopic pregnancies. Maternal health/morbidity/mortality.
- Stress. Depression. Emotional abuse.
- Beatings/physical violence. Sexual violence/rape. Problems getting men to use condoms.

4 PRIORITIZING (10 min): Ask – “*Which are the most important health problems?*” **Extra probes** – “*Which have the biggest impact on women? Which need to be addressed most urgently?*”

Ask participants to decide the priority – High, Medium, or Low – for each problem. Add a colored sticker to show the priority, e.g., red (high), blue (medium), green (low).

This is an example of how one group prioritized their list

High (red)	Medium (blue)	Low (green)
HIV and AIDS	Malaria	Colds
Sexually transmitted infections	Diarrhea	Headache
Sexual violence/rape	TB (tuberculosis)	Period pains
Cervical cancer	High blood pressure	Back pains
Teenage pregnancies	Lack of food & safe water	
	Beatings/physical violence	

Ask – “What are your reasons for your priorities? For example, why did you rate AIDS ‘high’ and period pains ‘low’?”

Then ask – “Which are the three most important health problems?” This will bring out people’s reasons for priorities, women’s health-seeking behavior and cultural factors around the issues. You may want to ask questions during the discussion, especially if issues are put forward and then dropped from the final list.

5 HOW TO RECOGNIZE DISEASES? WHAT DO WE DO ABOUT THEM?

This step is used only with HIV-positive women and untested/negative women.

Ask – “How do most people recognize diseases when they get them? What do they do to get treated if they are affected by diseases?”

Record this information on cards and tape on the body map, or on a flipchart if the body map is already too overloaded with other information.

Note: The aim of this step is to document women’s perceptions, understandings, and any misconceptions or myths about diseases mentioned in this exercise. Get participants talking openly about their views and keep a careful record. Don’t worry at this point about providing correct technical information. The aim is to get people talking to find out what their perceptions are and to listen carefully and record them. However, you should, in a sensitive way, challenge major misconceptions.

Examples from the workshops:

- We think that menstruation is a disease.
- We have been told that you can get cancer from sleeping with a woman who is menstruating.
- We’ve heard that cancer of the cervix is a big problem, but we have no idea how to get tested for this disease.
- Traditional healers can cure malaria, using bitter roots or herbs or getting a patient to bathe in certain places at certain times of the day.

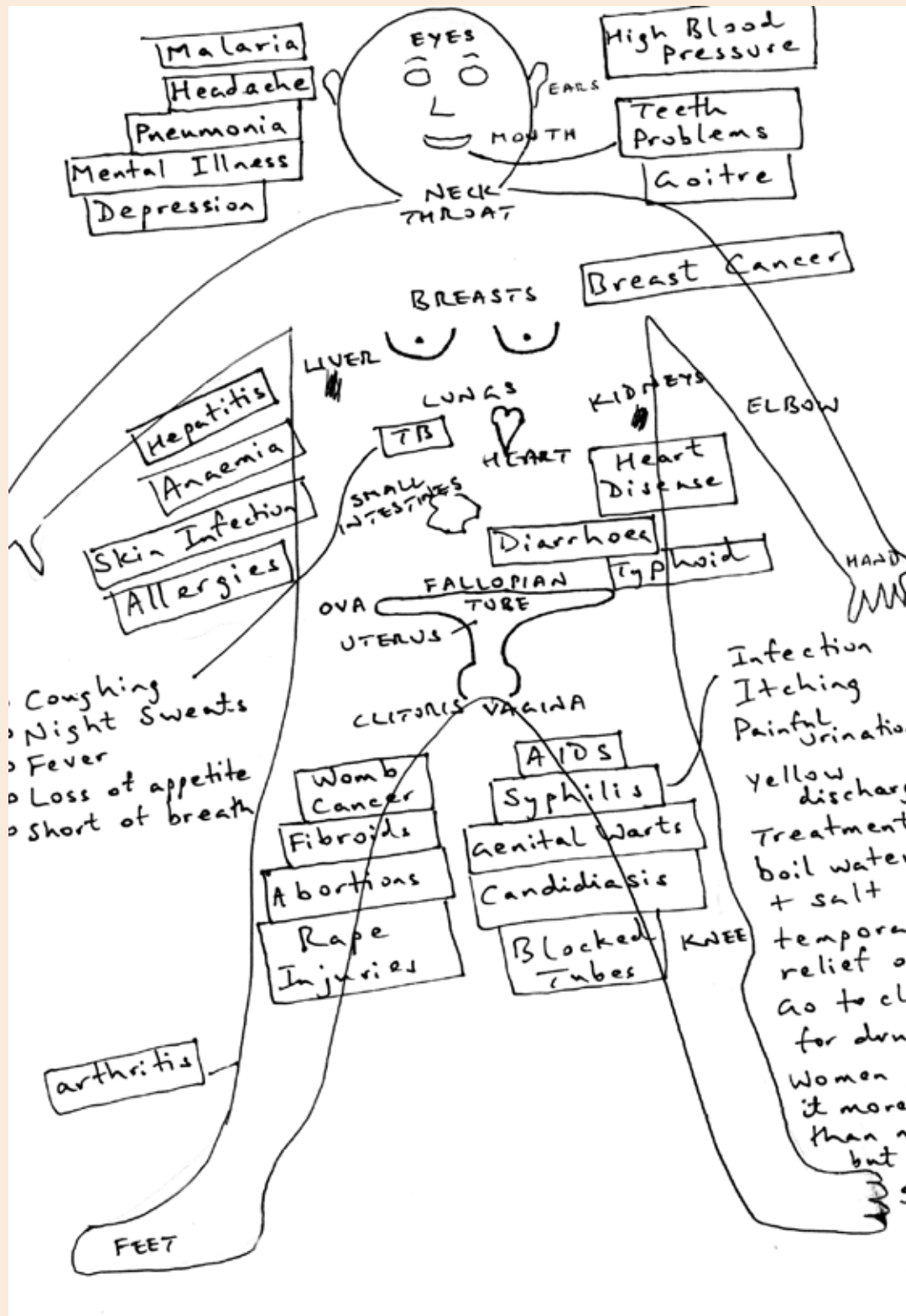
6 QUESTIONS AND ANSWERS (10 minutes): Put up the model body map, showing the correct placement of major organs if necessary. Use this to clarify points on body parts, their positions and functions. Then encourage participants to ask questions about major body parts and their functions.

Correct any ideas that are BADLY wrong in terms of where things are in the body or how diseases are contracted.

Explain that we cannot make diagnoses or give medical advice, but a medical expert will be available during the joint feedback meeting on Day Five. Encourage women to get answers to their questions by asking their local health providers.

The session on Day Five will be used to answer questions about how to access and obtain different services.

EXAMPLE OF BODY MAP



Session 4: Identifying Health Services and Gaps

Target Groups: ALL

Facilitator's Note: In this session participants will list health services in the community and the surrounding area that address the health problems identified in Session 3. They also will list services that are missing.

If the workshop is held in a small rural community, this session starts off by making a COMMUNITY MAP – a rough map of key features and institutions in the community. This becomes a reference point for naming different services in the community.

If the workshop is held in a large urban area or participants have come together from many villages, community mapping is not used and participants, working in small groups, simply list services available in their area. Ideally the groups are formed with participants from the same village or area.

Things to Guard Against:

Creating the map is fun, but don't waste too much time on this. The important point is the discussion that follows on health services.

Getting participants to generate a full list of existing services will take some probing, including the use of the checklist. In one community where we piloted this approach, women said at first they had no services. Further prompting got them to say they had a clinic, school, church and orphanage – all of which provided different services – and a *shebeen* that sold condoms.

Objectives:

- Clarify understanding on what health services are available at community level.
- Identify the major gaps in existing health services for women.
- Increase awareness of health rights and services, and encourage participants to share this information with other women, service providers and community leaders.

Time: 1 hour and 30 minutes

Materials:

- Sticker labels (three different colors) or yellow card (half sheets of A4 paper)
- One marker for each participant. Pencils and erasers
- Checklist of possible services – each service written on a card

Preparation: Ask participants during the morning break whether they want to do the community map on the floor or on sheets of flipchart paper. If the former, ask them to gather stones, sticks, etc. to mark up the map.

Steps:

The first two steps are optional, depending on the location of the workshop.

1 INTRODUCTION: Say – “We will make a map of your community and then use this map to identify health services in your community.”

2 COMMUNITY MAPPING (15 minutes): Ask participants to make a map of the community on the ground or on flipchart paper. If prepared on the ground, have one facilitator make a copy of the map on flipchart paper. Have the group stand or sit in a semicircle around the map on the ground with the flipchart map on the wall.

Help participants get started and then let them take over this activity. Ask them to show the major landmarks – village boundaries, roads, rivers, housing pattern, clinics, schools, churches and other public spaces. Encourage everyone to take part and do the basic map quickly, because the main activity is the discussion afterward.

At the end of the session, leave one copy of the map with the group for display in the community.

3 IDENTIFYING HEALTH SERVICES AND SERVICE PROVIDERS (20 minutes): Put up the flipchart list of women’s major health problems identified in Session 3. Then ask – “What service providers exist in the community to provide treatment, care or support for the health issues we identified earlier?” As participants list each service provider and service, write these on a card and tape on the map. At the same time make a list of service providers and services under five categories – TREATMENT, CARE, SUPPORT, INFORMATION and PREVENTIVE HEALTH CARE.

If you have not started with a community map, divide into small groups (based on geographic proximity) and ask each group to make a list of service providers and services. Then bring the groups together to combine their lists.

Possible Service Providers:

Hospitals, clinics, private clinics, traditional healers, traditional birth attendants, social workers, counseling centers, Red Cross, non-governmental organizations, projects, church organizations, women’s or youth organizations.

Use a checklist of potential services to probe for other services that have not been mentioned. You could start by getting participants to sort the checklist cards into two piles representing services that are and are not available.

Alternatively, use the following broad questions to probe:

- a) “What services are available for women who want to have children?”
- b) “What services are available for women who get beaten or raped?”
- c) “What services are available for people living with HIV?”

One example of the lists of service providers and services produced by participants in one workshop is given in the box on page 42.

4 IDENTIFYING MISSING SERVICES (15 minutes): Ask – “*What health services are needed but missing?*” As participants suggest missing services, add them to the map, using a new set of cards. Ask participants to decide where the new cards (services) should be located. If there is disagreement, say – “*Let’s put it here for now, and we can always move it later.*”

Note: Find out what services are available in advance so you can tell participants. In some cases, the services may be available on paper but poorly provided in reality. In your probing, ask participants to think of services outside government (such as cancer testing services provided by National Cancer Association in Namibia). If the services are not available, participants should make demands for them.

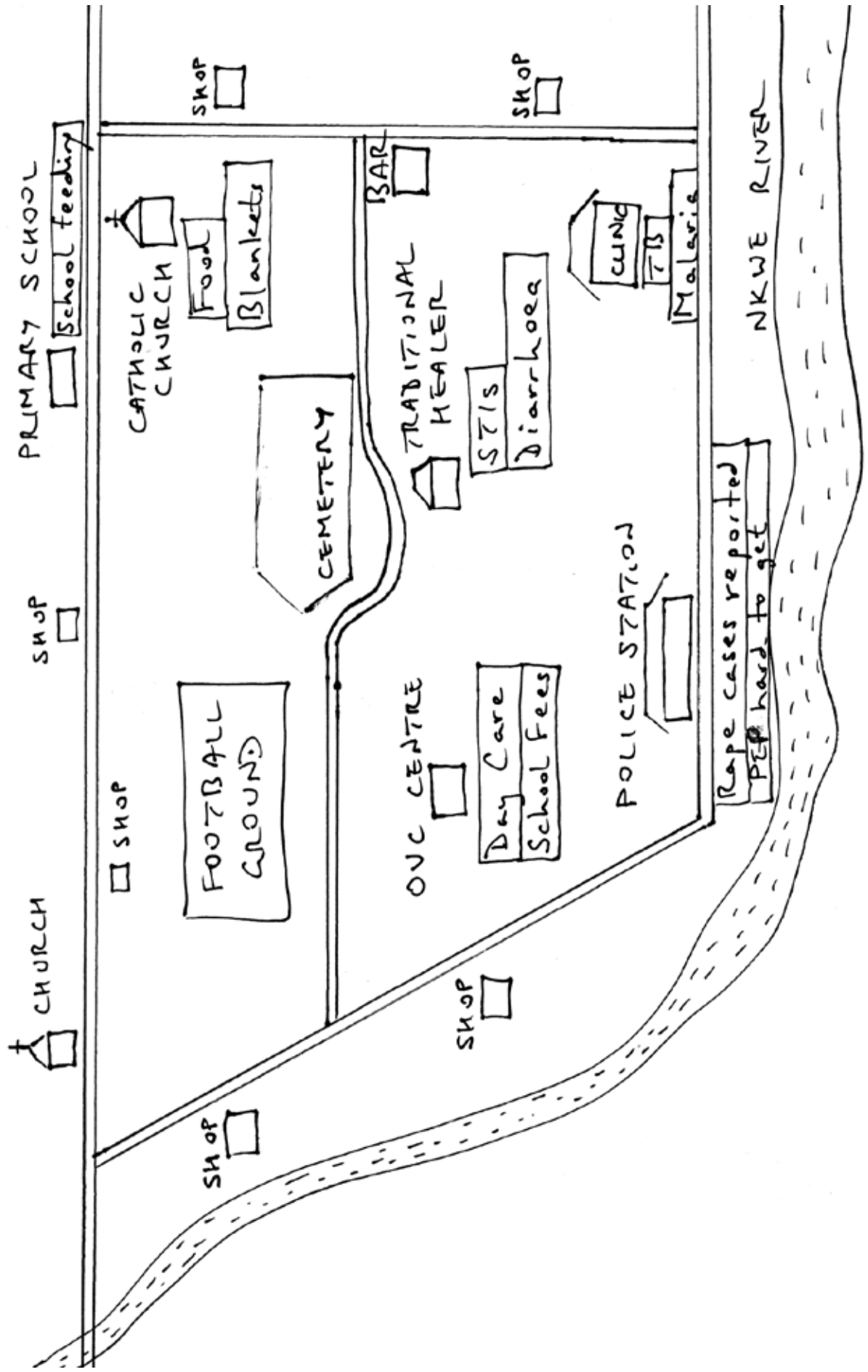
Examples of Missing Services or Service Gaps

- Lack of information on pap smears and pap smear testing.
- Contradictory information on breastfeeding for HIV-positive women.
- Lack of equipment for viral load testing, CD4 counting, pap smears, etc.
- Insufficient numbers of health staff with the right attitudes and training.
- PMTCT and ART nurses too busy to counsel HIV-positive women on family planning.
- Lack of family planning services for HIV-positive women and young people.
- No provision of food for HIV and TB patients on medication.
- Burnout and lack of psychosocial care for health workers.
- No shelter or counseling services for women who have been beaten.

Service Providers and Type of Services (produced by participants in pilot workshop of the Parliamentarians for Women's Health project)

Treatment	Care	Support	Information	Preventive Health Care
District hospital – 30 km – VCT, ART, CD4 count, OI treatment, lab, PMTCT, PEP, TB, family planning, reprod. health checkups	Counseling	Take patients to national hospital.	IEC on and health issues. Information on nutrition and diet provided by ART program.	TB awareness program
Clinic – TB treatment, PMTCT, maternity ward, antenatal care, malaria	Home-based care programs	Counselors (no advice on FP for + women). Bed nets to prevent malaria.	Posters on prevention and cure of malaria.	Health education by comm. health volunteers. Immunization campaigns.
Social welfare department – adherence counseling	HIV related counseling	Government grants for burial and support		HIV-related counseling
Red Cross – paracetamol and bandages (not all get)	Home-based care, food, and blankets (not all get)	Home-based care		
Traditional healers – treat diarrhea and sexually transmitted infections, help women get pregnant, help with abortions	Advice and information (some lack of confidentiality)	Counseling and information to women in need	Information on herbal remedies for malaria, diarrhea, etc.	
Church – malaria tablets, vitamin supplements	Home-based care, mosquito nets, donations	Spiritual support + food, clothes, blankets, school fees & uniforms		
Non-governmental organizations (NGOs)	Counseling, mosquito nets	Income-generating activities, food security and feeding programs, shelters for abused women	Information brochures on HIV and AIDS and gender-based violence, women's rights	AIDS education, ARV literacy. Distribution of (male) condoms. Campaign on violence against women
Project X – buddy project for treatment adherence	Counseling	Seeds and training to produce food		
Support groups – adherence counseling	Home-based care/counseling	Vegetable gardens		
Pharmacies – sell medicine		UN – food during drought		
Youth-friendly clinic	OVC programs – food, shelter, school fees/uniforms		Youth to youth education program	Awareness for street kids

EXAMPLE OF COMMUNITY MAP



Session 5: Women's Experience Using Services

Target Groups: HIV-positive women and negative/untested women

Facilitator's Note: In this session women share personal experiences of using health services and identify barriers that prevent them from accessing health services.

Working in groups, women share their stories – both “good” and “bad” experiences – and turn them into role plays, with one role play per group. The role plays show in a funny way the actual experiences and relations between patients and service providers.

The role plays can be, but don't have to be, the real stories of group members.

Things to Guard Against: Make it clear that the “good” and “bad” stories relate to a woman's health care experience and *not her life experience*. For example, having a child (a life experience) is usually seen as something good – but you could still be treated badly by the service providers (health care experience). Similarly, receiving an HIV-positive test result is a bad experience, but the experience within the health sector (e.g., kind doctor, plenty of support, etc.) can still be a good.

