



USAID
FROM THE AMERICAN PEOPLE

**HEALTH POLICY
INITIATIVE**



Women-Centered Curriculum:

Addressing HIV among Women and the Gender Dimensions of HIV in the Middle East and North Africa Region

Investing in PLHIV Leadership in the Middle East and North Africa—Volume 3

This publication was produced for review by the U.S. Agency for International Development. It was prepared by staff of the Health Policy Initiative, Task Order 1.



USAID
FROM THE AMERICAN PEOPLE

**HEALTH POLICY
INITIATIVE**



WOMEN-CENTERED CURRICULUM:

Addressing HIV among Women and the Gender Dimensions of HIV in the Middle East and North Africa Region

Investing in PLHIV Leadership in the Middle East and North Africa — Volume 3

JULY 2010

This publication was produced for review by the U.S. Agency for International Development. It was prepared by staff of the Health Policy Initiative, Task Order I.

Suggested citation: Amy Kay, Mari Jo Vasquez, Shetal Datta, Rita Wahab, and Eman Said. July 2010. Women-Centered Curriculum: Addressing HIV among Women and the Gender Dimensions of HIV in the Middle East and North Africa Region. Investing in PLHIV Leadership in the Middle East and North Africa—Volume 3. Washington, DC: Futures Group, Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order I, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. HIV-related activities of the initiative are supported by the President’s Emergency Plan for AIDS Relief. Task Order I is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute.

ACKNOWLEDGMENTS

The USAID | Health Policy Initiative, Task Order 1, “Investing in PLHIV Leadership in MENA” initiative has worked with key partners since 2005. The MENA initiative has been funded by the U.S. Agency for International Development through the Office of HIV/AIDS and the Bureau for Asia and the Middle East. We are also grateful for the partnerships with the United Nations Development Program’s HIV/AIDS Regional Program in the Arab States, the International Community of Women Living with HIV, the AIDS Alliance, and national AIDS programs in the region, as well as L’Association Tunisienne de Lutte Contre Les Maladies Sexuellement Transmissibles et Le Sida and other local organizations, including nongovernmental organizations and support groups region-wide.

This curriculum was developed because women living with HIV in the region wanted to create a specific workshop that provided space for other women like them to discuss their concerns, create bonds, and unite in their responses to HIV to aid them in meeting challenges women face and opening doors for service and hope. After piloting the workshop, participants wanted the opportunity to share sessions and information in their home countries.

The authors also acknowledge the overall guidance and support lent to the Investing in PLHIV Leadership in MENA initiative by Jennifer Mason, Gary Cook, Billy Pick, Shelley Snyder, as well as Marissa Bohrer, Emily Osinoff, Patty Alleman, Shannon Kelly, and Karen Stewart of USAID, Washington D.C. We are also especially thankful for the inputs of women from the 16 states the Health Policy Initiative Investing in PLHIV Leadership in the Middle East and North Africa (MENA) activity covers. These women provided their stories, suggestions, and valuable insights to ensure that the curriculum reflected the situation of women living with HIV in the region and provided information they can use to address issues they face every day.

TABLE OF CONTENTS

Acknowledgments	ii
Abbreviations	v
Introduction to the Manual.....	vi
Women’s Workshop Overview Agenda.....	1
Day 1: Introduction, Human Rights, Gender Terms, and Key Concepts.....	2
Session One: Introductions.....	3
Session Two: Training Expectations, Goals, and Objectives	12
Session Three: Review Women’s Workshop Agenda and Logistics	16
Session Four: Participant Baseline Questionnaire.....	18
Session Five: Setting Ground Rules	19
Session Six: Why a Human Rights Focus?	24
Session Seven: Gender and HIV	28
Session Eight: Closing and Evaluation.....	39
Day 2: Power, Identity, Understanding Our Bodies, and Sexual Health.....	42
Session One: Welcome and Review	43
Session Two: Body Mapping	44
Session Three: About Sex and Sexual Health	46
Session Four: The Gender Lens.....	51
Session Five: Power in Relationships.....	54
Session Six: Agree / Disagree / I Don’t Know	57
Session Seven: Young Women’s Dialogues	60
Session Eight: Closing and Evaluation.....	63
Day 3: Family Living	64
Session One: Welcome and Review	65
Session Two: HIV-positive Women Discuss Safe Motherhood.....	66
Session Three: Violent Relationships.....	69
Session Four: What Is Love?.....	75
Session Five: How to Discuss Feelings about a Problem and Couple’s Communication.....	77
Session Six: Serodiscordant Couples Discussion	82
Session Seven: Closing and Evaluation.....	85
Day 4: Stigma and Discrimination, Disclosure, Participation, and Leadership.....	86
Session One: Welcome and Review	87
Session Two: Naming Stigma in Your Life and Community.....	88
Session Three: Addressing Stigma and Discrimination	90
Session Four: Disclosure: What, When, How, and to Whom?.....	92
Session Five: Addressing Disclosure to Our Children and Those Who Interact with Them	95
Session Six: Participation	98
Session Seven: Building Leadership	102
Session Eight: Building the Dream and Next Steps	104
Session Nine: Workshop Closing.....	106
Glossary of Terms.....	108
Annex 1: Interpreter Confidentiality Agreement	113

Annex 2: Subject Release Form/Photo Consent Form	114
Annex 3: Women’s Workshop Participant Criteria	115
Annex 4: Women’s Workshop Agenda	116
Annex 5: The Tripoli Declaration.....	117
Annex 6: Women’s Workshop Participant Baseline Questionnaire	118
Annex 8: Sexual and Reproductive Health Rights.....	127
Annex 9: Prevention of MTCT	128
Annex 10: Couple’s Communication Handout	131
Annex 11: Scenarios for Exploring Strategies to Improve Couple Communication and Decisionmaking	132
Annex 12: VAW-ICW-GCWA Fact Sheet.....	134
Annex 13: Evaluation Template	138

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
CEDPA	Centre for Development and Population Activities
FGC/FGM	female genital cutting/female genital mutilation
GBV	gender-based violence
GIPA	greater involvement of people living with HIV
HIV	human immunodeficiency virus
MENA	Middle East and North Africa (Region)
MIPA	meaningful involvement of people living with HIV
MTCT	mother-to-child transmission
NGO	nongovernmental organization
PLHIV	people living with HIV
PPT	PowerPoint
PMTCT	prevention of mother-to-child transmission
PTCT	parent-to-child transmission
Q&A	question and answer
S&D	stigma and discrimination
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
USAID	United States Agency for International Development
VCT	voluntary counseling and testing

INTRODUCTION TO THE MANUAL

Curriculum Overview

The purpose of this Women’s Workshop Curriculum is to support a truly sustainable HIV response in the Middle East and North Africa (MENA) Region, centered on positive leadership, women’s leadership, prevention, education, and mentorship, as well as gender equity and sensitivity. It is the first curriculum of its kind to be implemented by and for women living with HIV in the MENA Region and thus marks a shift in power from people living with HIV (PLHIV) as beneficiaries, imparters of testimonies, and workshop participants to experts taking a more active role in the response to HIV. It also marks a shift in power to include women more equitably and meaningfully in the HIV response.

The authors of the curriculum include women living with HIV in the MENA Region and globally, as well as professionals and supporters who have worked on the HIV response in the region. Global practitioners and more than 50 women living with HIV from 13 countries in the MENA Region have provided inputs to this curriculum. It has been pilot-tested in trainings in Tunisia and sessions in Bahrain, Lebanon, and Yemen.

When implemented, the curriculum will help meet the following broad objectives:

- Women living with HIV and affected by HIV in MENA will have the opportunity to work together and understand and solve issues that are important in their lives;
- Participants will have strengthened ability to address challenges they face as women living with HIV, parents of HIV-positive children, and partners of HIV-positive people;
- Women living with HIV in the region will have created a foundation for greater networking and support for themselves and other women like them.

Methodology and Design

The Women’s Workshop is part of a broader sustainability methodology under the Investing in PLHIV Leadership in MENA initiative, which has focused on capacity transfer. It is based on the premise that capacity transfer is a process that leads to sustainability. The process includes:

- **Awareness raising** among people living with HIV and those affected, based on evidence and followed by social mobilization and dialogue;
- **Networking** by first building group cohesion, followed by strategic alliance building and learning by doing; and
- **Capacity building**, focusing first on individual competencies, then regional and local organizational competencies, technical knowledge, and systems development.

The Women’s Workshop curriculum provides a basic program designed to promote capacity transfer focused on women and HIV in the MENA region. The curriculum is primarily discussion based, with the aim of drawing the most knowledge about women living with HIV in MENA from the participants themselves—using them as experts who can both contribute to and benefit from awareness raising, networking, and capacity building in lieu of the facilitators simply transferring knowledge.

The program is divided into four full-day sessions; however, the length of both days and sessions can be modified as needed. For example, workshop facilitators can also set aside time for sessions that feature local experts or visits to local service providers, nongovernmental organizations (NGOs), and support groups, as well as time for informal discussion and group activities. You may also find that on the first day, the local group of women joining your workshop may want to talk a lot with each other and share from personal experiences. Because of this, you may want to modify the times for sessions based on the participants and what you know about them.

Learning Principles

The Women's Workshop curriculum is based on the following adult learning principles and those of Greater Involvement of People Living with HIV (GIPA):

- **Learning is self-directed.** Adults can share responsibility for their own learning because they know their own needs.
- **Learning fills an immediate need and is highly participatory.** Motivation to learn is the greatest when it meets the learner's immediate needs. The most effective learning is from shared experience; learners learn from each other, and the trainer often learns from the learners.
- **Learning is experiential.** Again, participants and the trainer learn from one another; learning is based on doing and on a collection of experiences.
- Time in training is allowed for **reflection and corrective feedback.** Maximum learning from a particular experience occurs when a person takes the time to reflect back on it, draw conclusions, and derive principles for application to similar experiences in the future.
- A **mutually respectful environment** is created between facilitators, resource staff, and participants.
- Workshop facilitators provide a **safe atmosphere** and comfortable environment.
- **PLHIV leadership, prevention, education, gender equity, and mentorship** are crucial components of the HIV response.

This participant-centered workshop format uses interactive and experiential activities, including small group discussion, role plays, interpersonal skills practice, personal and group assessment, training and knowledge-sharing tools, and open discussion formats.

The curriculum is organized according to a daily agenda. Each section begins with a general introduction to the topic. Sessions contain background notes for the facilitator, learning objectives, descriptions, and directions. The approximate time required to complete each session is indicated at the start of the session, as are the needed materials and preparation. Within each day, facilitators present activities such as role plays, discussions, and brainstorming to help participants internalize their learning.

Training techniques used in this manual include the following:

- **Presentations**—activities conducted by the facilitator to convey information, theories, or principles
- **Case Study Scenarios**—written descriptions of real-life situations used for analysis and discussion
- **Role Plays**—two or more individuals enacting parts in scenarios as related to a training topic
- **Small Group Discussions**—participants sharing experiences and ideas and problem solving together
- **Hands-on Application**—learning skills through hands-on training and practice

Tips for Using the Curriculum

It is the facilitator's role to present each session's background material, objectives, and activities as clearly as possible. Skills used to enhance communication include key verbal and nonverbal communication skills. Effective facilitation also includes the following:

Setting the Learning Climate

- Read each session and review all materials and activities before each training session so that as the facilitator you are fully comfortable with the content and process.
- Start on time and clearly establish yourself as the facilitator by calling the group together. Remember, the facilitator does not have a supervisory role, but rather is someone who facilitates the learning process of the group. If punctuality is an issue—as it often is in our region—do your best to start on time but perhaps with a less critical session, such as a review of the previous day, an evaluation, or an energizer, to start the day.
- Organize all of the materials you need for the session and place them close at hand. You should make any handouts, flip charts, and PowerPoint presentations beforehand during the preparation week. These always take longer to prepare than we think!
- Stay within suggested timeframes. If you see that the group is processing and learning, allowing a bit more time is appropriate, but with group work, one group often will be rather fast, while another will need more time. Be sure to strike a balance so no one feels rushed or bored.
- Gain participants' attention and interest by establishing a rapport with them. Make them feel welcome at all times. Encourage any questions and never criticize participants for their questions or work.
- Anticipate questions. It is always best to be able to answer all questions participants may have, but if there is a question you do not know the answer to, do not pretend you do. Let the participant know you will research the answer and get back to them.
- Prepare responses and examples to help move the discussion forward. It is always best to give an example or illustration of the answer you are providing. Stories based on work and life experiences are helpful.