Objectives:

- Share different experiences (good and bad) on the use of health services
- Identify the major barriers that prevent women from accessing health services

Time: 1 hour 30 minutes

Materials:

- One marker for each participant
- Topic cards – HEALTH SERVICES, COMMUNITY, HOUSEHOLD, WORKPLACE

Preparation:

To save time you could ask the groups to prepare the role plays during the lunch break.

Steps:

1 INTRODUCTION: Say – “*In this exercise we would like to find out about your experience of using health services. What happened? Was it good or bad?*”

2 TASK GROUPS – BRAINSTORMING AND DRAMA-MAKING (10 minutes): Divide into four small groups. Ask two groups to share good experiences of health services and the other two groups bad. Then each group selects one story and makes a role play to be presented to the whole group.

Report back. Each group performs the role play (two to three minutes). At the end of each drama, ask: “*What happened?*” Then, after a few quick responses, ask: “*What was good (or bad) about that experience?*” Try not to elicit bad points from the “good” drama or good points from the “bad” drama – and remember, you are looking at the experiences, not at the acting!

Record the points on a flipchart (see sample below).

Positive/good	Negative/bad
<ul style="list-style-type: none"> ● Health providers treated patient with care, respect and empathy. ● Doctor took time to explain health problem and how to use medication. ● Doctor gave client lots of attention and plenty of time to ask questions and make an informed decision. ● Counselor helped the woman deal with her HIV test result and to prepare herself emotionally. ● Staff were sensitive to the vulnerability of client. ● Health staff respected confidentiality of the patient living with HIV. 	<ul style="list-style-type: none"> ● Doctors and nurses didn't explain things – too rushed and impatient. ● Long wait to get treatment. ● Nurses insulted an HIV-positive woman for getting pregnant. ● Nurses gossiped about HIV-positive woman in front of other patients. ● HIV-positive woman was insulted by a nurse for coughing in the clinic. ● When asking for a doctor's report to document a rape, the doctor lectured the woman about going out at night and said she deserved to be raped.

Note: Have a break at the end of the drama, so that during the discussion participants are clearly back in their participant roles and no longer role-playing. One way of doing this is to have a group clap at the end of each role play.

Once all four role plays have been shown, probe any points that are not completely clear. Then give a brief summary along these lines:

The kind of things we would like to find in the health environment are: friendly staff, cleanliness, health staff making time for their clients,but sometimes staff can be rude, break confidentiality, etc.

Ask – “Why do you think bad service occurs?” Don't limit this question to service providers. Client groups often do have a huge amount of empathy for health workers, even though the latter have treated them badly, and their analysis can contribute to coming up with solutions.

Note: At the end of this step, invite women to give their stories. This helps to validate their experience. Some women have had bad experiences and are angry about how they have been treated. You (as the facilitator) need to say, “You're right to be angry. I can understand how this can hurt.”

3 BARRIERS TO USING HEALTH SERVICES (15 minutes): Put up the list of barriers identified through the dramas. Then ask – “What are some of the other barriers that prevent you from using health services?” Focus this discussion around the priority health issues. Explain that barriers would include limitations in the service themselves (e.g., pap smear testing only provided once a month); and constraints in the home or community that prevent them from using the service, e.g., women's heavy workload or lack of money for clinic fees.

Put up the four topic cards along the wall – HEALTH SERVICES, COMMUNITY, HOUSEHOLD, WORKPLACE – and ask participants to identify barriers under each heading. Use small or buzz groups for this discussion. If you are short on time, discuss this issue in plenary.

Health Services	Community	Household	Workplace
<ul style="list-style-type: none"> ● Long distances to health facilities and long waiting times. ● Insufficient levels of health care staff. ● Nurses too busy and lack skills to counsel HIV-positive women re: family planning. ● Stigma by health staff toward people living with HIV. ● Inconsistent information on breast-feeding for HIV-positive women. ● Pap smears – no information, not easily available. ● Lack of treatment services for cancer. 	<ul style="list-style-type: none"> ● Lack of openness re: talking about sexual and reproductive health issues. ● Traditional healers don't have protective gloves and poorly briefed on HIV and AIDS. ● Erosion of extended family & community spirit results in less voluntarism and mutual support ● Police overcharge rape victims for forms used as evidence in court. 	<ul style="list-style-type: none"> ● Poverty – people cannot afford clinic fees & drugs. ● Women's inequality: women depend on partners economically and have little say over sex/use of condoms or control of resources. ● Women's heavy workload stops them from going to the clinic. ● Violence stops women from reporting cases of abuse to the police. ● High cost of mosquito nets. ● Culture – women need permission from mother-in-law to get treatment. 	<ul style="list-style-type: none"> ● Stigma and discrimination. ● Lack of confidentiality. ● Taking time off work is unpaid (especially for women in the casual sector) or may result in loss of employment. ● Difficult to talk about health issues with employers without being victimized.

Session 6: Problem Analysis and Problem Solving

Target Groups: ALL

Facilitator's Note: This is the final major step in the analysis process. During this step the group identifies the most important health problems (from those identified in Sessions 4 and 5) and works on solutions.

Some groups may not have time for this step. If so, don't worry – it also is included in the workshop on Day Five.

Things to Guard Against:

It is important to get everyone to see this exercise as something real, and not just a wish list to be sent to government. The idea is to get participants to think of what they could do themselves as a community without a lot of outside support, and what things they would like to tell their MP. One way to organize solutions is into "no cost" and "low cost" categories.

As part of introducing this step you should re-explain the objectives of the workshop and help people understand that we are not there to deliver a list of demands to the MP or anyone else. Talk about why it's good that the priority issues will be taken up by MPs and what they will be likely to do with them – the next stage of the process, assuming that there will be a round table meeting or something to follow up with.

In Namibia communities who participated in the community assessment process have initiated the following actions:

- Conducting house to house participatory research on people’s experience of using health services for women.
- Organizing a community campaign to raise awareness on gender-based violence.
- Conducting house to house campaign to encourage couples to go for HIV testing.

Objectives:

- Prioritize women’s health issues.
- Identify possible solutions to the health problems that can be managed at the community level without great inputs of cash and human resources.

Time: 1 hour and 15 minutes

Materials:

- Post-it notes, or yellow cards
- Prepared flipchart lists of health problems, service gaps and barriers

Preparation: During the lunch break prepare flipchart lists of health problems, service gaps and barriers (based on earlier sessions). Leave room on each flipchart for additions during the discussion.

Steps:

1 INTRODUCTION: Say – *“In this exercise we would like to pull together all of your ideas on health problems and look for solutions.”*

2 SUMMARY OF MAJOR ISSUES (15 minutes): Read out each suggestion and invite participants to comment and make additions. Underline issues that participants decide are the most important.

Health Problems	Service Gaps	Barriers

3 PROBLEM SOLVING AND FRAMING RECOMMENDATIONS (20 minutes): Divide into three groups of four people. Ask each group to:

- a) Decide on a specific problem area.
- b) Work out solutions and divide into low cost and no-cost categories.

See Session 3 from Day Five for an example.

4 REPORT BACK (40 minutes): Each group makes a five minute presentation. After each presentation others add ideas and comments on the presentation (eight minute discussion after each presentation).

Record points on a flipchart. If parliamentarians are present, invite them to co-facilitate this session.

Session 7: Evaluation, Follow up and Closing

Target Groups: ALL

Facilitator's Note: This session ends the workshop. Participants evaluate the workshop and develop plans for follow up, and then you invite them to attend the joint workshop on Day Five and thank them for their participation and time.

Objectives:

- Evaluate the workshop – what was learned, what worked, what didn't work.
- Agree on how to share what was learned with other people.
- Agree on follow up, including the final joint meeting.
- Thank participants.

Time: 25 minutes

Materials:

- One marker pen for each participant.
- A4 paper (three colors)
- Cards with titles – LEARNED, LIKED, DIDN'T LIKE

Steps:

1 EVALUATION (5 minutes): Hand out three slips of paper to each participant, each a different color. Ask participants to write:

One thing they have LEARNED

One thing they have LIKED

One thing they have NOT LIKED

Then tape these slips on a flipchart labeled with the three titles – LEARNED, LIKED, DIDN'T LIKE

2 SHARING LEARNING (10 minutes): Go round the circle asking each participant to say one thing they learned that they would like to share with others. Keep a record.

3 FOLLOW UP (5 minutes): Agree on contact person(s) to whom you will send the report on the community assessment. This should be someone who is willing to give his/her address and who has a phone. This person could be contacted at a later point to clarify any further details.

4 JOINT MEETING (5 minutes): Invite the whole group to come to the joint meeting on the fifth day. Try to get firm commitments from at least five people.

Thank participants for their time and participation.

Additional Activity: Community Health Walk

Facilitator's Note: This is an extra activity if you have the time. It involves a walk, guided by a few participants, through one section of a village to find out more about the community, its activities, resources, and problems. While you are walking, you can ask questions to the participants who are guiding you and any villagers you meet.

“At the end of one day in Dordabis, we went for a walk through the village with a few participants. This completely changed the day – it made things real for me. During the workshop women had talked about the “toilet water” and we assumed they meant sewage. However, during the walk we discovered that they meant water full of excreta. A whole section of the village was dominated by the smell of raw sewage which was not being treated properly. Through the walk we also saw the houses and the level of poverty. This walk significantly changed the meaning of the things that the women had been talking about in the workshop.” (Comment from a facilitator with the Parliamentarian project’s pilot community assessment.)

Objectives:

- Collect information on the community: its activities, resources and problems.
- Get to know the larger socio-economic context, which will help with the understanding of issues raised during the workshops.

Time: 30-60 minutes

Steps:

1 COMMUNITY HEALTH WALK: Ask a few participants to show you their village so that you can get a better understanding of health issues and services available. As you walk ask questions about the things you see: economic activities, food production, social activities, women’s work, condition of houses and families, water points, latrines, etc.

2 WRITING NOTES: While you are walking, keep notes and write up a report when you are finished. Use the information to help deepen your understanding of the issues identified in the workshops.

Photo Record: Photos can be more powerful than words in depicting certain conditions. Before you start taking photos, check that it is acceptable to take photos of the village and the things you see.

Additional Activity: Site Visit to Health Facilities

Facilitator's Note: This activity involves a visit to facilities providing services to women (e.g., clinics, hospitals, shelters for battered women, rape crisis center, etc). During the visit you will interview staff and tour the facilities. This will give you a better sense of the facilities and services in the area, as well as service gaps and barriers limiting women's access.

This is a good activity to involve MPs, who can help with the observation and data collection.

Things to Guard Against: Show interest in what clinic staff are doing and solicit their opinions about health care issues, so the interview does not feel like an interrogation. A friendly and informal approach to the interviews will help encourage staff to talk openly about their work, women's health problems and the challenges they face as health workers.

Objectives:

- Collect firsthand information on health facilities.

Time: 60 minutes

Materials: Checklist for Observation and Interviews (see next page)

Preparation: Contact the manager of the health facility in advance to get permission for a visit (including a tour and interviews).

Steps:

1 SITE VISIT: Meet with the head of the institution and thank him/her for hosting the visit. Ask to be shown around the facilities and then to interview some of the staff. If the visiting team is large, split into smaller teams and get each team to talk to a different member of staff. Use the checklist to guide the interviews. Take notes during the interviews.

There is a lot to be learned simply by careful observation of how things are done in the health facilities: How long do patients wait in line to see a doctor? Are there stigmatizing signs? How are patients treated? Is confidentiality protected?

2 RECORDING: After the visit meet with the whole team to share observations and information collected. Make a record of this meeting and your joint observations.

CHECKLIST FOR SITE VISITS

Region: _____ Name of hospital/clinic: _____

Date of visit: _____ Length of visit: _____

Which health services does the health center specialize in?

General Observations

1. The visit

How were you greeted?

Were you expected, and was someone available to speak to you?

Were you shown around the hospital/clinic?

2. Cleanliness

Did the site appear clean and orderly?

What general observations can be made about the cleanliness, the equipment, the size of consultation rooms, etc.?

3. Waiting room

Was there a waiting room?

What was in it?

Did it appear clean and comfortable?

How many people were in it, approximately?

How long have patients been waiting to see the doctor? (Ask a few patients.)

Was there a place for children to be left safely while their caregivers were having consultations?

4. Information, Education and Communication (IEC) Materials

Were there any leaflets/posters/other information available?

Where were they?

Were they easy to read or reach?

What language(s) were they in?

Did they use pictures/diagrams or only words?

What issues did they address?

Were they gender-sensitive (i.e. addressing issues of specific concern to men and women or recognizing the potentially different experiences of men and women)?

Were any HIV-specific leaflets/posters/other information available?

5. Confidentiality

Were rooms/departments labeled in an indiscreet or stigmatizing way? (Example: clinics labeled "HIV Clinic," or HIV clinics painted in a different color?)

Were there separate waiting rooms for specific conditions (e.g., for sexually transmitted infections, HIV-related services, other potentially stigmatizing ailments, etc.)?

6. Male/female areas or services

Were there any male- or female-only areas (e.g., waiting rooms or consultation rooms)?

Were there any special clinics or services for men and women?

General Information (to ask a member of staff)

1. How many people work at the health center? How many doctors and nurses?
2. Is it possible to see a male or female doctor or nurse on request?
3. Is there a gynecologist? (if so, male or female? HIV-specialized?)
4. How often does the staff undergo training?
5. Has everyone there had HIV-related training? What kind?
6. Who uses the health center (Mainly men? Mainly women? Adolescent girls?)? Where do they come from?
7. Does the center run any programs or clinic specifically for:
 - Men/women living with HIV and AIDS?
 - Young women?
 - Treatment for sexually transmitted infections?
 - Family planning?
 - Prevention of mother-to-child transmission services?
 - Voluntary counseling and testing?
 - Antiretroviral therapy distribution (including adherence counseling)?
 - Other counseling services?
 - Nutrition advice?If so, where are the clinics held?
8. How is the confidentiality of HIV-positive service users protected?
9. Is there a user fee? Which services/medications are free, which do users have to pay for?

Attitudes of health providers

1. Did the staff you spoke to seem friendly?
2. Did they display negative attitudes toward service users when speaking about them? (If so, who in particular?)
3. Were you able to observe any interaction between staff and service users? How were the service users addressed?
4. Was the attitude of the staff/service provider: Friendly? Helpful? Informative? Judgmental? Hostile? Patronizing?

Questions for service providers

(There may not be an opportunity to ask all these questions to one person, but it would be good to ask some of them to doctors or nurses who are available to talk – even if only one question to one person).

1. What are some of the main issues affecting women who use this service?
2. What are some of the challenges that the service providers face in addressing women's health issues?
3. What additional resources/training/services/programs would the provider like to see allocated or implemented at community level? (Make it clear that this is just an assessment exercise with no promises to address these issues.)
4. What are the main differences perceived by service providers between men's and women's health issues in the community and how these are addressed?
5. What services are available for young women and men?

SAMPLE SITE VISIT REPORT

CAPRIVI REGION: BUKALO HEALTH CENTER: CAPRIVI (approx. 60 East of Katima): July 2006

Health Institution	Bukalo Health Center: Caprivi (approx 60 East of Katima)
Date of Visit	Thursday, July 6, 2006
Contact Person	Nurse: Mary Masule 08102019154 Record Clerk: Patricia Kamwi 0812367265 Community Counselor: 0812139256
Staffing	3 registered nurses female (2 Namibians, 1 Kenyan; no language problem as we help translate for her), junior counselor (Rapid Testing), cleaner, security guard, no doctor (patients referred to Katima hospital)
General Observations	1 consulting room, 1 treatment room (2 beds) emergency room, delivery ward
Cleanliness	Very clean, inside and outside of building
Waiting Rooms	Yes quite large with TV
IEC Materials	Yes: lots of posters and information: Posters: SAY NO TO SEX, SAVE LIVES TAKE CONTROL, ITS MY LIFE (GTZ – maximum gold condoms), Family Planning and contraception, Word health day, Soul City (DFID): Choose Life booklet and Join the Fight against HIV and AIDS, Namibia Red Cross, Hand drawn: AVOID TRADITIONAL HEALERS, WHY? BECAUSE: transmission of HIV, exploiting patients, high charges for poor, long process of healing
Confidentiality	Yes: from counselor and nurses
Male and Female Areas or Services	General: Family planning: condoms (no femidoms), injections and pills are available, Rapid Testing: HIV screening, special area for adolescents (ages 10 years up) Female: ante- and post-natal health education, delivery and maternity room, provide PMTCT: nevaparine before delivery
Missing Services	No incubator (if premature refer to Katima), no pap smear facilities (explain to patients they need to have one) ARV treatment: only in Katima No overnight services for patients: only for observation

<p>General Information from Member of Staff</p>	<p>No ambulance (call one from Katima)</p> <p>About 30 patients per day: malaria incidents in both adults and children are coming down</p> <p>Fees: office hours (8 a.m – 5 p.m.): N\$8-00, after hours N\$20-00</p> <p>24 hour service as nurses have housing and live on the premises</p> <p>No cases of violence against women and child abuse from last year</p> <p>More female patients than males</p> <p>Treat quite a lot of opportunistic infections</p> <p>Work together with home-based care (HBC) support groups: CAA , DED, Lirongo Eparo, Red Cross</p> <p>If patients default on treatment they are referred to Katima</p> <p>Nurses all received HIV training workshops and information, including PMTCT workshop</p>
<p>Does the Center run any programs or clinic</p>	<p>School health education at schools: from Grade 1 through to grade 12: education includes HIV, sexually transmitted infections, pregnancy, general outreach</p> <p>From grade 1: Examination and personal hygiene and immunization</p> <p>Nutrition program: under health education</p> <p>Health education in community</p>
<p>Attitudes of Health Workers</p>	<p>Very helpful and friendly, we did not make an appointment and they welcomed us</p> <p>What about attitudes toward service users? Any difference in attitude to HIV+ users?</p>
<p>Main Issues Affecting Women</p>	<p>Malaria, skin diseases, pneumonia, diarrhea, sexually transmitted infections, no polio</p>
<p>Challenges</p>	<p>Understaffed: should be 5 or 6 nurses</p> <p>Counselor: work overload as she helps out with other needs as well: if she goes away then no one to do counseling</p> <p>Only one clerk who keeps safe key with money: if she goes away then no one to do this</p> <p>Medicine does not always come on time</p>

Joint Workshop (Day 5)

Introduction

At the end of the four workshops, organize a joint workshop bringing all the groups together to share what they have learned, work together on problem solving, develop recommendations for action and provide answers to their questions.

The joint workshop would use the following agenda:

Session	Assessment Topic or Activity
1	Opening Activities
2	Sharing Outputs of Different Groups
3	Problem Analysis and Problem Solving
4	Questions and Answers
5	Evaluation, Follow up and Closing

Preparation:

Before this workshop you need to:

- 1) Contact a well-informed local doctor or medical expert who can attend the workshop and answer participants' questions. Give list of the questions to him/her before the workshop.
- 2) Collect the lists of priority health problems, service gaps and barriers, and display them at the start of this workshop.

Session 1: Opening Activities

Objectives:

- Break the ice and help participants get to know each other.
- Explain the importance of the workshop and how participants will benefit.

Time: 30 minutes

Materials: Registration sheet. Name tags.

Preparation: Put up body maps and lists of priority health issues and service gaps.

Steps:

- 1 **ARRIVAL ACTIVITY (Registration and Rhyming Name Tags):** Ask participants to record their name on the registration sheet and make "rhyming name" tags – their own name plus an adjective starting with the same letter, e.g., **Crazy Christine**, **Magical Mary**, **Sexy Sara**.
- 2 **WALKAROUND:** While participants are waiting for others to arrive, ask them to look at the body maps and lists of health issues.

3 WARM-UP AND INTRODUCTIONS (10 minutes): Organize a warm-up game to break the ice and help participants get to know each other.

Get to Know You Game. Ask participants to divide into pairs and give pairs a task. Then form new pairs and assign a new task, and so on. Examples of the instructions are given below:

- a) Find a new partner. Greet them as if you have not seen them for a long time.
- b) Find a new partner and tell them something about yourself.
- c) Find a new partner. [Then give the following directions and asks pairs to follow: “*Front to front. Back to back. Side to side. Foot to foot. Hand to hand....* .]
- d) Form a big circle. Ask each person going round the circle to introduce his/her rhyming name.

4 OBJECTIVES (5 minutes): Explain the objectives for the workshop (see below).

During the earlier workshops each group produced a number of outputs: body maps, a list of priority health problems, a list of services available, a list of things that prevent women from accessing services and ideas for improving services.

The objectives for today’s workshop are to:

- Review these outputs.
- Work together in deciding on things we can do to solve some of these problems.
- Raise questions about specific diseases and get some answers.

5 GROUND RULES (5 minutes): Put up a list of the ground rules developed by all of the groups. Then say – “*The workshop process will be similar. We encourage everyone to talk openly, to listen to and respect each other’s views, and to keep things you hear in this workshop confidential.*”

Session 2: Sharing Outputs of Different Groups

Facilitator’s Note: During this step the different groups share the major outputs they produced during the workshops; identify similarities and differences; and agree on priorities.

Things to Guard Against: Don’t let the service providers or community leaders dominate and make sure that the views of women are heard and given full recognition.

Objectives:

- Share the outputs of the different groups and allow participants to learn from the analysis of other groups.
- Identify priority health issues, service gaps and barriers.

Time: 60 minutes

Materials: Body maps and lists of priority health issues. Lists of service gaps. Lists of barriers to women accessing services

Preparation: Take all the lists on a topic and put them on the wall.

Steps:

1 GROUP PRESENTATIONS: Take each topic one at a time and get each group to explain what they produced.

a) **BODY MAPS & PRIORITY HEALTH ISSUES** – Ask each group to present its priority health issues. Write up the common issues on a new flipchart and get the group to agree on them. Clarify why they regard each issue as a priority. (See sample below.)

Priority Issue	Why Priority?
HIV and AIDS	Leading cause of death. Results – orphans, loss of income and poverty. Women highly vulnerable to HIV due to lack of power to make decisions re: sexual activity.
Sexually transmitted infections (STIs)	Stigma and lack of knowledge prevents women from getting treatment. Taboos prevent women from talking about STIs.
Cancer – breast, cervical & uterine	Low knowledge about cancer among women and health workers. Lack of services to detect or treat cancer.
Tuberculosis (TB)	Dangerous, highly stigmatized and highly prevalent among vulnerable populations such as people living with HIV.
Malaria	Major cause of death. Affects large % of population. Mosquito nets too expensive for many women.
Violence against women	Experienced by large % women. Major cause of injuries, stress, depression and HIV.

Note: Use the differences among groups to drive the discussion. For example the women might name sexually transmitted infections as a priority, while the service providers might not mention STIs at all. If this happens, ask the group questions, such as: *Why have the women rated sexually transmitted infections as a high priority, while the health workers have not mentioned it? Do the women go to the health workers for treatment, or to the local healers? How can health workers change their practices so that more women come to them for treatment?*

b) **GAPS IN SERVICES:** Use the same process.

c) **BARRIERS PREVENTING WOMEN FROM ACCESSING SERVICES**

Note: Keep a list of participants' questions. Explain that a later session will go over these issues and provide answers.

Session 3: Problem Analysis and Problem Solving

Facilitator's Note: During this step the group looks in more detail at some of the issues raised and identifies potential solutions.

Things to Guard Against:

This exercise is not meant to deliver a list of demands to the parliamentarians or government. Get participants to think of what they can do themselves as a community and what they would like to tell their MPs about the different issues.

Don't let the service providers or community leaders dominate and make sure that the views of women are heard and given full recognition.

Objectives:

- Clarify the root causes and effects of problems.
- Identify possible solutions.

Time: 60 minutes

Materials: Notepads and pens or pencils for participant groups

Steps:

1 INTRODUCTION: Explain that the aim of the session is to look at the priority issues in more detail and come up with solutions, working in small groups. Encourage participants to consider things they can do themselves, rather than producing a list of things they want government to do.

2 WORK IN TOPIC GROUPS: With the help of participants, identify priority service gaps or barriers requiring more discussion and problem solving. Then divide into mixed groups (consisting of women, service providers, community leaders and MPs) and assign one issue to each group.

Group Task:

- a) Clarify the problem – its causes and effects
- b) What could be done to solve this problem? What things can you do? What things would you like government to do? What additional information is needed?

Report back: Ask each group to give a report and invite other groups to make comments and additions.

At the end of the session ask the MPs to explain what they might do with the information.

Community-oriented Solutions to Women's Health Problems

Issue	Detailed Description	Possible Solutions
No or limited information provided on women's health issues	No/limited information on pap smears, family planning, sexually transmitted infections and HIV, ARV treatment, proper use of medication, medical risks for HIV-positive women of getting pregnant. Results – women confused about what services are available; incorrect use of medication	<ul style="list-style-type: none"> Community awareness campaign on HIV and AIDS and sexual and reproductive health, organized by HIV-positive women and civil society organization. Health staff spend more time talking to women – clear explanation of medication and how to take it.
Lack of family planning services	HIV-positive women don't have support of health staff to make informed choices about having a child or not. ART & PMTCT staff too busy & lack skills to advise on family planning. Health services only provide condoms, yet women find it difficult to get partners to use condoms. Safe abortions are not available to HIV-positive women. HIV-positive women afraid to use PMTCT fearing they will be stigmatized/judged by nurses for getting pregnant	<ul style="list-style-type: none"> HIV-positive women to meet health staff as a group and explain their concerns about stigma and inadequate family planning services. HIV-positive women and civil society organizations to make links with National Family Planning Association to provide a wider range of contraceptives.
Health worker issues – long hours, low pay, burnout, etc.	Insufficient staff, heavy workloads, long hours, low pay, burnout, isolation and lack of support. Stress of dealing with death & dying. No opportunities to deal with their own fears about HIV. Lack of psycho-social support and counseling to deal with stress. High turnover of community volunteers due to poor conditions and lack of support, resources, and incentives.	<ul style="list-style-type: none"> Establish support groups for health workers to help them cope with their own health issues and stress. Community to monitor the use of volunteers and provide recognition and incentives.
Stigma and poor communication by health workers	Health staff rude, unfriendly, insensitive; breach confidentiality; and stigmatize women and girls seeking HIV and family planning services. Signs – “ARV Treatment Room” – expose patients to stigma	<ul style="list-style-type: none"> HIV-positive women and health care staff to form joint monitoring group; and appoint HIV-positive women to community health committee. Make immediate changes to the signs.
Lack of services for victims of gender-based violence	Health staff are legally required to report cases of rape, but not required to report other cases of violence. Police treat cases of domestic violence as “civil matters” to be solved in the home. No shelters for battered women. PEP procedures are cumbersome and time consuming (e.g. getting a police report) and this prevents women from using PEP after being raped.	<ul style="list-style-type: none"> Community campaign to create a “violence free home and community,” with regular monitoring. Involve all community leaders and groups. Challenge men re: practice of controlling & abusing women, and cultural justifications for this practice. Encourage men's groups to take up violence against women as an issue.
Poor relations between traditional healers & clinics/hospitals	Lack of coordination and communication. Communities prefer traditional healers because of their mobility and range of services, including psycho social support; but they lack information about HIV and AIDS and sometimes offer ineffective treatments.	<ul style="list-style-type: none"> Organize regular meetings between clinic staff and traditional healers. Provide training for traditional healers on AIDS and ARV therapy literacy.

Session 4: Questions and Answers

Facilitator's Note: This step is designed to provide answers to the questions raised in the earlier workshops. You will have made a list of these issues and invited a local medical specialist to join you to respond to these issues.

The questions and the dialogue provide a source of data, telling you how much people already know about these issues and the health system.

Objectives:

- Respond to participants' questions about health issues.
- Deepen participants' knowledge about diseases, health issues and the health services available.

Time: 60 minutes

Materials: List of questions (raised in the workshops). Fact Sheets (Annex A).

Preparation: Invite a local medical expert to join you. Give these questions in advance so she or he can come prepared to answer them.

Steps:

1 INTRODUCTION: Explain that the aim of the session is to answer participants' questions on health issues and health services. Introduce the medical expert.

2 PRESENTATION: The medical expert responds to each of the questions. Then invite other questions and ask him/her to respond.

Note: The information should include simple basic facts about the health problem, including prevention and treatment information, e.g., Where can they go to get a pap smear test? If services are not available in government clinics, where else can one go to get this test?

3 FACT SHEETS: Hand out the Fact Sheets (Annex A).

Session 5: Evaluation, Follow up and Closing

Facilitator's Note: This session ends the joint workshop. Participants evaluate the workshop and develop plans for follow up, and then you thank them for their participation and time.

Objectives:

- Evaluate the workshop – what was learned, what worked, what didn't work.
- Agree on how to share what was learned with other people.
- Agree on follow up.

Time: 30 minutes

Materials:

- One marker pen for each participant
- A4 paper (three colors)
- Cards with titles – LEARNED, LIKED, DIDN'T LIKE

Steps:

1 EVALUATION (5 minutes): Hand out to pairs of participants three slips of paper, each a different color. Ask participants to write:

One thing they have LEARNED

One thing they have LIKED

One thing they have NOT LIKED

Then tape these slips on a flipchart labeled with the three titles – LEARNED, LIKED, DIDN'T LIKE

2 SHARING LEARNING (10 minutes): Ask each participant to say one thing they have learned that they would like to share with others. Keep a record.

3 FOLLOW UP (5 minutes): Explain that a report will be produced on the whole process and sent to the community through the contact persons.

Ask the MPs to explain how the information collected might be used. They might say something like this:

- “We have learned a lot today and will take your concerns about women’s access to health care back to parliament where we will brief our colleagues.”
- “We have been inspired by your words and passion for change, and we will do our best to use your ideas to make new policies and improve health services.”
- “We have a number of constraints – it takes time to change laws, and practical implementation costs money.”
- “We have been inspired by HIV-positive women and other AIDS activists who are working on these issues and would like to continue to work with you to push for change.”

4 MONITORING (5 minutes): Review the proposed actions agreed by the community (the things they have decided to do using their own resources). Then ask the group to decide on a small monitoring group (e.g. one person from each of the four stakeholder groups) who would meet once a month to review progress and report back to the community.

5 CLOSING (5 minutes): Thank participants for their time and participation, and encourage them to put their ideas into action.

Pulling It All Together – The Round Table

Introduction

Once the field reports from the different locations have been completed and the data across different locations aggregated, you may want to organize a round table – a meeting of key groups who participated in the Community Assessment process, e.g., the parliamentarians, representatives of the HIV-positive women’s groups, civil society organizations and other key stakeholders.

The objectives of the Round Table would be to:

- Review and compare the findings from different sites.
- Agree on priority health issues, gaps in services and barriers to women’s access to services.
- Make recommendations on how to solve some of the problems raised.

In our experience, the Round Table provided an opportunity for MPs and other policy-makers to listen further to the views of HIV-positive women, and then work with them to agree on priority problems and the way forward.

Having participated in the earlier workshops, the HIV-positive women were no longer shy in the presence of the MPs and spoke out forcefully about their lives, issues and concerns. The status differences were largely overcome and the different groups worked together as equals and with mutual respect. By this stage, the MPs saw that the women have a powerful insight into local health problems. These insights, in turn, could inform their own work as MPs.

From the workshop, you can produce an initial list of targets and strategies for action. (See box below for example.)

Next Steps to Improve Women’s Health in Communities

- Establish a working group of HIV-positive women to keep MPs briefed on HIV and health issues, and encourage MPs to take up these issues in parliament.
- MPs should distribute information on health issues to their constituents, including information on pap smear testing.
- MPs should become role models in publicly condemning gender-based violence.
- Educate health workers on this issue and equip them with more skills in counseling women on sexuality and pregnancy.
- Strengthen family planning services – make a wider range of contraceptives available and strengthen counseling on sexual and reproductive health.
- Expand and improve pap smear and cervical cancer services, and educate HIV-positive women on the benefits of pap smear testing.
- Monitor the procedures used by the police in taking up cases of violence to ensure that these cases are treated seriously.
- Encourage men’s organizations to report cases of gender-based violence and educate other men that it is unacceptable.

CHAPTER D:

Tips for Running Participatory Workshops

Introduction

This chapter is divided into two sections:

- a) Tips for facilitating workshop sessions.
- b) How to document sessions and write a report.

Part A – How To Facilitate Workshop Sessions

Punctuality and Presence of Facilitators

- Arrive at the venue an hour before the starting time to get everything organized. If you are seeing the venue for the first time, you may need extra time to rearrange the facilities to suit the program and participants.
- If participants arrive while you are setting up, welcome them and make them feel comfortable, help them get registered, etc.
- You should be available to participants during breaks and lunch. This is a useful time to talk informally to participants and respond to their questions or concerns.

- If you have to leave during the workshop, explain at the beginning of the workshop why and where you are going; encourage participants to do the same. It is extremely disruptive to have participants coming and going at different times. If someone must leave, ask him/her to give a reason, and share this with the group.
- If you can, stay overnight in the community. This provides an opportunity for more informal discussion and observation on the issues.

Preparation

- The more you prepare in advance, the smoother the day will go.
- Preparations for the start of each day:
 - a) Set up the chairs in a circle/semi-circle, remove the tables (to allow you to move around and make the workshop less formal) and set up a table for materials.
 - b) Sweep the floor if the day's activities involve sitting, lying or crouching on the floor. If it's too dusty, find an alternative surface.
 - c) Arrange the materials: put up blank flipchart paper for recording, write up flipchart instructions for exercises, tape the flipchart sheets together for body mapping, etc.
- Think about how best to facilitate each session. What is the goal of the session and how will you ensure that it is accomplished? How much facilitation is needed for each step? What is the best way of explaining each exercise or asking questions? What examples can you give if the group doesn't understand clearly what you mean?

Openers

Use the following activities to help participants feel comfortable, overcome their inhibitions and begin to trust the team. Creating an open climate to encourage people to share their experiences is a crucial objective at the start of the day.

- Organize games or songs to break the ice, build a sense of community and help participants relax and have fun.
- Invite participants to give their expectations about the workshop and then clarify what the workshop will do and what it will not do.
- Make a clear working agreement on confidentiality and other ground rules.
- Get the whole group to help enforce the ground rules to minimize disruptive behavior.

Photos

Photos help capture what happens in a workshop but find out from your participants how they feel about being photographed. Explain how you plan to use the photos (e.g., internal record only, in a report, on a Web site or in a publication).

If anyone does not want to be photographed, have them identify themselves. Let them know they are under no obligation to be in the photos.