Presenting the Objectives

- Provide a link between previous sessions and the current one to ensure consistency and ensure that the participants understand and experience progression in the learning process.
- Use the background notes to introduce the topic or prepare for the session.
- Inform participants of what they will be doing during the session to meet the session's objectives. Write objectives on a flip chart and review them for each session. Review them again at the end of each session and include them in your evaluation.

Initiating the Learning Experience

- Introduce as appropriate an activity in which participants experience a situation relevant to the objectives of the session.
- Let participants use the experience as a basis for discussion during the next step.
- If you begin a session with a presentation, follow it with a more participatory activity.

Reflecting on the Experience

- Guide discussion of the experience.
- Encourage participants to share their reactions to the experience.
- Engage participants in problem-solving discussions.
- See that participants receive feedback on their work from each other and from you.

Applying Lessons Learned to Real-life Situations

- Encourage participants to discuss how the information learned in the activity will be helpful in their own work.
- Discuss problems participants might experience in applying or adapting what they have learned to their own or different situations. However, the conversation should not get weighed down with potential problems; instead, focus on realistic solutions and adaptations.
- Discuss what participants might do to help overcome difficulties they encounter when applying their new learning.

Providing Closure

- Briefly summarize the activities at the end of each day.
- Refer to the objective(s) and discuss whether and how they were achieved.
- Discuss what else is needed for better retention or further learning in the subject area.
- Provide linkages between the sessions of the day and the rest of the workshop.
- Help participants leave with positive feelings about what they have learned and accomplished.
- A certification or a “graduation” can provide a great means of closure, acknowledgment of learning and hard work, and legitimacy for trainers-in-training to implement their own local or country-level trainings. It also can be provided to local co-facilitators and partners to demonstrate accomplishment.

Covering All Details

- Prepare all training materials (resources for research, reference materials, handouts, visual aids and supplies) and deal with logistics (venue, tea breaks, and audiovisual equipment—including making sure the equipment is working) well in advance.
- Clarify everyone’s roles and areas of responsibility if other facilitators are helping to conduct the training. Meet with co-facilitators daily to monitor the progress of the workshop and provide each other with feedback. Create a team spirit and an environment where everyone feels valued and invested in the goal and objectives of the workshop.
- Ask participants to evaluate the training both daily and at the end of the workshop.
- Plan follow-up activities and determine additional training needs.

For maximum effectiveness and group interaction, we recommend the group size be between 12–20 participants. Generally, we recommend a mixed group of women of different ages and backgrounds. However, facilitators should ensure that the participant criteria (see **Annex 3**) are satisfied so that basic workshop expectations and objectives can be met. A survey of needs and expectations from participants ahead of time will also help set the final agenda and a sample survey can be modified to context (see **Annex 6, Women’s Workshop Participant Questionnaire**).

Workshop participants who have benefited from this curriculum have been varied in their knowledge of HIV and the many complex issues that surround it both personally and regionally. Some women already had attended workshops and participated in HIV activities. Others who attended the pilot women’s workshop had never before been either to a workshop or outside their village. These new participants provided a fresh perspective and more energy to the network of HIV-positive women and PLHIV forming in the region. Other women who attended the women’s workshop had been involved in developing regional and local networks, and even NGOs of their own. Some participants were single women, others were mothers of positive kids, while others were HIV-negative spouses of HIV-positive partners. The workshop aimed to build on the diversity of those participants present and the region itself, using this diversity as a strength in the network- and coalition-building process.

Women region-wide provided feedback on the sessions that benefited them most in the workshops and the pilot curricula. We also asked participants with more experience in certain areas to aid our facilitators in their sessions and serve as mentors to other women in the group; these others in turn passed on the information to their support groups, women they knew who were living with HIV, and others who then benefited from the information shared and friendships formed at the regional workshop.

Main Topics Covered by the Women’s Workshop Curriculum

Key issues covered in the Investing in PLHIV Leadership in MENA Women’s Workshop Curriculum include the following:

Human rights and HIV—Strides have been made in the MENA Region to ensure that women achieve their basic rights to health. In particular, the International Conference on Population and Development, held in Cairo in September 1994, first recognized links between sexual and reproductive health, women’s status, and social and economic development. These links encompass relationships and the broader context of women’s lives, including their economic circumstances; education; employment opportunities; family structures, and the political, religious, and legal environment. Many women and men in the region have worked tirelessly to ensure that the rights of women living with HIV are protected and promoted, while increasing numbers of NGOs and support groups are led and attended by women living with HIV, who are themselves becoming advocates. The discussion on this issue will explore what exactly are your rights as a person living with HIV, a parent of an HIV-positive child, or a spouse of an HIV-positive partner and, further, how you can make these rights a reality in your own life and for those you care about most.

What is gender?—Gender, equity, sex, and identity are all words we may have heard of, but what do they mean in different contexts, including our own lives? This session aims to discuss our basic understanding of key gender terms and provide a framework for further discussions regarding gender in MENA and what it means to us.

Health—Women living with HIV have particular health needs. For example, HIV-positive pregnant women need information about prevention of mother-to-child transmission (PMTCT), and those caring for and in families affected by HIV also need information about living a healthy lifestyle. Further, women in MENA need access to information about understanding their own bodies and sexual health.

Disclosure—Disclosure is the first step in accessing treatment and care, yet it can be a complex and emotional situation that is often more difficult for women who face social and family constraints. Participants will benefit from hearing other women’s stories about disclosure, participating in role plays, and discussing personal challenges and coping mechanisms.

Communicating with our children—As more children in the MENA Region grow up in families affected by HIV or as HIV-positive people themselves, mothers and fathers need to be equipped to deal with the difficulties and hopes related to children living positively and productively with HIV.

Relationships and power—Relationships are central to our lives and can fill our day with support and love, as well as neglect and fear. How we negotiate relationships as HIV-positive women and women affected by HIV is essential to our well being. Some women living with HIV have faced violence, while others have faced isolation. Some have found that HIV brings

them closer to those they love, while others have found that HIV has pushed them further apart from others. This topic focuses on concerns and ways to pursue healthier and happier relationships.