If no one wants his or her photo to be taken, you can take photos of the body maps and other diagrams, but make sure people know they will not be in the photos.

Breaks

The program includes a lunch break and two coffee breaks. This allows participants to have a short rest and talk informally. Make sure that people know the breaks are short, otherwise you might lose your audience. Assign one person to do the timekeeping and to liaise with the person organizing lunch and coffee breaks so that food or coffee is ready when you need it.

Flipchart Recording

- A team member should take notes on a flipchart during discussions, but these notes include only the main points. The recorder is responsible for taking detailed notes.
- Flipcharts are not as important as what the participants are saying, so do not interrupt a discussion to ask someone to repeat something you have not recorded on the flipchart.
- Don't worry about putting the flipcharts up on the wall if this is going to hold up moving to the next part of the exercise. Wait until a break, and do it then.

Instructions for Exercises

- Start off by telling participants what the exercise is and its purpose.
- Explain one step in an exercise at a time and then have participants follow your instruction. If you try to explain all the steps at once, they likely will become confused, which wastes time.
- Keep your instructions simple and clear and use examples to help with understanding. If participants look confused, have them ask questions so you are sure they understand. Write the instructions on the flipchart if that helps.
- If you are breaking into groups to do an exercise, go around to each group to check that they are clear about the task, how they are to record their ideas and how to report back.
- Practice giving these instructions in the local language beforehand.
- If you have stepped back from the discussion to allow participants to complete a task on their own, you should still be available in case they have questions. Don't leave the room, make phone calls or read a newspaper. You don't want to interfere with their process, but you do want to be on hand in case they need your help.

Questions, Listening and Rephrasing

One of your main tasks as a facilitator is to ask effective questions.

- Open questions encourage many different opinions and get all participants talking and contributing.
- Probing questions clarify what has been said and explore more details.

After asking each question listen carefully to what the person says. Active listening is crucial when facilitating a discussion. If you don't know what the person has said, it is hard to ask the next question or shape the flow of discussion.

You should also use **rephrasing** or restating what a participant said in simple words to verify that you and the whole group understood correctly. Rephrasing also helps the recorder who is taking notes.

Active Listening – When participants know that they are being heard and understood, they are more likely to be open about sharing their experiences, thoughts and feelings. This is particularly important when you are encouraging women to talk about sensitive and taboo subjects such as sex, gender-based violence, abortion, etc.

Active listening involves:

- Eye contact – Looking at the person to show interest and understanding.
- Encouragers – Signals to the other person that you are listening (e.g., nodding your head, saying things like “Yes.... Okay.... I see.... Tell me more....”)
- Rephrasing at points to check that you have understood what she/he is saying.

Probing is a technique where you ask questions to get more information on an issue, find out the views of other people, find out how people feel about an issue or look for solutions to a problem. General responses are normally unsatisfactory. You need more details so you have a clear understanding of the problem and how people want to solve it. The more detail, the more valuable the data. However, probing should always be linked to the purpose of the exercise – don’t probe just for the sake of it. Use neutral language to ensure that participants are not influenced by the beliefs of the facilitator.

Probing can be used in the following circumstances:

- When you don’t understand what a participant or group has said.
- When someone has said something interesting and relevant to your discussion and you would like to hear more about it.
- When someone has said something vague or general and you are looking for more specific details (ask for examples).
- When you want to highlight the difference between two situations or gain understanding about the thinking behind an exercise (e.g., why is syphilis a top priority, but thrush is only a low priority illness?)
- When you want to address a certain issue that has not been mentioned in the discussion. (However, if the topic is not discussed after some probing or prompting, then you can bring it up yourself or move on to another topic – don’t turn the discussion into a guessing game!)

Handing Over Control of the Process

You are leading the workshop, but during exercises such as body mapping, it is important to let participants take control. Hand over the marker pens and let participants make the body maps and add the extra notes. They will demonstrate and explain how they view the body, its parts and the diseases. If you try to control this activity, you will stop participants from telling their story. Be patient, let groups take the lead and minimize interruptions. Your role is to ask probing questions to get them to think more deeply.

Discussions: Prompting and Stepping Back

- In any discussion, it is important to find a balance between prompting and stepping back. Participants will need more prompting if they are not sure what they should be doing or discussing. Write the discussion question on a flipchart. If instructions are complicated, write these on a flipchart too.
- Sometimes it is useful to prompt if the discussion is slow, but be judicious because prompting can alter the quality of the data. For example, in an exercise where participants are asked to rank issues by importance, a facilitator that prompts too much discussion could influence the participants' ranking criteria or reveal your own beliefs. Remember that answers are not right or wrong – anything the participants say is useful data. In the case of ranking or developing criteria, prompting should only be used if participants are not saying anything or not following instructions. A facilitator's job is to step back and stay out of the way.
- In a general discussion, a facilitator should remember the purpose of the discussion. You may prompt the group to discuss certain issues. If the discussion is slow, speed things up by asking participants to focus on specific areas. Another way of changing pace is to break into pairs or small groups to get everyone talking and then organize a report back to the larger group. This can generate further discussion among the group.
- The most important thing is not to tell people what to think or what their experience has been. Good facilitators ask good questions and allow participants to talk.
- Remember the purpose of any given exercise to guide you about how much facilitation the exercise needs. See table below for examples.

More Facilitation	Less Facilitation
Reaching agreement on what is understood by certain terms	Participants setting criteria for a ranking exercise
Highlighting the difference between a good experience at the clinic and a bad experience	Participants making priorities according to their own criteria
Analyzing data or experiences	Participants describing how they felt in certain situations
Intervening to ensure women are not left out of the decision-making	

Keep Objectives in Mind

As the facilitator, your job is to keep the discussion and process in line with the workshop's objectives. What information are you looking for? Why? What is important to know, and what is not very useful? If the discussion does not go according to plan, think about the purpose and outcomes of the exercise to determine how to ensure you get the information you need.

Verify and Compare Information: Community assessment workshops are designed to obtain information from different sources: HIV-positive women, untested women, health care service providers and community leaders. One of your tasks as facilitator is to cross-check and compare this information. For example, if you get incomplete or confusing information from one group of participants, ask the same question to a different group and compare their views. You will also have an opportunity to bring together all four groups to examine what they agree on.

Clarify the Meaning of Key Words: It is important to ensure that you and participants are using the same language. You may assume that you share a common understanding of a term, but later discover that they understood it differently.

Find Ways to Equalize Participation

In some workshops you will find a few dominant participants. For example, women may say little and instead defer to male participants to speak for them.

Follow these principles to involve everyone in the group:

- Establish ground rules that promote everyone's participation.
- Direct questions to the quieter participants and encourage them to contribute.
- Divide into pairs or small groups to get everyone talking.
- Go around the circle getting one point from each person.

Handle Sensitive Issues

Be prepared to manage sensitive issues, especially when talking about sexual and reproductive health. In many societies, talking in public about topics related to sex is taboo.

Part of the skill in managing these issues is to build an atmosphere of openness. The body mapping exercise is particularly effective in getting people to talk about sensitive issues.

Facilitators should prepare beforehand. You may be uncomfortable talking about sexual body parts and their functions, or issues such as rape, child abuse, abortion or female genital cutting. If you will facilitate these discussions, you need to be able to discuss these issues without feeling uncomfortable. Practice ahead of time with other team members.

While the workshop's goal is to explore issues, be careful not to expose or isolate participants, or proceed into discussions beyond the scope of the workshop. To manage sensitive issues, facilitators should:

- Get as much information as possible beforehand on potentially sensitive areas and work out strategies to bring out these issues and handle them well.
- Include facilitators who are from the community and more attuned to sensitive issues. Work closely with local partners who understand the culture and can lead the discussion around these issues.
- Observe the group's body language to determine whether to explore an issue and or back off. People who don't want to discuss something may avoid eye contact or cross their arms.

Build Consensus

Be careful that you don't make decisions for the group. Ask the group if they all agree and be sure to include quieter participants.

Manage Conflict

Participants' views may lead to disagreement and even conflict. This situation can be explosive or it can be turned to advantage – using the passion around the issues to understand them better. Your aim as a facilitator is to defuse conflict and get participants to explore the issues.

- Restate the ground rules (i.e., active listening and respect) to create the right spirit.
- Ask the speakers to state their concerns and the reasons for them to help everyone fully understand the issues and avoid making assumptions.
- Ask everyone to listen to the speakers. Rephrase what each has said to make sure everyone has heard the views clearly.
- Help participants identify common ground and points of difference that need further discussion or that people can agree to differ on.

Work with Feelings

In some exercises participants are asked to think and talk about experiences in their lives. This may trigger strong emotions and you need to be ready to deal with them.

As emphasized earlier, it is important to create a safe and supportive space where participants can talk openly about their experiences and feelings.

The following tips may help:

- Set clear ground rules and expectations around confidentiality and listening.
- Be aware of your own feelings about the topics you are going to cover. This will help you feel more confident during the exercise.
- Participants will be more likely to trust you if you share your own feelings. By doing this, you lead by example. If you are HIV-positive, you might talk about your personal experience as a way of encouraging others.
- Leave enough time for participants to share their feelings. Help the group create an atmosphere where participants know they will be heard.

In some cases a participant may talk about a personal crisis and break down. You will need to find a way to take time out so you (or another participant or organizer) can talk to the person. You also should arrange for referral to other counselors in the area.

Work with Translators

If you need a translator, be sure to select someone who will not allow his/her feelings to affect what gets translated and will translate everything.

Tips for working effectively with translators:

- If possible, have more than one person who speaks the local language. One person can facilitate and the other can take notes. At the end of the day, they can review the notes together to ensure that everything discussed is included in the notes.

- Be clear with the translator about her/his role. Emphasize that the translator should translate (and back-translate) what is being said word for word. She/he must not paraphrase, embellish or translate only those parts that support personal moral preferences and sensibilities. Stress that no one from the facilitation team, including the translators, is there to pass judgment on the workshop participants.

Handle Technical Questions and Referral

Your workshops will spark lots of questions from community members. The workshop process allows time to respond to these questions.

Keep a record of the questions asked at each workshop. These questions can be answered during the Day 5 workshop that brings together all groups. Invite a local medical or health expert to join you for this session, and give the expert these questions in advance so she/he can come well prepared.

This guide also includes fact sheets on some of the major HIV, AIDS and reproductive health-related diseases in Annex A. Translate these into the local language and give them to participants at the end of each workshop, along with a list of local health services.

You also might have individuals approaching you for advice on personal problems (e.g., a woman who has been beaten or sexually abused). Be prepared with information, including referral to counselors or other professionals in the community, to assist participants.

Review Daily

Convene a team meeting at the end of each day to review the day's activities and plan for the following day. Start off with a quick go-around to get each person's views about the day. Then, go through each of the activities and ask for comments. Encourage everyone to give an honest appraisal of the team's performance.

Discuss some of the following issues:

- Which exercises worked and why? What didn't work and why?
- How was the level of participation for each exercise?
- Which questions were effective and which fell flat?
- How could some questions be phrased differently?
- How did the local context influence the information and analysis?
- Which issues were deliberately avoided or hidden?
- How was the pace and the time allocated to each activity?

Once you have finished, go through the plans for the following day, adding what you have learned from the review.

10 Steps for Participatory Facilitation

1. BE WELL PREPARED

- Plan each of the sessions before the workshop.
- Practice how to conduct the sessions in the local language.
- Assign tasks within the team, giving each person a clear task.
- Bring all materials – manual, handouts, flipchart paper, markers, cards, etc.
- Arrive early so you are ready to welcome participants when they arrive.
- Be flexible – leave room in your planning to make changes.

2. PREPARE THE ROOM

- Remove tables to make room for activities and make the workshop more informal.
- Set up chairs in a semi-circle and ensure that participants will be able to see each other and the flipchart.
- Put flipchart sheets on the front wall.
- Set up a separate table for markers, tape, handouts and other supplies.

3. MAKE PARTICIPANTS FEEL COMFORTABLE

- Welcome everyone when they arrive.
- Break the ice and make everyone feel comfortable at the start of the workshop.
- Learn participants' names. Use games, songs or divide into smaller groups to develop rapport.
- Respond to participants' expectations and set ground rules.

4. ASK QUESTIONS AND LEAD DISCUSSION

- Ask clear, simple and open questions that allow people to give their opinions.
- Solicit contributions – use your hands and body to encourage participants.
- Wait for responses. Give people time to think and come up with an answer.
- Encourage everyone to talk. Buzz groups (where you divide participants into groups of three to five people to discuss a topic and then regroup to discuss) are effective; or have participants sit in a circle and ask each person to say something.
- Equalize participation – draw out the silent and control the talkative.
- Don't be satisfied with the first response or one answer. Keep asking more questions: "What do others think? Who would like to add to that?"
- Be a good listener. Show that you are listening and interested in what people say.
- Praise responses to encourage participation.
- Rephrase responses to check that you and other participants understand.
- Redirect to involve others: "She said.... What do others think?"
- Keep the focus. If the discussion goes off track, restate the objective or question.
- Summarize and check agreement before moving to the next question/topic.

5. USE SMALL GROUPS TO BUILD PARTICIPATION

- Give a clear explanation of the group task, time and reporting method.
- If the task is difficult, write instructions on the flipchart and ensure that everyone understands what needs to be done.
- Vary the size of groups for different sessions – pairs, trios, fours and fives.
- Keep changing the groups so participants work with different people.
- When participants move into groups, go around to be sure they understand the task.

6. KEEP INSTRUCTIONS CLEAR AND SIMPLE

- Write out your main points using key words on a flipchart and then explain them.
- Speak slowly, clearly and loudly.
- Look at people and use your hands and body to emphasize points.

7. CHANGE YOUR METHODS

- Use different activities to keep interest and energy levels high.
- Use different methods for different topics.
- Use different sizes of groups.
- Change the setting. For instance, you can hold some sessions outside.

8. CHECK THE ENERGY LEVEL

- Observe body language. Do participants look bored? Tired?
- Ask, “How are you feeling? Is it time for a break?”
- When people are tired, change the activity, take a break, or do a song or game.

9. WATCH THE TIMING AND PACING

- Be time conscious. Decide how much time you need for each session.
- Remember that small group work takes more time than you expect. You also will need to allocate time for report backs.
- Don't go too fast. Let the group help you set an appropriate pace.
- Give groups enough time to do their work. Don't rush them.
- Do small group work in the afternoon when the energy level drops.
- Don't forget to take breaks to relax, get tea and talk informally.
- End on time.

10. WORK AS A TEAM

- Plan and run the workshop with another facilitator and debrief afterwards.
- Take turns in the lead facilitation role and as the recorder.
- Support each other. If one runs into trouble, help him/her out.
- Agree beforehand on how to support the lead facilitator when she/he encounters difficulty.

Part B – How To Document Sessions and Write a Report

A crucial part of the community assessment process is to document participants' comments during each workshop and produce a report that summarizes the assessment's findings. It is important to dedicate sufficient attention and resources to this task. The team member who is responsible should be someone who is a good listener, is not likely to get drawn into the discussion and understands how to take notes that will be useful.

There are three levels of documentation during a community assessment process:

- 1) Taking notes during the workshop sessions;
- 2) Preparing site reports; and
- 3) Writing the final synthesis report.

Good information can be lost if notes are not taken properly. Be aware of some common pitfalls:

- Sharing this work within a team but not clarifying whose responsibility it is to pull all of the notes together.
- Getting wrapped up in the discussion and forgetting to take notes.
- Missing crucial information by trying to record all of the detail, rather than key words.
- Losing some of the cards, flipcharts and other materials produced by participants during the body mapping, community mapping or other exercises.

Taking Notes During Workshop Sessions

The workshop recorder is responsible for documenting:

- All the discussions during each one-day workshop;
- The material produced by participants (body map and extra information that participants add, community map and services); and
- A summarized profile of participants – numbers, age groups, gender, occupation.

Here are some tips for recording notes:

- Sit where you can easily hear the participants.
- Get permission at the start of the workshop to take notes on what people are saying. Explain that you will not identify those present in relation to any statement recorded.
- Use a notebook or a laptop computer for taking notes.
- Record all the statements made, including arguments and disagreements.
- Record key phrases in the local language.
- Record stories, examples or proverbs participants use to explain their ideas.
- Keep it simple. Use short words and avoid technical/academic jargon.
- Be factual – record what was said, rather than what you think was implied. Record your own observations separately.

- Keep a record of your observations (e.g., “Participants said....., but they did not seem to show much enthusiasm.”).
- Go through your notes at the end of each day and check any unclear notes with other team members.
- Keep a record of discussions during the daily team review/planning meeting.
- Make copies of all body maps and community maps.

Preparing Site Reports

Allow enough time to write a report at the end of each site visit before moving to the next site; don't leave it all to the end. Meet as a team to review the findings from the five workshops and produce a synthesis of major findings. Review the key questions and arrange your findings according to this list.