Sex and sexuality—Taboos in the region and community often forbid women in particular to talk about matters of sex and sexuality. Adding to the complexity of this issue is the stigma and discrimination surrounding HIV and social expectations surrounding women and sometimes enforced by them. This topic focuses on women’s concerns surrounding sex and sexuality, while offering a safe space to voice frank concerns.

Caregiver support—Many women have played the role of caregiver—for husbands, children, and others living with HIV. Women in the workshop will discuss how we can lessen the burden of caregiving, most effectively give needed attention to those we love and ourselves, and avoid caretaker and caregiver fatigue and burnout.

Young women—According to the UNAIDS 2008 Report on the Global AIDS Epidemic, young women in the MENA Region are twice as likely to be HIV positive as their male counterparts. However, it is difficult to reach these women who are most at risk. We will explore why young women are most at risk and how we can reach them and offer support.

Stigma and discrimination—Stigma and discrimination can be easy to recognize but also are such a consistent part of daily life that it is difficult to name exactly what is happening. We will address how we identify stigma in our own lives, both internally and externally, as well as how we are stigmatized and can stigmatize others. By naming the stigma in our lives, we aim to find ways to eliminate it.

Positive women changing and connecting—Women are great networkers, both informally and formally. Many women living with and affected by HIV in the MENA Region already are in regular contact and share challenges, successes, and hopes with each other. This session asks how we as women can use these connections to shape a brighter future for ourselves, our children, and our families. What regional and global networks can we support that will also support our work?

G/MIPA and women’s leadership—Many of us know that GIPA stands for the greater involvement of people living with HIV and AIDS, while MIPA refers to meaningful involvement of people living with HIV, but what can these concepts represent in the MENA Region, and further, what do they mean to a woman living with HIV, a mother of an HIV-positive child, or a spouse or partner of an HIV-positive person? How can empowering women living with HIV to become leaders strengthen the regional HIV response?

Regional, country, and community-level activities and networks of support—Some of the participants at our workshops already are involved in PLHIV-led activities, support groups, and networks. During our workshop, we ask participants to share their current activities in

their own countries and communities and how they see regional and national activities, including reaching out to more women, highlighting women as leaders, and addressing the challenges that women in the region face.

This curriculum is a living document, open to changes, input, and modification by local and regional trainers to serve women and men in their own countries and community contexts; it is also open to global practitioners with lessons learned to share. We thank those women and men in the region who have provided their valuable time and inputs and look forward to more feedback as gender is increasingly integrated into awareness raising, planning, and policy-level activities in the MENA HIV response.

Background on HIV in the MENA Region

HIV is one of the greatest challenges of the 21st century. Since the first scientific recognition of HIV more than 25 years ago, 33.2 million people worldwide have been identified as HIV positive, and millions have died from AIDS-related causes. These statistics are a testament to the difficulty physicians and practitioners face in managing the complex nature of HIV and AIDS, which can overwhelm a person's immune system, especially without access to appropriate treatment and care.

In addition to the science of the disease, it is important to understand the socio-cultural and development issues that can fuel the spread of HIV and must be addressed to prevent it. These include poverty, gender disparity, human rights, and governance, among other vulnerabilities and key issues.

Although there are risk situations and behaviors that create greater HIV vulnerability, anyone can infect another person with HIV, regardless of your religion, locale, the language you speak, the family to which you belong, your sex or gender identity, your race or ethnic group, or your sexual orientation.

HIV affects not only individuals but also entire families and communities, weakening the social structures upon which people depend to order society and daily life. Because HIV usually affects people in their most productive years (between the ages of 15 and 49)—from port workers to truck drivers, traders, tea sellers, school teachers, business professionals, and mothers and fathers—it has affected the productivity of entire countries. It has also left an orphaned generation in many countries, and elderly relatives may be left to shoulder the burden of care for increasingly large numbers of children left behind.

HIV also has been described as a complex set of epidemics, including a parallel epidemic of stigma and discrimination. In addition, PLHIV often face self-stigmatization and discriminatory practices that cause harm and violate basic human rights. This can include being denied housing, marriage, a job, or community acceptance, leaving some HIV-positive people without support and hope for the future.

However, there are many ways to prevent stigma and discrimination in the family, community, workplace, church, or mosque. HIV transmission can be prevented with the help of HIV-positive leaders supporting awareness raising and other positive prevention methods. One of the first steps in addressing HIV and limiting both stigma and infection, while promoting greater health, is creating a better understanding of HIV. This complex understanding is best brought to light by PLHIV themselves, who have proven in many regions, including MENA, that they can provide key leadership in creating a sustainable HIV response.

HIV and Gender in MENA

The HIV pandemic is growing more rapidly among women than men in almost every part of the world, including MENA. Women account for about half of PLHIV in the world.¹ Globally, young women are 1.6 times more likely to be living with HIV than young men.² The growing proportion of HIV-positive women reflects multiple risk factors that reinforce HIV vulnerability and infection among women and girls in particular.

In 2008, there were an estimated 310,000 people living with HIV in the MENA Region, up from 200,000 in 2001. Also in 2008, approximately 35,000 people became newly infected with HIV in the region.³ Further, an estimated 90 percent of people living with HIV in the MENA Region are not aware that they are HIV positive.⁴ The feminization of HIV is becoming particularly acute in the Middle East and North Africa. If trends continue, the vast majority of PLHIV in the region will be women and girls. Currently, women make up half of the HIV-positive population in the region and girls and women ages 15–24 are twice as likely to be HIV positive as their male counterparts.⁵

A woman's vulnerability to HIV infection is in direct proportion to the lack of control she has over risk factors that directly affect her life. Globally and in MENA countries, the majority of women living with HIV became infected via heterosexual intercourse and frequently in settings where there is lack of negotiating power in sexual relationships. **This is why empowerment of women is key to decreasing HIV.**

In addition to physiological vulnerabilities, factors that contribute to greater vulnerability among women in MENA include the following:

- **A culture of silence surrounding sexuality**—Complex social and cultural barriers have made talking about sexuality, and in particular women's sexuality, taboo in MENA countries.⁶ If people cannot talk about sexuality, talking about HIV and AIDS can be especially challenging.

¹ UNAIDS. 2008. *2008 AIDS Epidemic Update*. Geneva: UNAIDS.