Sample Report Structure

Data recorded separately for each target group – HIV-positive women, negative/untested women, service providers and local/community leaders	
Village or area profile	Name of village(s). Main occupation and source of income.
Profile of participants	Gender. Age. Occupation. Organization. HIV-positive women – level of openness.
Unusual expectations	Medical, first aid or home-based care training, service provision, direct aid, etc.
Priority women's health issues	List of diseases and health problems.
Diseases and health issues that are poorly understood	Unusual perceptions or misconceptions of diseases and health problems.
Questions about health issues	What questions did participants raise and want answered?
Service providers and services available in the village or area	Separate lists of service providers and services, organized into: a) treatment b) care c) support
Gaps in health services	What services are not provided or poorly implemented?
Experiences of health services	What experiences contributed to a positive or negative experience of health services?
Barriers preventing women from accessing services	Organize barriers according to: a) health services b) community c) household d) workplace.
Recommendations for action	What did participants suggest is needed to address priority health issues and gaps?
Extras:	
<ul style="list-style-type: none"> ● Copies of body maps and community maps – the originals should stay with participants ● Report on site visits ● Report on transect walk 	

Synthesis Reports

The analysis for the synthesis report should involve the whole team. The team should go through the site reports and identify common findings across all sites. As part of this process refer back to the checklist of issues used to guide the field work. Go through each issue and document what was learned from all of the different sites. If you have not been able to get community responses to some of the key questions, state this clearly in your report.

The community assessments reflect a variety of views, experiences and conditions across different sites and regions. Your synthesis report should show this diversity, as well as identify things that are common across these different contexts.

ANNEX A:

Fact Sheets

- A1. HIV and AIDS and HIV Transmission***
- A2. Why Women are More Vulnerable to HIV than Men**
- A3. Condoms***
- A4. Sexually Transmitted Infections (STIs)***
- A5. Opportunistic Infections (OIs)**
- A6. Thrush***
- A7. Post-exposure Prophylaxis (PEP)**
- A8. Human Rights and HIV***
- A9. Pregnancy, Child Birth and Feeding Your Baby***
- A10. Gender-based Violence**
- A11. Cervical Cancer and Pap Smear Tests**

*Adapted from fact sheets produced by the International Community of Women Living with HIV/AIDS (<http://www.icw.org>).

A1. HIV and AIDS and HIV Transmission

A Brief Definition of HIV and AIDS

HIV stands for human immunodeficiency virus. If you are HIV-positive you are infected with this virus. Your body reacts by producing HIV antibodies. If you have access to an HIV blood test it will show these antibodies. If you are HIV-positive you may have no symptoms and may remain healthy for many years. However, no matter how well you feel, the virus remains in your body and can be passed on to other people.

AIDS stands for acquired immune deficiency syndrome. If you are HIV-positive your immune system may be weakened, making you vulnerable to a group of illnesses (syndromes) that would not affect a healthy person without the virus. These illnesses include tuberculosis, some cancers, and eye, skin and nervous system conditions. Though these can be serious, being diagnosed with AIDS does not mean you cannot recover your health. Many HIV-positive people have a serious illness, but recover and go on to live well.

HIV Transmission

HIV can be transmitted through:

- unprotected (without a condom) vaginal or anal sex with someone who is HIV-positive.
- sharing syringes and injecting equipment that have not been properly cleaned.
- contaminated medical equipment that has not been properly cleaned.
- being given untested blood transfusions or blood products that are infected with HIV.
- donor insemination with HIV-infected semen.

Transmission of HIV from mother to baby can happen when:

- the virus is transmitted to the fetus across the placenta during pregnancy.
- the baby is infected during childbirth.
- the baby is infected through breast milk.

Children also can get HIV from:

- receiving infected blood transfusions.
- receiving treatment with unsterile medical equipment such as needles, syringes or surgical instruments.
- suffering sexual abuse involving penetrative vaginal or anal sex.

HIV is unlikely to be transmitted through oral sex, which is when someone licks or sucks a man's penis or a woman's clitoris or vagina. Some people think there may be a slight risk if an HIV-positive man's semen is swallowed. Even fewer people think there may be a small risk of transmission from an HIV-positive woman's vagina if someone is licking it. If an HIV-positive woman is menstruating, it is advisable to avoid unprotected oral sex.

Compared to unprotected vaginal or anal penetrative sex, the risks of HIV transmission through oral sex are minimal. Some people prefer to use condoms or latex barriers such as dental dams or plastic wrap when engaging in oral sex. Other people weigh the risks and decide that because they are so minimal, it is okay to go ahead without protection.

HIV is not transmitted by:

- shaking hands or hugging.
- tears or sweat.
- sneezing or coughing.
- using other people's cutlery, glasses, plates or bed linen.
- using a toilet.
- dogs, cats or insect bites.
- kissing or saliva.
- eating from the same plate.

To prevent HIV infection, keep the following in mind:

- If you have sex with many partners or you are unsure of your partner's sexual relations, **always use or insist on a condom during sex.**
- Protect yourself from contaminated bodily fluids.
- Women who are pregnant or intending to get pregnant **should seek services to prevent mother-to-child transmission of HIV to the unborn child.**

A2. Why Women are More Vulnerable to HIV than Men

Socio-Economic Reasons for Women's Vulnerability to HIV

- **Fear of violence:** Because they fear violent reactions from their partners, women find it difficult to negotiate safe sex and protect themselves against HIV and sexually transmitted infections (STIs). Women often fear they will be beaten if they refuse to have sex or ask their partner to use a condom, even if they know he has been having sex with other women or that he has HIV or STIs. Fear of violence also prevents women from getting treatment for STIs, increasing the risk that they will pass it on to their partner.
- **Marriage:** Many women are at risk because of their husbands' high-risk sexual behavior. Even when women are faithful, their husbands may be having sex with other women, bringing HIV or STIs home. The wives cannot refuse sex, and they become infected with STIs or HIV as a result.
- **Sexual violence:** Forced sex causes bleeding and small internal cuts in the vagina that make it easier to get HIV.
- **Sexually transmitted infections:** Women's partners often do not tell them they have STIs (or HIV) and continue to have unprotected sex. The women get the STIs, which produce sores or cuts in the skin, and subsequently make women more vulnerable to HIV.
- **Cultural norms:** Women are expected to have less sex during pregnancy or post-delivery, and their partners often are expected to have other sexual partners during this time.
- **Poverty:** Poor women may be forced into sex work to survive, making them vulnerable to HIV infection and sexual violence.

Biological Reasons for Women's Vulnerability to HIV

- **Women get HIV and other STIs during sex twice as easily as men.** Semen has a higher concentration of HIV than vaginal fluids. The woman's vagina has large areas of exposed and sensitive skin surfaces that can develop small tears during sexual intercourse. This allows HIV and other STIs to enter the woman's bloodstream. Also, semen stays in the vagina after sex, increasing the risk of transmission. In contrast, the penis has a small surface area that is in contact with vaginal fluids for a shorter time, and men can more easily wash off vaginal fluids after sex.
- Men usually know when they have an STI. With women, however, some STI symptoms do not appear, and other symptoms may be hidden in the vaginal canal. Women must depend on their husbands or partners to tell them they have an STI. This limits their ability to protect themselves against STIs, and having STIs increases their vulnerability to HIV.
- During labor or delivery, women often get vaginal cuts or lesions, making it easier for them to get HIV.
- Teenage girls, whose vaginal tissue is not fully mature, are more likely to develop lesions during intercourse, increasing their vulnerability to HIV.

More attention should be given to addressing these particular vulnerabilities that women face.

A3. Condoms

Male Condoms

Rubber, Johnny, French Letter, Durex, Nirodh, Prezervatfin, Capout, Rokesh or Sheath – the condom has many names. It is made of a very thin rubber, normally latex. It is unrolled over a man's erect penis before penetrative vaginal or anal sex. Some people choose to use a condom for oral sex too. A condom prevents infectious blood, semen or vaginal fluid being passed from one person to another. Using condoms during vaginal and anal penetrative sex prevents infections, including HIV and other STIs. It also prevents conception.

How to use a male condom

The following tips will help you to use condoms successfully.

- If the wrapping is ripped or damaged in any way, do not use it. The condom may be damaged. If the “use by” date is past, throw it out.
- Use a new condom every time you have penetrative sex.
- Don't use your teeth to open the wrapping.
- Be careful of long nails or jewelry damaging the condom as it is taken out of its packaging.
- Pinch the air out of the tip of the condom before rolling it onto a stiff penis.
- Roll the condom onto an erect penis before any genital contact with a partner.
- If lubrication is wanted, try rubbing a generous amount of water-based lubricant on the outside of the condom after it is on the man's penis. This ensures comfortable penetration and is more pleasurable for many men and women. Oil based lubricants like vaseline or cooking oils can damage the male condom.
- After he has ejaculated, get your partner to hold onto the base of the condom as he pulls out so it doesn't come off while he is still inside.
- Throw used condoms in a bin.
- If using flush toilets, don't put used condoms down. They block the toilet.

Femidoms or Female Condoms

Femidoms are female condoms which can be inserted into the vagina before having penetrative vaginal sex. They are relatively new and are becoming more available. Some women like them a lot, especially if a man is resistant to using a condom himself. Others are not so keen on them.

How to use female condoms

- If you have access to female condoms, you could practice using one on your own first. You can explore the best way to insert it.
- The femidom is made of a type of thin plastic. It is different from latex which is a rubber. Because it is plastic you can use it with either water based or oil based lubricants.
- The femidom has an inner and outer ring. The thin plastic sheath stretches between the rings. The inner ring must be pushed high up into the vagina where it fits snugly over the cervix. The cervix is the firm, rounded bump at the top of the vagina. The entrance to the womb is in the cervix. Some women like it better without the inner ring. It can be removed.
- The outer ring fits snugly over the vaginal lips outside the opening to the vagina. The man's penis can enter through the outer ring into the vagina. Inside, the sheath lines the walls of the vagina. It is important to guide the penis in so it doesn't by chance go down the side of the female condom.
- If you hear funny "squashy" or "poppy" noises while you are having sex wearing a female condom, you can check to see that none of the plastic lining is hanging outside the vagina.

Anal sex

The female condom can be used effectively for anal sex because it is highly lubricated.

- Either insert it into the anus or put it on the penis first.
- If used on the penis, the inner ring should be removed first.
- It may be more difficult to insert the inner ring of the female condom into the anus than into the vagina. Some women can push it up with their fingers. Some women like the feel of the ring in their anus. Others don't and find it uncomfortable or painful. If you are using a female condom for anal sex, only do what is comfortable for you. You should not continue to do anything that is painful.
- If you don't use a female condom for anal sex make absolutely certain you do use an ordinary condom. Unprotected penetrative anal sex is a very high risk activity for HIV transmission.

A word about lubricants

For many people lubricants are an important part of safer sex. Many condoms come pre-lubricated with a spermicide which kills sperm, called Nonoxynol 9. A minority of people are allergic to Nonoxynol 9. If it turns out you are one of them, look instead for non-lubricated condoms and use a plain water-based lubricant. If you are using female condoms, you can use water or oil-based lubricants.

A4. Sexually Transmitted Infections (STIs)

Many people have STIs without being aware of it due to lack of symptoms. This means that they may not feel any pain or discomfort.

STIs are important to know about because if they are not treated they can have very damaging effects such as chronic pain, infertility and cervical cancer. If you are pregnant and have an untreated STI, the risk of infecting the baby with HIV and other infections increases.

It is now understood that the presence of an STI makes sexual transmission of HIV from one partner to another much more likely.

Protect yourself

It is important to protect yourself against STIs. Practicing safe sex and using condoms during penetrative sex is the only effective way to avoid STIs. STIs can really affect your health and may make the HIV disease progress more rapidly.

Diagnosing

Diagnosing an STI if you have no symptoms is not easy in many countries because screening is not always widely available. Screening for STIs and treating them is an effective way to slow down the numbers of new cases of HIV, and treatment is now increasingly being offered in antenatal clinics, maternal and child health clinics, and through family planning services.

If your partner has STI symptoms but you don't, you should still get treatment.

STIs – what to look out for

Women need to be aware of the following:

- Unusual bleeding from the vagina
- Unusual discharge coming out of the vagina or your partner's penis
- Sores, lumps or a rash on or around the vagina, anus or your partner's penis
- A burning feeling when you urinate
- Itching around the vagina or anus, or partner itching around the penis

If you have or suspect you have an STI you can seek advice and treatment at a health center.

Treatment

Treatment of STIs can be fairly cheap and simple. Sometimes it is just one dose of antibiotics. However different infections need different treatments so it is important to get medical advice.

If you are pregnant or planning to get pregnant, it is important to have antenatal care and to treat and clear up any existing STIs. STIs can infect the baby at birth and cause serious damage. It is also important to tell your health practitioner if you are pregnant because this may affect the treatment you get.

What about having sex if I am being treated for an STI?

With any STI the best way to avoid infection is to use condoms and practice safe sex every time you have sex. Avoiding oral sex during an outbreak of sores or blisters will reduce the risk of infection. Try to avoid touching any open sores, warts or blisters.

Some sexually transmitted infections

Chancroid

Chancroid is a bacterial infection common in tropical countries. It causes painful ulcers on the genitals. Chancroid can be identified by a laboratory test and cured with antibiotics.

Chlamydia

Chlamydia is an infection that affects the genitals. It is one of the most common sexually transmitted infections. Most women have no symptoms. It can be treated with antibiotics.

Gonorrhoea

Gonorrhoea is caused by bacteria and again many women will have no symptoms. Gonorrhoea is passed from one person to another through vaginal, anal and oral sex. It is very easy to catch. It also can be passed on to babies during birth, causing eye infections and blindness. To diagnose gonorrhoea a swab is taken from the cervix, urethra or the throat. Treatment is usually with antibiotics. If left untreated, gonorrhoea can lead to Pelvic Inflammatory Disease (PID) which can make it impossible to have a baby.

Genital Warts

Genital warts are small pinkish/white fleshy growths which may appear anywhere in the genital or anal area. They are caused by a virus called Human Papilloma Virus (HPV). Women with untreated genital warts may be at increased risk of developing genital cancers.

Warts are spread through skin-to-skin contact. If you have unprotected vaginal or anal sex or genital contact with someone who has genital warts you may develop them.

After being infected with the virus, it usually takes between one to three months for warts to appear on the genitals of women and men. They may itch but are usually painless. There are several methods used to treat genital warts. The most common one is to paint them with chemicals, which can be done either by your doctor or by yourself. Other methods include freezing with liquid nitrogen or burning them off with a laser.

Genital Herpes

Genital herpes is caused by the herpes simplex virus (HSV). It causes painful tingling or itching, blisters or ulcers. Some people have aching muscles and fever.

Herpes Type I causes sores around the nose and mouth. Herpes Type II causes sores or blisters around the genital and anal area.

Herpes is passed on through direct contact with the infected part of the person's body.

- Herpes sores on your mouth or your partner's mouth can infect the genital area of the other person.
- Avoid sharing towels and wash cloths (face flannels) with partners, family members or friends. Unlike HIV, the herpes virus can be passed on in this way.
- Always wash hands with soap after touching the sores.

Herpes cannot be cured, but there are several things you can do to soothe the affected area:

- If the pain is severe, take pain killers (aspirin/paracetamol).
- Keep the affected area as dry and clean as possible. Gently bathe the sore areas with a salt solution (half a teaspoon of salt to half a pint of warm water). You can add five drops of tea tree oil in warm salt water too. It may soothe and help dry up the sores.
- Put gentian violet onto the sores to prevent secondary infection.
- Honey applied to herpes sores will burn for a minute and then soothe and help to heal.
- Take 50mg zinc and 500mg vitamin E daily from the moment the herpes pimple appears. (To prevent re-occurrence of a herpes attack, take 50mg zinc and 200mg vitamin E every day.)
- If you can get it, Zovirax (Acyclovir) will shorten and ease a herpes attack. Take it with the zinc and vitamin E.
- Wear loose clothing so that the air can circulate around the sore areas.
- Place an ice pack wrapped in a clean cloth or towel on the affected area.
- Get plenty of rest.
- Drink plenty of fluids.

Syphilis

Syphilis is a bacterial infection. It is usually transmitted through vaginal, anal or oral sex. It also can be passed from an infected mother to her unborn baby.

The signs and symptoms are the same in both men and women. Usually a sore appears on the penis or vagina, anus or mouth about ten days to three weeks after sex with an infected person. The sore disappears in a week or two but the bacteria remains in the body. However, most women do not see the sore and may not have any symptoms. The only way to be sure is to have a blood test.

During the secondary stage which may occur during the next two years, a rash may appear on the hands and feet, the face, and other parts of the body.

Treatment at any time during these first two stages of syphilis will cure the infection. But if it is left untreated, a later stage will occur some years later that will cause serious damage to your health.

A5. Opportunistic Infections (OIs)

What are Opportunistic Infections?

Opportunistic infections (OIs) are HIV- and AIDS-related illnesses caused by bacteria, fungi and viruses that take advantage of a weakened immune system. OIs would not normally cause illness in a healthy person, but can affect an HIV-infected person whose immune system has been weakened. Most OIs can be prevented or treated with medication, which can help improve the quality of life for a person living with HIV and delay the onset of AIDS.

There are more than 20 opportunistic diseases associated with AIDS, including tuberculosis (TB), diarrhea, pneumonia, bowel infection, Kaposi's Sarcoma, candidiasis, skin cancer and meningitis. An individual with an AIDS diagnosis may have two or more diseases at the same time.

When AIDS first appeared in the mid-1980s, many people living with HIV rapidly died from opportunistic infections because their doctors did not know how to treat and prevent these diseases in people with damaged immune systems. But as doctors learned how to prevent OIs with medication, and how to recognize and treat these infections more effectively, people living with HIV began to live longer.

Different Types of Opportunistic Infections

Tuberculosis (TB) is a lung disease that affects many people with HIV. It is preventable and curable.

Candidiasis is a fungal infection, commonly known as “thrush” in infants. It appears as white patches on the tongue and ulcers in the mouth. These patches are sometimes painful, making it difficult to swallow. This fungal infection can also affect the vagina, causing vaginal candidiasis. Symptoms include thick, curd-like vaginal discharge, painful intercourse and redness of the vaginal wall.