² UNFPA. 2007. *Woman and HIV Confronting the Crisis*. Retrieved from <http://www.unfpa.org/hiv/women>.

³ UNAIDS. 2010. *Spotlight on the Middle East/North Africa Region*. Retrieved from http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2010/20100127_Qatar.asp.

⁴ Obermeyer, Carla. 2006. *HIV in the Middle East*. Geneva: WHO.

⁵ PRB. 2008. *Sexual and Reproductive Health in the Middle East and North Africa*. Washington, DC: PRB.

⁶ *Ibid.*

- **Harmful traditional practices**—These include wife inheritance, polygamy, and female genital mutilation (FGM). When practices that are unhealthy for women are secured by longstanding traditions, it is even more difficult for women to be empowered to make healthier choices and transform unhealthy norms; also, in many harmful traditional practices, such as FGM, their bodily integrity is compromised and agency limited.
- **Exploitative sex**—Among these are transactional and exploitative intergenerational sex; many women at risk are exploited by older men offering means for survival while demanding high-risk behavior in exchange.
- **Poverty**—In the MENA Region, women have limited access to independent means of income generation and so often are dependent on male family members or live in poverty and often abject poverty. When women live in poverty, daily survival takes precedence over access to HIV information, testing, and care, which seem less urgent than food, water, and basic needs.
- **Lack of access to education**—Three of every four illiterate adults are women, and two-thirds of children denied primary education are girls. Although in some MENA countries the gap between girls' and boys' access to education is narrowing, illiteracy and lack of access to education remain barriers in a region that faces the highest incidence of illiteracy among women and girls in the world.⁷ When women have access to education, they have better access to correct information and greater knowledge and are empowered to make healthy personal choices.
- **Sexual and gender-based violence**—Women are more likely than men to experience gender-based violence (GBV), including physical and sexual abuse, in situations in which they do not have control over the safety of, let alone consent to, sexual intercourse. Further, in MENA countries, domestic abuse in particular is often normalized and under-reported. When women lack negotiating power and are abused, they are less likely to access support.

Denial, stigma, and discrimination are another set of risk factors reported by participants in the region as major barriers to health and happiness for women living with HIV and those women and girls most vulnerable to HIV. To avoid discrimination and becoming socially outcast, many women and girls living with and vulnerable to HIV do not seek counseling, testing, and treatment and may not disclose HIV status. Access to care and support is especially problematic for women who may face partner, family, and social exclusion and violence. HIV and stigma prevention programs, including PLHIV-led activities and support groups, have a difficult time reaching individuals who need this support the most. Reaching women living with and vulnerable to HIV and stigma is further complicated by the social status of many women in the region, who face strict family and social regulation that often leaves women with little of the control over their own bodies—control necessary for maintaining health and well-being.

⁷ UNDP. 2005. *The Arab Human Development Report, Towards the Rise of Women in the Arab World*. UNDP, New York.

Experience around the world proves that societies cope best with HIV and prevent its spread when governments are open about the issue, actively provide accurate information and services to all people, are gender aware and sensitive, and collaborate with organizations that represent affected communities, including PLHIV and those most at risk.

PLHIV, and women living with HIV in particular, are key to any successful HIV response to ensure that women, girls, men, boys, families and communities are secure, healthy, and thriving. GIPA is a basic principle that has been incorporated into national and international program and policy responses and adopted as a model of best practice in the response to HIV. But GIPA is also a broad and dynamic process that must be linked to PLHIV social movements, organizations, networks, support groups, and individuals. As increasing numbers of women and men come forward as leaders in the MENA HIV response, the GIPA principle that has guided national and regional responses worldwide is surfacing. Women are key to shaping this response by and for PLHIV in the region and first must explore what it means to be a woman living with, vulnerable to, and/or affected by HIV and how to best use their strengths and talents as women to address one of the most complex and challenging issues of our time.

WOMEN'S WORKSHOP OVERVIEW AGENDA

Day	Morning	Afternoon
Day 1		
Introduction, Human Rights, Gender Terms, and Key Concepts	Introductions	Why a Human Rights Focus?
	Training Expectations, Goals, and Objectives	Gender and HIV
	Review Agenda and Logistics	Closing and Evaluation
	Participant Baseline Questionnaire	
	Setting Ground Rules	
Day 2		
Power, Identity, Understanding Our Bodies, and Sexual Health	Welcome and Review of Day 1, Housekeeping, and Agenda Overview	Body Mapping About Sex and Sexual Health
	The Gender Lens	Agree/Disagree/I Don't Know
	Power in Relationships	Young Women's Dialogues
		Closing and Evaluation
Day 3		
Positive Parenthood, Our Relationships	Warm-up, Review from Day 2, Housekeeping, and Agenda Overview	What Is Love? How to Discuss Feelings about a Problem Sero-discordant Couples Discussion
	HIV-positive Women Discuss Safe Motherhood	Closing and Evaluation
	Violent Relationships	
Day 4		
Stigma and Discrimination, Disclosure, Participation, and Leadership	Warm-up, Review from Day 3, Housekeeping, and Agenda Overview	Addressing Disclosure with Our Children and Those Who Interact with Them
	Naming Stigma in Your Life and Community	Participation Building Leadership Building the Dream and Next Steps
	Addressing Stigma and Discrimination Disclosure: What, How, When, and To Whom?	Workshop Closing

DAY 1: INTRODUCTION, HUMAN RIGHTS, GENDER TERMS, AND KEY CONCEPTS

Schedule

Session 1: Introductions	1 hour 30 minutes
Session 2: Workshop Expectations, Goals, and Objectives	45 minutes
Session 3: Review Women's Workshop Agenda and Logistics	10 minutes
Session 4: Participant Baseline Questionnaire	30 minutes
Session 5: Setting Ground Rules	55 minutes
Session 6: Why a Human Rights Focus?	1 hour 30 minutes
Session 7: Gender and HIV	2 hours 30 minutes
Session 8: Closing, Evaluation, and Feedback	1 hour 15 minutes

*Please be sure to factor in time for a coffee/tea break in the morning and afternoon, as well as a lunch break.



SESSION ONE: INTRODUCTIONS

Time: 1 hour 30 minutes

Materials: Flip chart, tape, markers, computer, projector, display screen, adapter plug

Prepared Materials:

PowerPoint (PPT): Workshop Agenda, Goals, and Objectives (*Please note, almost anything that you put on a PowerPoint can also go on a flip chart or handout if needed.*)

Prepared Flip Chart: Participant Introduction Questions, Icebreakers, and Energizers

Handouts: Interpreter Confidentiality Agreement (**Annex 1**), Subject Release Form/Photo Consent Form (**Annex 2**), Women's Workshop Agenda (**Annex 4**)

Objectives:

- To ensure that participants feel welcome to the Investing in Middle East and North Africa Women's Workshop.
- To introduce participants to the workshop.
- To clarify the role of participants within the context of the workshop.



Trainer Notes: Beginning on Time

No matter how hard we try to start on time with **everyone** in the training room, someone is usually late! Try to avoid this by making an announcement at 8:50 a.m. or so for participants to leave breakfast in the next few minutes for the training.



Facilitator Background Note: Introductions, Icebreakers, and Energizers

Introductions can take time but are very important because we are trying to make personal connections with our participants and build support in our countries and region that will last beyond the Women’s Workshop. Further, in the MENA Region, introductions have special significance. People like to take more time to get to know one another before starting the nuts and bolts of working together. There are many creative and participatory ways to introduce participants to each other in trainings or workshops. As training experience increases, trainers can develop a catalog of useful “icebreakers” and participatory introductions for different situations and different groups.

Remember—the women’s workshop curriculum is based on the following adult learning and GIPA principles, which apply to all activities, from discussions to icebreakers:

- **Learning is self-directed.** Adults can share responsibility for their own learning because they know their own needs.
- **Learning fills an immediate need and is highly participatory.** Motivation to learn is the greatest when it meets the learner’s immediate needs. The most effective learning is from shared experience; learners learn from each other, and the trainer often learns from the learners.
- **Learning is experiential.** Again, participants and the trainer learn from one another; learning is based on doing and on a collection of experiences.
- Time in training is allowed for **reflection and corrective feedback.** Maximum learning from a particular experience occurs when a person takes the time to reflect back on it, draw conclusions, and derive principles for application to similar experiences in the future.
- A **mutually respectful environment** is created between facilitators, resource staff, and participants.
- Workshop facilitators provide a **safe atmosphere** and comfortable environment.

Icebreakers are activities used in trainings to introduce new groups to each other—in other words, to “break the ice,” a term in English used to describe breaking through any uncomfortable first feelings some participants may have when they’re new to a group and do not know anyone. Along with introducing *new participants* to each other, icebreakers also introduce *new subjects* to participants. Sometimes we find participants are shy at first and it is important to be sensitive to this—usually among women, these activities help alleviate shyness.

Energizers are usually used when participants have been sitting too long or in the morning when they are still not fully awake, energized, and flexible. Sometimes energizers include stretching, which helps get blood circulating through the body in a gentle way. It is important for participants not to sit all day. Breathing exercises and simple yoga techniques are also excellent ways to get the blood flowing.

Remember the cultural context when you implement these activities. Remember to note the gender norms and appropriate boundaries for touching and the physical capability of the group. Also remember that, as positive people, we all have different kinds of energy levels and strength. Some of us have physical disabilities that weaken our sight, hearing, walking, and mobility. Also, it is important to recognize that, even without HIV, many people have physical limitations. Trainings need to be accessible and appropriate to people with disabilities and physical limitations.

Sometimes our participants in the Women's Workshop bring one or more children to the training. We love having children at workshops, but remember to plan ahead! Be sure to arrange child care—with the help of your local support group if possible—so that there are fewer barriers to participation for women attending. Although some of the training content may not be appropriate for children, they can be invited to join in some of the lighter/more fun energizers and icebreakers.

General Welcome—*Ahlan wa Sahlan!*

Time: 5 minutes

Main facilitators will provide the first welcome and thank participants for traveling and taking the time out of their busy family and/or work lives to spend this training week together.

Introduction of the Facilitation Team

Time: 5 minutes

Introduce any additional facilitators and/or honorable guests (e.g., a country director, ministry official, or USAID official). Staff will introduce themselves and welcome participants to the workshop.



Instructions for Facilitator: Introducing Ourselves

The facilitators will provide the following information in their introduction:

1. Name
2. How long and WHY I have been involved with HIV
3. Why I came to this workshop

Introduction to Confidentiality and Explanation of Interpreters and Note Takers

Time: 10 minutes

Explanation of Interpreters

If there are interpreters, explain that they will provide Arabic-to-English (or Arabic-to-French) interpretation for the English- or French-speaking facilitators. In addition, state that the interpreters have signed a *confidentiality agreement* for the women's workshop (see **Annex I**). This means that they will not share information from the meeting with anyone else. Interpreters are often asked to sign agreements in advance of sensitive political meetings, business negotiations, and community meetings where sensitive information is being shared.

1. **Stress** that all of us, participants and workshop facilitators, need to hold any personal statements and personal information disclosed as confidential.
2. **Emphasize** that we need to operate in a space of trust—“What is said in the room stays in the room.”

Explanation of Note Takers

1. **Explain** that they will record their notes on a computer and that these notes will contribute to a women's workshop report.
2. **Explain** that they will take notes throughout the training; however, any participant can ask the note taker to *stop taking notes*—for example, because the participant will be providing confidential information.
3. **Explain** that the women's workshop report will be submitted to potential donors, partners, and friends who may be interested in supporting our workshops and further women's greater participation in the HIV response in MENA.
4. **Emphasize** that *no one's name* will be used in the report or any other documents without express written permission from the participant.

Photo Consent

1. **Discuss** photo taking and ask how the group feels about it. Explain that if the majority of the group is not comfortable, photo taking will not be allowed.
2. **If the majority is comfortable**, explore the rules for photography, how the photos will be used (e.g., for internal reporting, for publications with limited distribution, the password-protected MENA+ website, etc.), and whether the materials will identify the person by country and name.
3. **Introduce** the Photo Consent Form (see **Annex 2**) and how it can be used now, as well as for adaptation and use in future trainings.



Activity: Participant Introductions and Icebreakers

Time: 15 minutes



Instructions for Facilitator

Explain that each of the **women's workshop participants** will have 1 minute for this first exercise. Some may complete this in a shorter period of time, but none should take longer than 1 minute.