Kaposi's Sarcoma is a cancer commonly diagnosed in people living with HIV. Symptoms include dark skin lesions or nodules appearing on different parts of the body. It usually affects the skin, the lymph nodes and the mouth. Lesions also can be found in the stomach and the lungs, causing severe breathing problems.

Pneumocystis Carinii Pneumonia (PCP) is an infection of the lungs that can cause severe pneumonia and results in difficulty breathing, fever and dry cough.

How to Prevent or Treat Opportunistic Infections

- Maintain regular medical check-ups. Seek medical care at the first sign of sickness.
- Get plenty of rest, good food and nutrition, good hygiene, and avoid alcohol and smoking.
- Avoid infection: Many people fear getting infections from people living with HIV, but in fact they have more to fear from getting infections from “healthy” people.
- Access TB prevention therapy.
- Use available medicines to cure most infections or reduce the impact of the symptoms (e.g., reduce itchiness of skin rashes).

Medicine for Treating Opportunistic Infections

- Fluconazole is used to treat severe oral candidiasis or thrush infections. Thrush causes painful little white sores in the mouth.
- Acyclovir is used to treat herpes, which are painful blisters on the lips or genitals.
- Cotrimoxazole is an antibiotic given to people living with HIV whose CD4 count is below 200. This medicine helps to prevent PCP (Pneumocystis Carinii Pneumonia).

Other Common Symptoms of AIDS and What to Do

The most common symptoms of AIDS include: weight loss; fevers; breathing problems; digestive problems; and infections of the mouth, skin, and genital areas. Some of these conditions can be treated at home, with support from a health care provider.

Nausea and vomiting. AIDS patients often feel nauseous. Patients should keep their mouths clean by frequently rinsing with clean water and using a toothbrush to brush the teeth and tongue. Nausea can lead to vomiting, making them unable to eat. If the patient is vomiting, he/she should avoid fatty foods and not eat or drink fluids for one or two hours, then gradually increase intake of fluids.

Tiredness and weakness. People living with HIV often feel tired and should rest often. Help them do simple exercises, such as moving their arms and legs. If the patient is bedridden, encourage him/her to regularly move the arms and legs. Turn the patient every now and then. Keep him/her involved in daily home activities and help with daily needs, such as bathing and using the toilet.

Sore mouth and throat. This is a common problem among people living with HIV.

- Rinse patient's mouth with warm, clean water mixed with a pinch of salt.
- For white patches in the mouth, give the patient a lemon to suck (this sometimes may be too painful).
- Apply gentian violet solution to sores on the lips.
- Use soothing local remedies to help the patient relieve soreness.

Pain. To help alleviate pain, give the patient two aspirin or paracetamol tablets every four hours. Make sure the patient does not have an empty stomach when taking aspirin or tablets.

Swelling. Raise the legs or the swollen part of the body on pillows and massage the sore muscle using some oil or soothing cream. Regularly move the patient to change positions.

Fever. Treatment for a fever can include:

- removing unnecessary clothing and blankets.
- wiping the patient down with a wet cloth, or using a cold compress.
- getting the patient to drink lots of water or other liquids.
- using aspirin or paracetamol (two tablets every eight hours).

If the patient is too hot and the fever continues for a long time or is accompanied by stiffness, severe pain, confusion, yellow color in the eyes, sudden diarrhea or convulsions, seek medical assistance immediately. The fever may be caused by malaria.

Diarrhea. Diarrhea is very common in AIDS patients. The stools are very watery and sometimes contain blood. Patients suffering from diarrhea often get dehydrated. Treatment for diarrhea can include the following:

- Keep the skin clean and dry. Wash with clean water after each bowel movement.
- Treat dehydration with an oral rehydration drink. Add half a flat teaspoon of salt and eight flat teaspoons of sugar to one liter of cooled boiled water. Make a fresh mixture every day. If the diarrhea continues, get help from a health worker.
- Give the patient solid or starchy foods such as rice water.
- Don't feed patients food containing a lot of sugar, which can worsen diarrhea.

Skin Problems. Skin problems include rashes, itching, painful sores, skin dryness, slow healing wounds, boils and abscesses. Each problem may need a different treatment.

Itching. Clean skin frequently with soap and water, and cool the skin with water. Apply lotions such as calamine. Keep the skin dry. Keep patient's nails short to minimize scratching, which will cause more injury to the skin.

Wounds. Clean the wounded area with boiled, clean water. Cover with a bandage or cloth wrapped loosely around the wound. Put a warm compress of weak salt water on the wound four times a day (a teaspoonful of salt to one liter of clean water). If the wound is on the foot or leg, raise the affected area as high as possible and as often as possible. During sleep, rest the foot or leg on a pillow. During the day, try to raise the foot for five minutes every 30 minutes. Walking helps circulate blood. Standing or sitting with the affected foot down for long periods is harmful. When wounds are infected, seek medical attention immediately.

Bed Sores. Bed sores are caused by pressure on parts of the patient's body, which often results from lying in the same position for long periods. Bed sores often occur on the buttocks, elbows, hips, back and feet. Treat bed sores by doing the following:

- Get the patient out of bed as much as possible.
- Change the patient's position often, at least every two hours.
- Use soft bed sheets and padding, which should be hung daily to air out. Change sheets when soiled with urine, vomit or sweat.
- Straighten the bedding because lying on wrinkled bedding can hurt the skin.
- Put a cushion under the patient to support bony parts.
- Encourage the patient to eat well. Extra vitamins help to heal the sores.

Shingles. Shingles is a rash, blisters or sores that develop on the chest or back. It is very painful and itchy. Treat shingles by doing the following:

- Apply calamine lotion twice a day to relieve pain and itching.
- Keep sores dry and do not let clothing rub against them.
- Let the patient wear clean, loose fitting clothing.
- Relieve pain with aspirin or paracetamol.
- Bathe sores with clean water three times a day or apply gentian violet solution.
- Watch for signs of infected sores, such as redness or pus.

Boils and abscesses. These are painful, raised, red lumps on the skin that commonly appear on the groin, buttock, armpits and upper parts of the legs. Treatment can include the following:

- Wash boils and abscesses with salt water (one teaspoonful of salt in a cup of clean water).
- Put a hot compress over the wound for 20 minutes four times a day. Be careful not to burn the patient.
- If the boil continues to grow, seek medical help.

Difficulties in breathing. People living with HIV often have infections in the lungs and experience chronic coughing and difficulties in breathing.

- Make the patient lay with pillows under their head, or with the head of the bed raised on blocks.
- Make the patient sit forward with their elbows on the knees or on a low table.
- Make sure someone is there to watch over the patient, as not being able to breathe could make them very frightened.

Coughing. If pain is felt in the chest or ribs during coughing, a pillow or hand should be held tightly over the area that hurts. This makes the cough less painful. When possible, encourage the patient to keep walking, turning around in bed or simply sitting up. This helps the lungs to drain. Give the patient a clean cloth to cover the mouth when coughing.

A6. Thrush

What is thrush (Candidiasis)?

Many women have thrush at some time in their life. It is common in adults who are stressed or have damaged immune systems because of HIV infection. Many babies also get it.

Thrush is caused by a tiny yeast-like organism called *Candida albicans* that normally lives quite harmlessly on your skin and in your mouth and gut.

Thrush is more likely to develop if you:

- are pregnant.
- are taking certain antibiotics.
- have diabetes.
- are unwell or ill.
- are taking the contraceptive pill.
- have unprotected penetrative sex with someone who has thrush.
- eat lots of sugar or sugar-based products.
- wear very tight jeans or trousers or nylon underwear.

How can you tell if you have thrush?

You may have one or more of the following symptoms:

- Sore spots or thick, white fur on the tongue, mouth or gums
- Itching, soreness and redness around your vagina, vulva or anus
- Thick, white discharge from your vagina that appears white and lumpy and smells like yeast
- Swollen vulva
- Pain when you have penetrative sex
- Pain when you urinate

Treatment

Medical treatment for thrush is easy, usually consisting of cream and pessaries (suppositories), or tablets.

Is there anything you can do yourself to relieve the symptoms of thrush?

- At the first sign of irritation, stop using soap and clean yourself with water.
- Stop wearing tight pants or jeans to allow improved air circulation.
- Don't be tempted to have frequent baths or to wash yourself more often. It may feel soothing for a short while but it tends to make the irritation worse.
- Don't put disinfectant or bubble bath in the water. However, you can put some vinegar in your bath, or 10 drops of tea tree oil.

In places where live yogurt is available, some women with thrush have applied it to the outside of the vagina where it soothes the irritation. Some women also put live yogurt into their vagina with a syringe or on a tampon. The beneficial bacteria found naturally in live yogurt are thought to destroy thrush. It works for some women, but not all. Garlic is an alternative that may work for you. Peel a clove, slit it and dip it in oil. Insert it into the vagina. Insert a clove once in the morning. Remove and insert a new clove in the evening. Repeat next day or until the symptoms improve.

Can you prevent thrush?

There are a number of things you can do to minimize the frequency of outbreaks:

- For thrush in the mouth avoid sugar at all times, particularly when you have an attack.
- If you have an attack of thrush avoid fruit, honey and yeast until the thrush has been gone for at least three weeks.
- Avoid wearing tights or underwear made with nylon, or tight jeans or trousers.
- Use sanitary pads rather than tampons if you are menstruating.
- Avoid perfumed soaps, genital sprays and deodorants, and disinfectants. Also avoid vaginal douching with chemical mixtures. All of these upset the beneficial chemical balance inside the vagina.
- After defecating, always reach from behind and wipe away from the vagina. You want to avoid getting fecal matter in your vagina.
- If you are prescribed an antibiotic for some other infection, remind your doctor that you tend to get thrush.

Can you have sex while having treatment?

It is best not to have penetrative vaginal or anal sex or oral sex until you have had your final check up with your health practitioner. If you have thrush in your mouth, stop kissing until you are well again. Hugging and cuddling are always fine.

A7. Post-exposure Prophylaxis (PEP)

Post-exposure Prophylaxis (PEP) is the ARV treatment provided to a health worker following a needlestick injury or exposure of mucous membranes (blood or body fluids splashed on nose/eyes/mouth). The aim is to reduce the chance of getting HIV.

PEP also should be provided to a woman who has been raped.

The PEP procedure involves the following:

Immediately following exposure

- Start the ARV treatment as soon as possible after the injury, ideally within two hours and at most within 24 hours.
- Provide counseling.

Follow-up care for health staff taking PEP

- Organize regular testing for up to six months after exposure.
- Provide ongoing counseling and support.

A8. Human Rights and HIV

Promoting human rights in the context of HIV and AIDS means:

- encouraging people to respect each other's rights, and to treat others as they themselves would wish to be treated.
- making sure that education and health care are available to everyone.
- educating people to help overcome the fears, ignorance and prejudice that lead them to abuse the rights of others.

Protecting human rights means:

- supporting and defending people whose rights are threatened or abused.
- remedying and compensating for abuses when they occur.
- working to change the conditions of poverty, powerlessness and dependence that make people vulnerable to human rights abuse.

Internationally accepted human rights

The human rights of people living with HIV and AIDS are abused in countries all over the world. The following are human rights, and examples of how those rights are being abused in the context of HIV and reproductive health.

Liberty, security and freedom of movement

Abuses:

- Compulsory HIV testing
- Quarantine, isolation and segregation, for example quarantining HIV-positive sex workers

Freedom from inhumane or degrading treatment

Abuses:

- Isolation, for example of HIV-positive prisoners
- Participation in drug or medical trials without fully informed consent
- Physical, emotional and psychological abuse of HIV-positive women

Right to marry or have relationships and children

Abuses:

- Forced abortion or sterilization
- Compulsory pre-marital HIV testing
- Discrimination against same sex relationships
- Forced pregnancy
- Forced wife inheritance
- Forced taking of children

Equal access to health care

Abuses:

- Lack of appropriate drugs, condoms, clean syringes and diagnostic and treatment procedures
- Refusal to care for or treat people with HIV, including refusal of hospital beds
- Lack of access to drug use treatment centers

Education

Abuses:

- Lack of access to information that enables people to make informed choices
- Refusal to provide education because of HIV status

Equal protection of the law

Abuses:

- Denying access to legal advice or services
- Compulsory testing of those accused in rape/abuse cases before a guilty verdict is pronounced
- Prosecution of HIV-positive sex workers

Privacy

Abuses:

- Lack of confidentiality or disclosure of test results without consent
- Compulsory reporting of people with HIV to health authorities (making HIV a notifiable disease)
- Partner tracing and notification without consent
- Compulsory testing of newborn babies

Self-determination

Abuses:

- Banning organizations by people vulnerable to or affected by HIV
- Lack of access to information that helps people make informed choices

Shelter, social security and housing

Abuses:

- Denial of access to housing or social services
- Eviction by landlords because of HIV status

Work and security

Abuses:

- Dismissal from or discrimination at work
- Limited or no insurance coverage or other benefits
- HIV testing as a precondition of employment

A9. Pregnancy, Childbirth and Feeding Your Baby

This sheet summarizes the information HIV-positive women need to minimize the risk of transmitting HIV to their babies. To obtain the most up-to-date information on prevention of mother-to-child transmission, consult a health professional; or if you have Internet access, go to <http://www.aidsmap.com/web/pb3/eng/1a3edd95-c60b-4bff-83d5-ce706aa88191.htm> or www.unaids.org.

HIV can be passed to babies from their mothers' bodies during pregnancy, during childbirth or through breastfeeding. Without effective prevention measures, the risk of HIV transmission from an HIV infected mother to her child, before or during the child's birth, is 15 to 25 percent. With some basic precautions, transmission rates during pregnancy, childbirth and breastfeeding can be reduced considerably, even as low as 2 percent.

Reducing the risk of HIV transmission

If you are able to keep healthy, this will be better for you and your baby. There are a number of ways that you can reduce the risk of infection being passed to your baby during pregnancy, during childbirth and if you breastfeed.

- Know your HIV status. This will help you to decide what steps you might be able to take to reduce the risk of transmission to your baby.
- Seek medical advice. Contact with health workers before or early in your pregnancy means that they can monitor your health and advise you about reducing the risk of transmission to your baby. It is best that your delivery is attended by a trained health professional who is aware of your status if you are HIV-positive, so that he or she can take the necessary steps to reduce the risk of transmission.
- Look after your health. Pregnant or breastfeeding women who are sick because of HIV are more likely to transmit HIV to their babies than women who are well. Rest is also important.
- Use condoms, especially if you have sex during your pregnancy and while you are breastfeeding. This will protect you against other strains of HIV and other sexually transmitted infections, which can be harmful to your own and your baby's health. If using condoms is a problem for your partner, it may help if you, or a health professional, explain that using condoms can reduce the risk of transmission to the baby.
- Eat a healthy balanced diet, including red meat and eggs, green vegetables, fruit and cereals.

Take antiretroviral (ARV) medicine if you have access to it (carefully following medical advice about what to take and when) to reduce the amount of the virus in your blood. ARV medicine can both reduce the progression of HIV in your own body and reduce the chances of transmission of HIV to your baby. There is more about antiretroviral medicine below.

Because all babies are born with their mother's antibodies in their blood, it can take up to 15 months before an HIV antibody test is able to show whether the baby has HIV.

More about pregnancy

All HIV-positive pregnant women ideally need regular care during pregnancy. Seeking early antenatal care means that tests can be carried out, illnesses identified (such as malaria or intestinal worms, which can cause anemia) and, where necessary, treatment given. Maintaining your own health by eating well, avoiding illness, using condoms, resting and taking ARV therapy is one of the most effective ways of reducing the risk of transmitting HIV to your baby.

More about childbirth

Strategies to reduce transmission of HIV during childbirth include:

- providing ARV therapy to women before and during delivery (and usually AZT or nevirapine to the baby after delivery).
- preventing prolonged and/or difficult labors. Birth attendants should not break the waters.
- avoiding interventions that cause bleeding such as episiotomies, using forceps to deliver or applying electrodes to the baby's scalp.
- having a caesarean section (CS) if you are HIV-positive but not on long-term combination therapy. Is this available near you?
- if you are HIV-positive and have a CS, you should be provided with antibiotics to reduce the risk of infection.

Feeding your baby

Breast milk is the best food for a new baby. However, breastfeeding is a route of HIV transmission.

Some HIV-positive women are now expressing their breast milk regularly and then pasteurizing it by heating it just until it starts to bubble round the edge of the pan, then letting it cool before feeding it to their baby. Preliminary research suggests that this might be a safe way of destroying the HIV virus in the milk.

If you would prefer not to breastfeed, consider the following questions:

- Do you have access to safe, clean water?
- Can you afford a replacement milk supply for six to twelve months?
- Do you have access to adequate utensils for feeding?
- Do you have access to fuel for sterilizing equipment and heating the milk?
- Will people guess that you might be HIV-positive if you do not breastfeed? Will that cause problems for you?
- Can you think of another reason to give if people ask why you are not breastfeeding? (For instance, that it hurts your breasts too much. Quite a few women find this, anyway.)

More about antiretroviral (ARV) therapy

A healthy mother is more likely to have a healthy baby. If a woman needs antiretroviral therapy for her own health, then giving these drugs to her is more likely to result in a) her own continued good health and b) reduced likelihood of transmission to her baby. In some situations, when a mother does not require therapy at present, “monotherapy” (normally zidovudine, also known as AZT, or nevirapine) can be given to her before and during delivery, and to the baby after delivery. Monotherapy also can be given in situations where combination therapy is not available (but where the mother ideally should have combination therapy). Although this reduces the risk of transmission to the baby, it does have drawbacks for the mother's health.

ARV therapy reduces the amount of virus in the bloodstream, therefore reducing the risk of transmission to a baby during pregnancy, delivery or through breastfeeding. ARV therapy may have side effects for both mother and baby. Many women believe that the benefits of having an HIV-negative baby outweigh the risk of complications in pregnancy or of the very low risk of birth defects.

A single drug (“monotherapy” – normally AZT or nevirapine) can reduce the risk of transmission to the baby during labor/delivery, but combination therapy is more effective. Ask your medical advisor about this. Monotherapy also can lead to the development of drug resistance in the mother. Again, it’s best to ask your medical advisor about this.

If you are already on combination therapy, you should continue your treatment while pregnant. Although taking drugs in the first three months of pregnancy is generally not advised, if you are already using combination therapy, it is best to continue. If you stop treatment, the amount of virus in your blood may increase, putting your baby at higher risk of infection.

Some combination therapy drugs are not recommended during pregnancy, so you may need to change them. Ask your medical advisor about this.

There are many things you can do that can help you and your baby stay healthy. If you can, try to find a group of other HIV-positive women with whom you can discuss the ideas and suggestions in this information sheet. Many HIV-positive women have found that it helps to do this.

A10. Gender-based Violence

What is Gender-based Violence?

Gender-based violence is when a man abuses or exerts his power to cause harm to a woman or girl. It is humiliating, painful and terrifying. The aim of the abuser is to intimidate, dominate and control the other person.

What Are the Forms of Gender-based Violence?

Gender-based violence takes four forms:

Physical: Hitting; slapping; punching; kicking; scratching; choking; pulling hair; biting; stabbing or hitting with a weapon; cutting; burning; throwing objects at; throwing gasoline or acid into face; forcing wife to abort a child; or dowry killings.

Emotional: Insulting; belittling; scolding; jealous suspicion; threatening; shaming and blaming the wife for having no children or having a girl; not raising children properly; or threatening the wife for questioning the husband's extra-marital affairs.

Economic: Controlling all household spending; withholding necessary household money; wasting family money (e.g., drinking, playing cards); preventing wife from earning money; forcing wife to do work against her will; grabbing the money she has earned; forcing a wife/daughter to do excessive work; or dowry harassment.

Sexual: Forcing a woman to have sex against her will (marital rape); forcing her to do oral/anal sex; inflicting pain during sex; preventing wife from using birth control; refusing to use a condom when wife has concerns about sexually transmitted infections (STIs) including HIV. Sexual violence also includes rape, sexual teasing and coercion at work places or schools, and incest.

What Are the Effects of Gender-based Violence?

Gender-based violence results in the following:

Physical: Cuts and bruises; broken bones and other injuries; chronic back or neck pain; beatings to the head, which may result in brain or eye damage, or hearing loss; disability (e.g., loss of function of fingers, hands, legs); disfigurement; miscarriages; exposure and increased vulnerability to STIs and HIV.

Psychological: Feeling belittled or worthless; shame; fear; isolation; loss of self-esteem; self-blame and denial; loss of sense of control over life; stress; anxiousness; depression; sleeplessness; feeling suicidal.

Economic: Deprived of income and economic support; loss of property; reduced ability to work and generate income.

Effects on family: Family breaks up through desertion, separation, divorce, property loss; children are fearful of violence, unable to talk, depressed, drop out of school.

Effects on HIV epidemic: Because of the fear of violence, the woman cannot negotiate safe sex, so she cannot protect herself from getting HIV. She does not tell her husband if she discovers she has an STI or is HIV-positive. As a result she may get infected or she may infect her husband, and the HIV epidemic spreads.

What Are the Causes of Gender-based Violence?

The central cause of gender-based violence is **gender inequality**, or unequal power relations between men and women. Men have been socialized to dominate and control women; and women have been socialized to submit to men and not question male behavior. Women are treated with contempt, stigmatized as “inferior,” “bad luck” and “a burden.” Given this lack of respect, men feel they have a right to abuse women.

Some men treat women as property. The men feel they own the women and therefore have a right to do anything to them without being questioned. They also feel that it is acceptable to express their anger through intimidation, verbal abuse or physical beating. Some men think that beating women is “a form of discipline.”

There are a number of “triggers” to gender-based violence, including poverty; alcohol; men’s insecurities and jealousies; perceptions that a woman is “talking back” or “disobeying”; arguments over money; a women’s perceived inability to bear male children; dowry pressures, etc.

Why Don’t Women Report Violence to Authorities?

Women don’t report violence to the police for the following reasons:

- They fear that if they report the violence, the physical violence will continue.
- They also fear they will lose economic support and be kicked out of the home.
- They fear that reporting the violence will bring shame on the family.
- They have been taught to stay silent and protect the family secrets at all costs.
- Women are not aware of their rights and have accepted gender-based violence as a norm.

Gender-based Violence, STIs and HIV

- Men who have sexually transmitted infections (STIs) like HIV and have sex with women despite this knowledge, are perpetuating a form of sexual violence. If a man who has STI symptoms has unprotected sex with a woman, he knows he is giving her the STI too. He may also be HIV-positive, since STI and HIV co-infection is relatively common. If he is HIV-positive and has sex while he has open sores or a discharge on his penis, the risk of giving the woman HIV increases significantly.
- Fear of violence prevents a woman from protecting herself from HIV or STIs. She is afraid she will be beaten if she refuses to have sex or asks the man to use a condom, despite knowledge of extramarital affairs or HIV/STI infections, and therefore finds it difficult to protect herself from HIV or STIs.
- Fear of violence stops a woman from telling a man that she has an STI or HIV. This fear prevents her from seeking STI treatment from a health care provider, which she cannot do without her husband’s consent. As a result she will continue to have unprotected sex with her husband and give him the STI or HIV.
- Sexual violence, which involves forced sex, increases risk of HIV transmission. Sexual violence results in bleeding in the vagina and small internal cuts or sores that make it easier for the virus to be transferred.
- Women are vulnerable to getting HIV because of their vulnerability to other forms of violence such as rape in the workplace or in the community.

- Women’s fear of violence, which limits their control over their sexual lives, is a major factor in the growing spread of HIV in Africa.
- Women face severe violence when HIV or STIs enter the home. They are the first to be blamed and abused (for getting HIV) even if the husband is the carrier. Women are beaten, chased from their homes, abandoned to relatives, and lose their property. When women become sick, they are abandoned and left on their own.

Cycle of Domestic Violence

Domestic violence often follows a pattern. The man first abuses the woman verbally, then starts to slap her, and then moves to battering. Following this there may be a “honeymoon” phase, when the husband is loving and kind. However, the cycle usually repeats itself.

Women’s Response

Many women who suffer through a long-term, violent relationship are often reluctant to get out of the relationship. Men may threaten women to keep them from leaving. Women may feel unable to tell their relatives, fearing that they will be blamed or not taken seriously. Women also may fear losing their children or that the children will be harmed if there is an open conflict in the marriage. Women may not want to break up the family, admit the marriage has failed or they may simply have nowhere to go. Sometimes they have no choice but to stay in a violent relationship.

How Does the Community View Gender-based Violence?

Gender-based violence can be seen as normal. Communities may believe men have the right to beat their wives as a form of discipline.

Health care providers may see gender-based violence as normal. They treat it as an “accident,” rather than something they need to take action on.

Gender-based violence is perceived as a “domestic affair,” which needs to be resolved at home, not taken to the police station. Communities often believe that women should not tell others about being beaten by their husbands.

Gender-based Violence is Wrong

- Gender-based violence is painful and humiliating. It destroys women’s health and self-esteem, their productivity, and the health of the family and community.
- Gender-based violence also fuels the HIV epidemic. Women become silent out of fear and don’t disclose their status to others, creating a cycle of HIV infection.
- Gender-based violence is not acceptable. Even a slap is violence. Gender-based violence should be stopped, rather than accepted in silence.
- There is no excuse for violence. Nobody deserves to be beaten. Women have the right to be safe from all forms of violence.
- Assault is a criminal offense. People who beat women should be held accountable for their behavior.
- Health providers should do more than patch women up and send them home.

What Can a Community Do to Fight Gender-based Violence?

- Talk with family, friends and clients, and encourage community leaders to speak out against gender-based violence. Get people talking openly and make this problem visible.
- Help everyone—men, women and children—understand that gender-based violence is wrong.
- Stand up and challenge others when they “blame and shame” women. Stop the stigma toward women and girls. Women should be respected.
- Reach out to abused women and support them. Once they feel accepted, they will be more open to discussing their situation with others and getting help.
- Empower women and educate them on how to get support when abused.
- Form women’s groups and encourage women to support each other.
- Encourage women to report violence to police and get police to treat them seriously.
- Get police to enforce existing laws on domestic violence.
- Address problems of excessive drinking.

What Can Health Care Providers Do to Counsel Women Who Have Been Abused?

- Welcome the woman and make her feel comfortable. Treat her with respect.
- Meet with the woman without her husband and help her decide what she wants to do. Don’t try to counsel the couple together and “negotiate violence.”
- Give her time to tell her story and express her feelings. Let her do the talking.
- Give her your full attention and listen attentively. Remember – a good counselor has big ears, big eyes, and a small mouth.
- Listen to and believe what she has to say. She needs a friendly, supportive ear, not a challenging or accusing response. She needs help, not disbelief or hostility.
- Build on her strengths. Compliment her on what she has achieved so far, her coping strategies and survival skills such as coming to see you.
- Don’t question her behavior by asking questions such as “What did you do to make him so angry?” or suggest that her behavior provoked the violence. Focusing on her behavior will not solve the problem. The problem is with the man’s controlling behavior.
- Tell her that:
 - you will treat her information in confidence, and you will not tell other people.
 - she is brave to talk about her problem. It is sometimes difficult to talk about these things and sometimes it feels easier to stay silent and suffer.
 - violence is wrong. No one has the right to beat another person.
 - getting beaten is not her fault. She did not ask to be beaten.
 - her feelings of love, anger, betrayal, hope, fear, sadness, guilt are all normal.
- After she has explained her situation, get her to talk about what to do next. Be realistic and do not frighten her.
- Help her plan for her safety. Don’t tell her what to do. Help her consider her options, but empower her to make her own decisions.

- The woman will decide if she wants to press charges. Many women want to end the violence, but maintain the relationship. If she leaves, she might lose her home, economic support and children, so this is a difficult choice.
- Some health care providers may refuse to take responsibility for this type of case by declaring that it is not a health issue. Gender-based violence, however, is a health issue. It results in injury, chronic health problems and even death. If a woman reports her case and you see her injuries, you are obliged to help get it reported to the police.

How to Advise a Woman on Her Options

- Discuss which trusted people might support her to cope with the situation.
- Discuss going to the police to take legal action.
- Discuss options to prevent or end the violence and help her decide on the best course of action. Her options might be:
 - Leave her husband and live with a supportive person.
 - Get support from others (e.g., community leaders, relatives, friends) to change the man's behavior.
 - Build the woman's support network to pressure the man to change.
 - Address triggers that result in violence such as alcohol abuse
 - Support the woman to go to the police.
- Consider the pros and cons of each option. This will help the woman make an informed decision. Do not expect a quick solution as it often takes time for a woman to work through her feelings and options.
- Support the woman in whichever action she wants to take.

ATI. Cervical Cancer and Pap Smear Tests

What is Cervical Cancer?

Cervical cancer is the rapid, uncontrolled growth of abnormal cells on the cervix. The cervix is the lower part of the uterus that opens into the vagina. If and when detected early, cervical cancer is curable.

Cervical Cancer and HIV

Women living with HIV are at greater risk of developing cervical cancer because HIV has suppressed their immune system. Women living with HIV tend to have multiple types of the Human Papilloma Virus (HPV) because as HIV progresses, the ability of the immune system to control the HPV infection is reduced. Higher levels of HPV can result in the development of HPV-related diseases such as cervical cancer.

What Makes a Woman Vulnerable to Cervical Cancer?

- Infection with a virus such as HPV
- Multiple sexual partners
- Engaging in sexual intercourse at an early age, especially before age 18
- Smoking
- Sex with someone who have had sexual contact with a woman with cervical cancer

The good news is that cervical cancer is preventable. It can be cured if it is diagnosed early.

How is Cervical Cancer Diagnosed?

Cervical cancer can be detected with a Pap smear test, which evaluates the health of the cervix and screens for cervical cancer. The doctor or nurse scrapes a small sample of cervical cells and smears them onto a glass slide to be analyzed under a microscope. Abnormal cells sometimes will go back to normal on their own, but sometimes they continue to develop and, if left untreated, can develop into cancer.

Why is a Pap Smear Test Important?

If the Pap smear test detects cervical cancer, treatment can prevent the cancer from developing.

Who Should Have the Pap Smear Test?

All women should go for a Pap smear test three years after their first sexual intercourse, and then once per year. The test is free in public hospitals.

What Should You Do Before the Test?

- Do not have sexual intercourse in the 24 hours before your smear test. Sperm, spermicidal gel, and lubricants can make it difficult to get a good sample of cells. If you are treating any vaginal infection, wait for at least a week after treatment has finished. Make sure you inform your doctor beforehand.
- Do not use vaginal creams or apply any the day of your smear test.
- Do not use a tampon for at least two days before your smear test.

Where Can You Get a Pap Smear Test?

Most women have the test at their local public hospital and it is usually done by a nurse. Ensure consultations with your doctor to closely monitor and manage HIV and HPV infection. This includes regular visits to the doctor, monitoring of CD4 count and viral loads, and routine pap smears as recommended by the doctor.

What are the Signs and Symptoms of Cervical Cancer?

During the early treatable stages there are usually no signs or symptoms of the cervical cancer. As cervical cancer progresses, the following signs and symptoms will appear:

- Persistent vaginal discharge, which may be pale, watery, pink brown, blood streaked or dark and foul smelling.
- Abnormal bleeding after sex, or before and after menstruation.

ANNEX B:

Energizers

You can use some of these games as warm-ups at the start of workshops or when energy levels are low.

Openers/Ice-Breakers

Write Your Name in the Air: Ask participants to write their name in the air – first with right hand; then left hand; and then both hands, elbow, nose, knee or foot.

Three Greetings and Run (Howdy, Howdy): Participants stand in a circle holding hands. The leader walks around the outside of the circle and touches someone on the back. The two people race around the circle in opposite directions. When they meet, they stop and greet each other three times. Then both continue going around the circle until they reach the empty place. Whoever loses walks around the outside and touches a new person and the game continues.

Front-to-Front/Back-to-Back: A caller shouts out “*Front to Front,*” “*Back to Back,*” “*Foot to Foot,*” etc., and pairs are expected to follow directions. When he shouts “*Change,*” everyone finds a new partner. The person left without a partner becomes the new caller.

Passing Objects around the Circle while Singing: Ask each participant to pick up any object (e.g., stone, pen, etc.). At an agreed signal, everyone starts singing a song and passing the objects around the circle to the rhythm of the song.

The Knot: Form groups of eight people. Ask each group to stand in a tight circle. Each person reaches out and holds the hands of **two** other people across the circle, not the people on either side of him. He should **not** hold the hands of the same person; they should be two different people. This creates a “knot.” The aim is to untangle without letting go of hands until everyone is standing together in one circle. Talk about the experience after the game.

Tsunami: Draw five, non-overlapping circles with chalk on the floor, big enough to fit all participants. Give each circle, or “island,” a name. Then say that one island will be hit by a tsunami so those people will have to move quickly to another island. Allow the suspense to build, then call out the name of the island that will be hit. Participants run to the other islands. The game continues until everyone is squashed into one island. Afterwards, discuss the game with participants, focusing on cooperation (or lack of it) within the group.

Competitive Games

Tiger-Person-Gun: Divide into two teams. Introduce three symbols: (1) TIGER (action: claws raised in the air and a roar); (2) PERSON (action: hands folded across chest); (3) GUN (action: hands pointing a gun). Then explain the scoring system: TIGER wins over PERSON; PERSON wins over GUN (PERSON controls GUN); and GUN wins over TIGER. Ask each team to secretly decide on their symbol. Then get the two teams to line up facing each other. At a signal, teams show their symbols. Announce the winner. Then ask teams to select another symbol (secretly), and the game continues.

Switching Roles: Set up the chairs in a circle so that there is one less chair for the number of people in the group. Allocate roles to each person going round the circle – “*health worker...traditional healer...chief... health worker...traditional healer...chief...*” When a role is called out, all those who have been assigned that role have to run and find a new chair. When the “caller” shouts “*revolution!*,” everyone has to run. Each time, the person left without a chair becomes the new caller.

The Wind Blows For: Set up the chairs in a circle so that there is one less chair for the number of people in the group. Then shout, “The wind blows for...” and add a descriptive phrase (e.g., “everyone wearing a watch.”) Everyone who is wearing a watch has to get up and run to another chair. As the caller, you also run and find a seat. Whoever is left without a seat becomes the new caller. Other examples include: “The wind blows for everyone who...has a beard, wears glasses, is single, is in love, ate too much for lunch, is bored with this game!”

Touch Blue: Ask participants to walk around. When you shout “Touch blue!” each player has to find something blue on another player and touch it. Then give other instructions: “Touch...someone with a beard, someone wearing glasses, something yellow, someone wearing sandals, etc.” Each time, participants must touch what the leader calls out.