Also **explain** that participants will answer the questions below in their introductions. These questions will also appear on a flip chart or PowerPoint slide for ease of reference.



Prepared Flip Chart: Participant Introduction Questions

1. Name
2. Something nice/interesting we may not know about you that you would like to share (such as a hobby, home village or town, award or degree you may have, or something about your children/family)
3. A hint to help us remember your name (for example, stating your name and then a word that rhymes with it)

For a helpful book of icebreakers and energizers, see:

100 Ways to Energize Groups: Games to Use in Workshops, Meetings and the Community (AIDS Alliance, 2003). Available online in English and French at:

http://www.icaso.org/vaccines_toolkit/subpages/files/English/energiser_guide_eng.pdf.



Example Activity: Icebreaker: Name Game

Time: 15 minutes



Instructions for Facilitator: Rules for the “Name Circle”

1. The facilitator will start by introducing him/herself first, stating his/her name only.
2. The participant to the right of the facilitator will state his/her name and then all the people introduced before him/her to the left—in this case the facilitator only.
3. The next participant to the right will then introduce himself/herself and all the people introduced to his/her left (two people).
4. As introductions go around the circle, people must introduce themselves but also the people already introduced to their left.
5. Participants who introduce themselves later have to introduce more people in the circle.
6. The aim, of course, is to remember each other’s names! So try your best not to help someone who may be stuck on a name; let the person try first.
7. Try to conduct this icebreaker at a good pace to keep it fun and challenging.



Example Activity: Icebreaker: Throwing Names

Time: 10 minutes

1. Participants stand in a circle.
2. The facilitator will throw a ball to someone in the circle, saying the name of the person who will catch the ball as she throws it.
3. The person who catches the ball throws it to another person and says her name (the person to catch the ball), and so on.
4. Once everyone has caught the ball, add extra balls so several are being thrown at the same time, following the same pattern.



Example Activity: Icebreaker: Name Diagnosis Line

Time: 30 minutes



Instructions for Facilitator: Directions for the Diagnosis Line

Note: This icebreaker has the potential to be sensitive—see #8 below:

Directions:

1. **Ask** participants to form a line according to the year they were diagnosed with HIV.
2. A **co-facilitator** may **demonstrate** by starting off the process saying: “I was diagnosed with HIV in 2000, so I stand here.”
3. Then, the rest of the participants will **take turns stating** the year of their HIV diagnosis and will **form a line** around this first date mentioned, creating a line in consecutive order.
4. Once all participants are in the line according to the year of their diagnosis, the co-facilitator will **ask** each participant to tell the year of their diagnosis to the group again and **explain** briefly how long and why they have been involved with HIV efforts (e.g., with volunteering, support groups, or any other types of training).
5. While still in the line, **ask** participants to raise their hands if they have done any public speaking as openly HIV-positive persons.
6. **Explain** that if we look at the years combined, we have a lot of history and strength in this room.
7. **Explain** that there is no prescribed time for a person to become an HIV educator, trainer, activist, or support group member; it is different for everyone.
8. One point to **discuss** later in private and individually,* if some are not open about their HIV status, is how they will be able to work with other PLHIV or participate in HIV-related activities.
9. **Thank** everyone and ask them to come back into the circle to take a seat.

*It is very important to have good judgment regarding when to discuss issues in public and when to discuss them privately and individually. It is best to introduce a subject and allow for voluntary feedback on individual experiences or general discussion, rather than putting people in an unexpected situation to answer specific personal questions in front of others.



Trainer Notes: Nuances on Facilitating Icebreakers

When facilitating this activity, remember that icebreakers can be emotional and it may be a participant's first time disclosing his/her status. Facilitators need to be prepared and trained to handle emotions and group dynamics when participants share painful or emotional feelings.

*Please note: Usually, the general selection criteria for this Women's Workshop (see **Annex 3**) specify that participants have been chosen because they are open about their status. However, their comfort levels will vary—depending on levels of stigma and discrimination, personal experience, current country and community context, family context, and willingness—and may even change as they move through the workshop process.



SESSION TWO: TRAINING EXPECTATIONS, GOALS, AND OBJECTIVES

Time: 45 minutes

Materials: Flip chart, tape, markers, post-it notes

Prepared Materials:

PPT: Workshop Agenda, Goals, and Objectives

Prepared Flip Charts: Group Expectations, Group Concerns, Women's Workshop Goals, Women's Workshop Objectives

Objective:

- To review the expectations, goals, and objectives of the workshop and why they are important.



Facilitator Background Note: Expectations, Goals, and Objectives

Each activity or session in this workshop, or any workshop, should consider the participant and facilitator **expectations, goals, and objectives**.

Expectations are simply what participants expect from the workshop (e.g., what skills participants expect to learn and how they expect to use these skills when they return home). These expectations should help define the training goals.

Goals are broad statements of purpose—what we would like to attain. These are the answers to an issue we are facing and may depend on achieving many objectives. Further, they may not be precisely measurable (e.g., ending HIV-related stigma).

Objectives are the specific, measurable, and time-bound actions we take to reach our goals. They can be the following:

- A specific statement of the ideal situation that will exist at the completion of a particular task—a future fact.
- A statement of exactly what the learner will be able to do at the end of the workshop.
- A precise element or unit of work that will contribute toward reaching a goal—one of the steps toward the goal.
- May be related to other objectives but measured against themselves.
- Must be precisely measurable (results can be seen and measured).
- Must answer the following questions: What? How much or how many? When? And sometimes, where, who, with whom, and how often?

For example, to help reach the goal of greater, meaningful inclusion of women living with HIV in the MENA response, after the Women’s Workshop, participants will provide an awareness-raising session or outreach meeting this year specifically to engage women living with HIV.



Activity: Expectations and Concerns

Time: 15 minutes



Instructions for Facilitator: Expectations and Concerns Activity

Directions:

1. **Ask** participants to **write** on colored sticky post-it papers their learning expectations (what they want to learn).
2. On post-its of another color, **ask** participants to **write** any problems, fears, or concerns they might foresee or have.
3. **Ask** participants to **list** one word per post-it note.
4. **Float** around the room to assist any participants who need help writing out their expectations and concerns.
5. **Ask** participants to **place** their post-it papers on a flip chart that has the title listed on top: “**Expectations:** What are your expectations/hopes? What do you want to learn?”
6. **Ask** participants to **place** post-it papers of the other color on another flip chart that has this title listed on top: “**Concerns:** What are your concerns?”
7. Have one woman read aloud all expectations and another woman in the workshop read aloud all concerns.
8. **Ask** if anyone has anything they’d like to add or say.