Pass the Action: Players sit in circle. “A” stands in the center of the circle. “A” walks toward “B,” using a specific action (e.g., hopping or walking with hands above the head). When she reaches “B,” “B” walks to the center of the circle using “A’s” action. When “B” reaches the center, he walks toward “C” using a new action or movement. The game continues until everyone has taken part.

Quick Energizer

Coconut: Ask participants to stand up and spell “coconut” with their arms, one letter at a time. Ask participants to use both hands and make large letters in the air.

Affirmation Claps

Unity Clap: Rub your hands together and shout “FIRE” (in the local language) and everyone joins you in rubbing hands together, and then, following your lead, the whole group does one big thundering clap, all at the same time.

Thunder Clap: Move your hands in the air forming the shape of clouds and shout in the local language, “*Rain clouds*” – and people join you. Then say, “*Let’s have a light rain,*” and start a soft clap, everyone joining in. Then ask for heavier rain and everyone claps harder. Then shout at the top of your voice “*Thunder*” and everyone claps once and then another “*Thunder*” again and a second clap.

Fingers-Hands-Feet: Three finger snaps in the air, three claps, and three foot stomps.

Nguni Clap: Ask everyone to clap fast and then throw their arms and body back and say “Aaaaaaaaaaaaaaaaaaaaaaa.”

Back Clap: Everyone claps the back of person to his/her right.

Locomotive Clap: Do a rotating motion with your hands. Every time you rotate your hands, participants do a single clap. Then you speed up and soon the whole group is clapping fast.

ANNEX C:

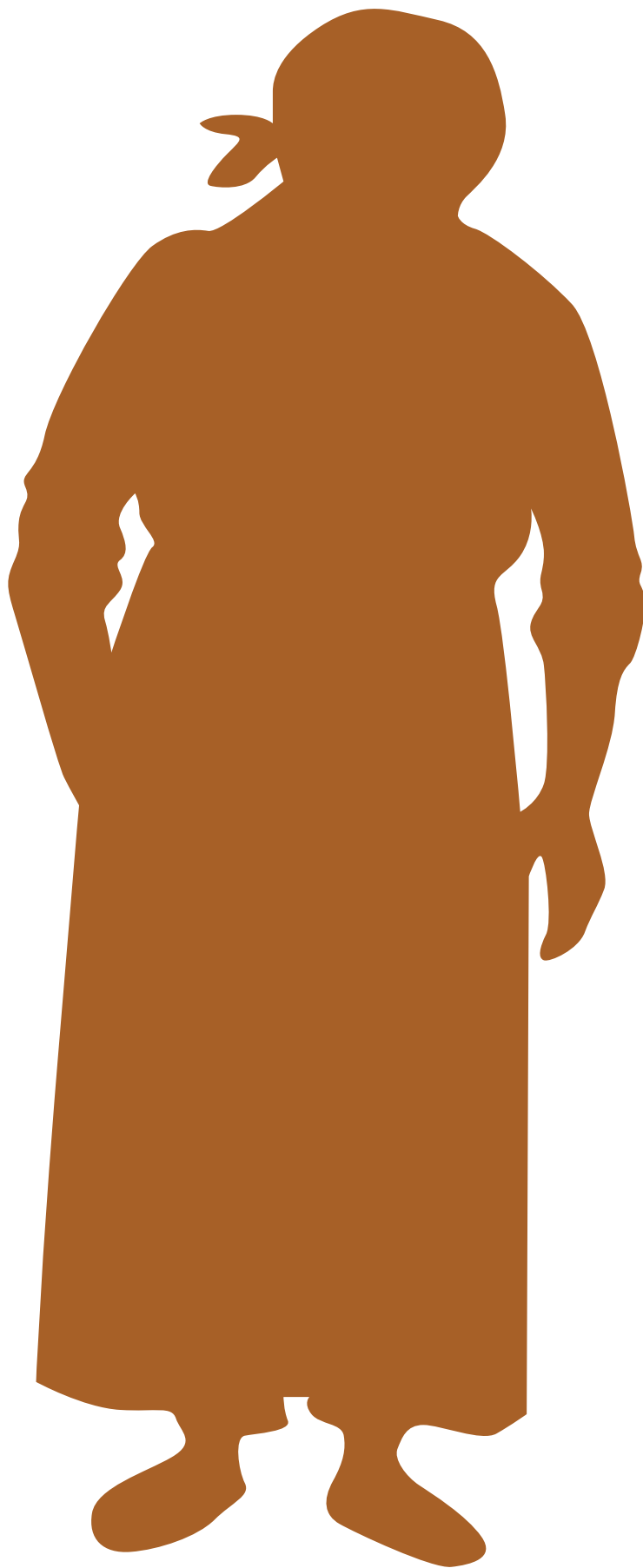
Silhouettes

Silhouettes adapted from Kidd, Ross; Sue Clay and Chipso Chiiya. 2007. "Understanding and Challenging HIV Stigma: Toolkit for Action." Brighton, U.K.: Academy for Educational Development, International Center for Research on Women (ICRW) and International HIV/AIDS Alliance.

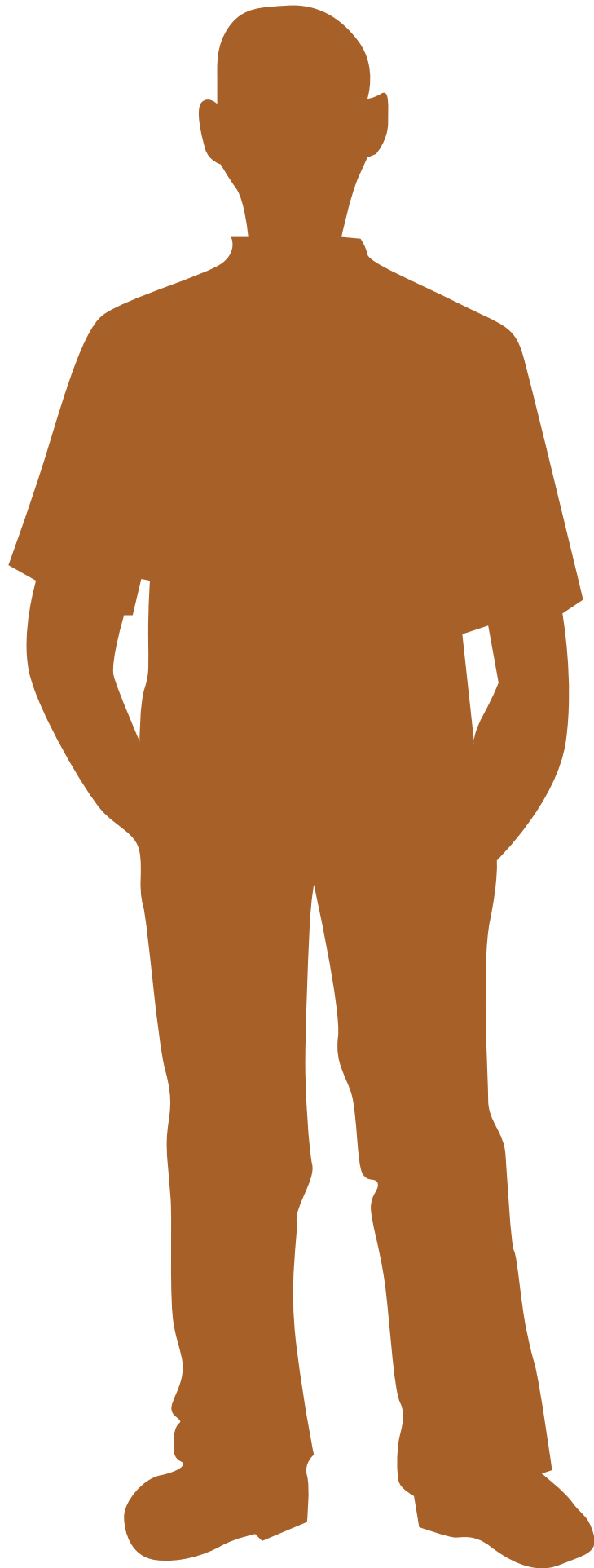
Silhouette 1



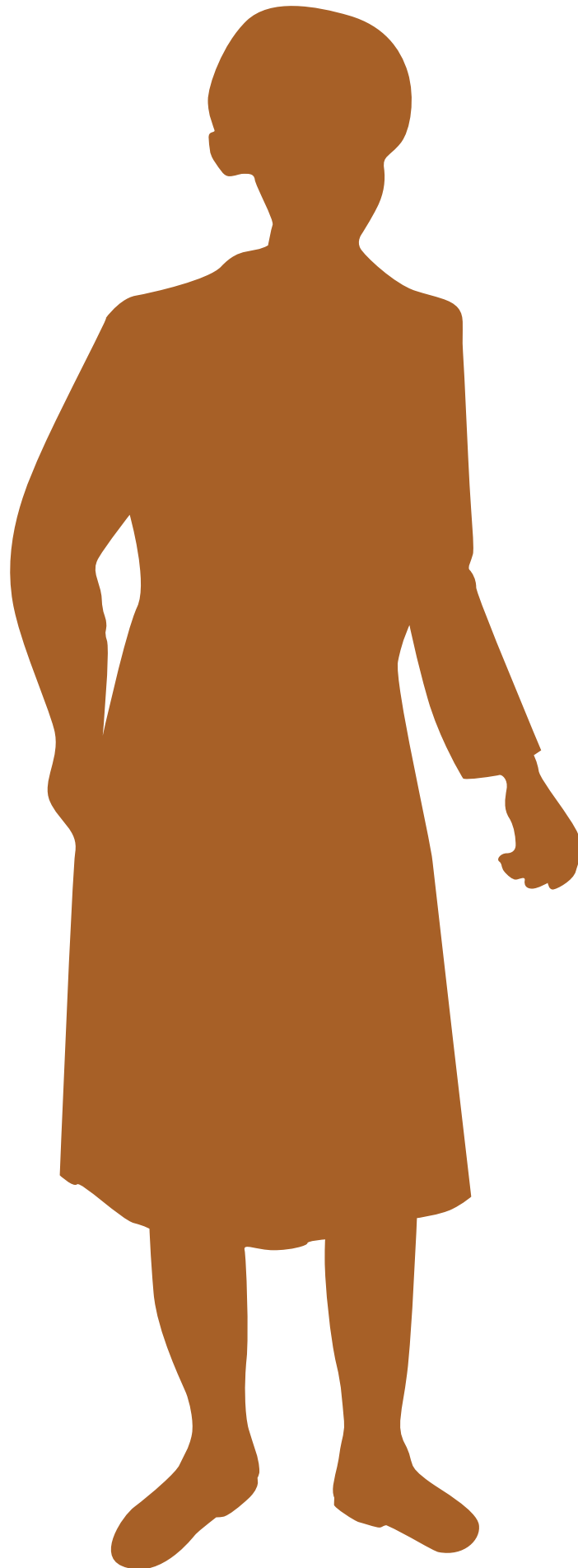
Silhouette 2



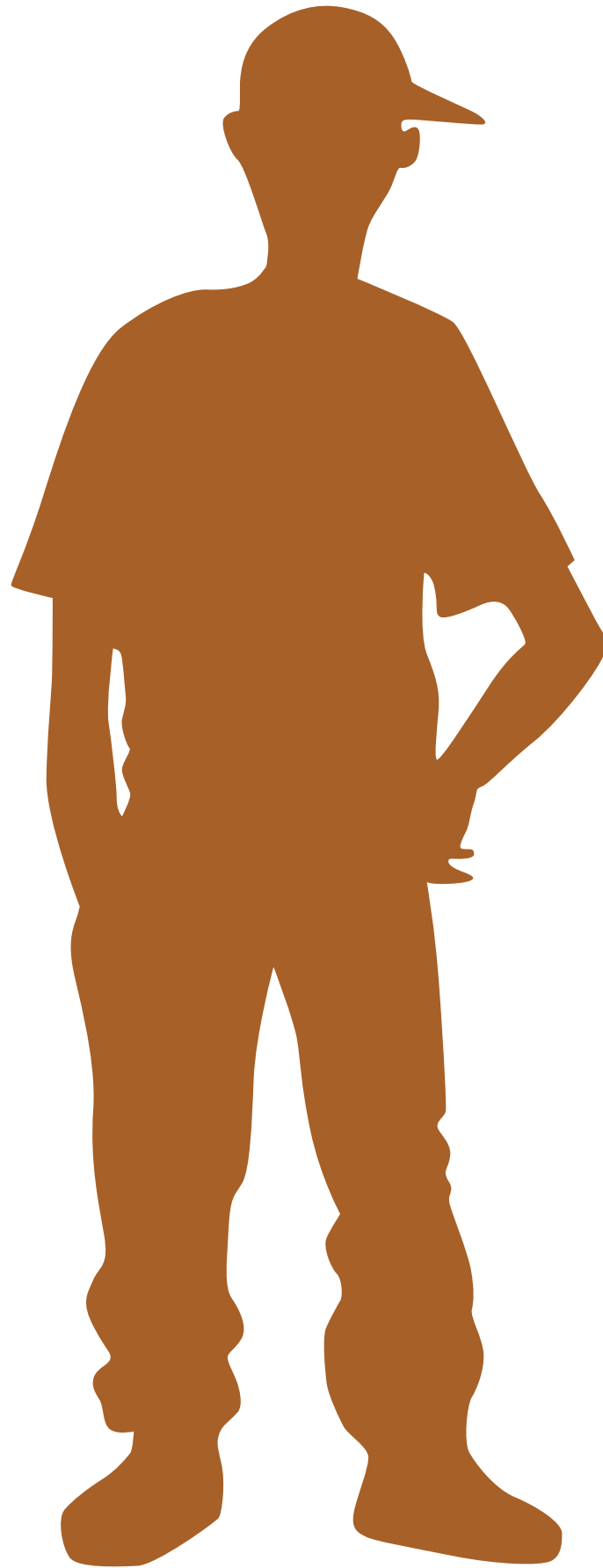
Silhouette 3



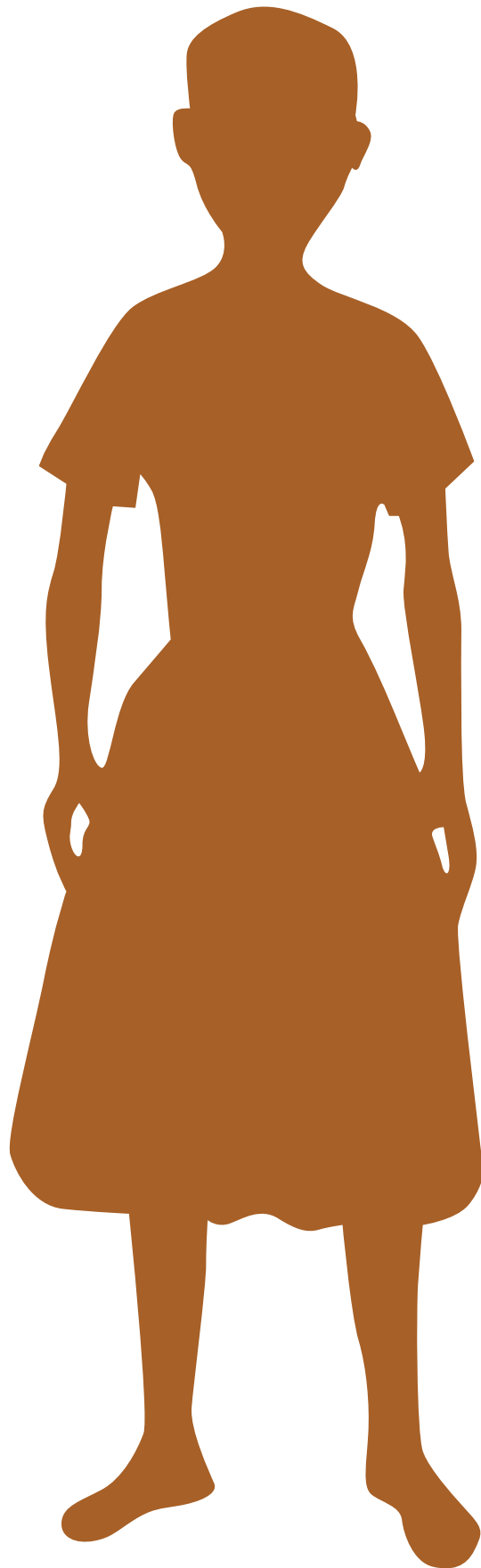
Silhouette 4



Silhouette 5



Silhouette 6



Silhouette 7



Parliamentarians for Women's Health

The Parliamentarians for Women's Health project seeks to assist select parliamentarians in East and southern Africa to more effectively improve women's and girls' access to health services, particularly HIV and AIDS treatment, prevention, care, and counseling. The project provides technical assistance to build capacity, increases links between parliamentarians and civil society (especially organizations of women with HIV), and convenes national and regional workshops for the purpose of increasing parliamentarians' awareness of women's health care needs and economic and political barriers in their countries. The expectation is that these and other project activities will support parliamentarians' leadership in improving women's access to health care services and resources.

Funded by the Bill & Melinda Gates Foundation, this three-year project is being implemented by the International Center for Research on Women (ICRW), the International Community of Women Living with HIV (ICW), Realizing Rights: The Ethical Globalization Initiative (EGI) and the Centre for the Study of AIDS (CSA) of the University of Pretoria. ICRW leads the consortium.



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