*Please Note: The facilitator should also address the concerns that have been listed and reassure everyone about the safe environment that will be created among the group throughout the workshop.

Review Training Objectives

Time: 15 minutes

Choose a volunteer to read aloud the women’s workshop goals listed on the flip chart or PowerPoint slide. Choose a volunteer to read aloud each workshop objective listed on the flip chart or PowerPoint slide.



Prepared Flip Chart: Women's Workshop Goals

Choose a volunteer to read aloud the women's workshop **goals** listed on the flip chart or PowerPoint slide.

Goal: To make progress toward an improved, equitable, gender-sensitive, and women-led HIV response in the MENA Region.



Prepared Flip Chart: Women's Workshop Objectives

Choose a volunteer to read aloud each workshop **objective** listed on the flip chart or PowerPoint slide.

1. Provide an opportunity for MENA women living with and affected by HIV to work together on issues that are important in their lives, as well as increase support and knowledge around those issues;
2. Strengthen participants' ability to address challenges they face as women living with HIV, as parents of HIV-positive children, and spouses of HIV-positive partners, such as stigma and discrimination.
3. Create a foundation for greater networking and support by and for women living with HIV in the region.

Setting Realistic Expectations

Time: 15 minutes



Instructions for Facilitator: Comparing Goals, Objectives, and Expectations

Facilitators with the group will

- Compare the objectives with the group's expectations listed from the previous exercise;
- See if the expectations match, differ, or support one another; and highlight which expectations will not be met during the workshop, yet offer suggestions for how those expectations could be met in the future.
- **Ask participants** to give an example of a goal and some objectives to meet that goal.



SESSION THREE: REVIEW WOMEN'S WORKSHOP AGENDA AND LOGISTICS

Time: 10 minutes

Handouts: Women's Workshop Agenda (**Annex 4**)

Objectives:

- To ensure that participants are familiar with the women's workshop agenda.
- To provide participants with time to understand and address logistical issues.



Instructions for Facilitator: Daily Agenda Review and Logistics

Explain to the participants each day's agenda, providing a quick day-by-day overview so participants know what to expect. **Annex 4** is the Women's Workshop Agenda.

Also **review** logistical issues, including the following:

1. Bathroom and water locations
2. If the water is safe to drink from the hotel tap and any other issues related to digestion/safety (especially if you are training people who are not from the community where your training will take place)
3. Rules about smoking (make sure there is no smoking in meeting areas)
4. Tea break areas (time and place)
5. Meals (if provided)
6. Per diem disbursement procedures (if per diem is provided—in most local settings it is not)
7. Transportation around host city/village
8. Medical needs, first aid, and who to contact in case of an emergency
9. Additional hotel charges that will not be paid for by the training (e.g., mini-bar,* laundry, room service, etc.—again, most local settings will not have hotel stay-over and many workshops depend on house stays with other participants to cut costs)
10. Room phone, mobile phone, and room numbers of Women's Workshop co-facilitators or assigned volunteer/staff who can deal with participant needs, especially during off-workshop hours

Ask participants if there are any questions. If individuals have specific questions, co-facilitators should **ask** them to see the logistics staff during the break, during mealtimes, or after sessions. Participants should know that there is a particular person in charge of logistics to whom they can go at any time.

*Please note: For most workshops that use a hotel, we ask the hotel simply to empty the mini-bar in each participant room. This can be for several reasons, including sensitivity to those who have or are facing addiction, offense taken to alcohol being in the room, as well as unexpected room charges.



SESSION FOUR: PARTICIPANT BASELINE QUESTIONNAIRE

Time: 30 minutes

Materials: Pens (enough for each participant)

Handouts: Women's Workshop Participant Questionnaire (**Annex 6**)

Objectives:

- To review and understand participants' baseline levels of knowledge, attitudes, and skills regarding the topics covered in the workshop.
- To develop an indicator from which to measure objectives and overall workshop goals and objectives.
- To provide guidance on further programming.

Introduction to the Questionnaire

Time: 15 minutes



Instructions for Facilitator: Introducing the Questionnaire

1. Hand out the **Women's Workshop Participant Questionnaire (Annex 6)**, to be filled out in 15–20 min.
2. Explain how Participant Criteria (**Annex 3**) were gathered before the Women's Workshop and how this information guided the development of the Women's Workshop Agenda (**Annex 4**).
3. Explain that this questionnaire will be used to assess the skills and capacity built throughout the Women's Workshop.



SESSION FIVE: SETTING GROUND RULES

Time: 55 minutes

Materials: Flip chart, tape, markers

Prepared Materials:

Prepared Flip Chart: Ground Rules

Objective:

- To establish a way of working together that will allow us to work freely, openly, and productively.



Instructions for Facilitator: Workshop Participation Framework

1. **Explain** that participants will be asked to be active members of the workshop group.
2. Every person participating in this workshop has personal experience that is extremely valuable to the process.
3. All together, we will try to come back home with new information and skills, and also review and share those skills and talents we already have.
4. The workshop will be a highly interactive process in which we learn from each other through critical thinking, doing, and feeling.
5. **Explain** that we are not divided into “experts” and “learners” but rather are women with lots of knowledge and wisdom who can share with each other and, further, bring a common understanding that will help all of us build on the common knowledge we possess. The new ideas we share will result in more open minds and hearts within our group and those we touch in our daily lives.
6. The workshop will be challenging and rewarding but also can be physically tiring. It is important to honor our bodies and rest appropriately if we become too tired or feel sick.
7. **Reinforce** that it is important to develop trust within the group—remember to respect each other and the safe space in which we will work. What is said in this room stays in this room.
8. It is your right to decide not to participate or contribute to a certain issue or discussion, although it will be richer when people participate fully and equitably.
9. Feedback is an ongoing process throughout the workshop. We encourage input and sharing of feelings and ideas on paper evaluations. If you have challenges with the paper evaluations, ask any facilitator or fellow workshop participant in the group to help you check the appropriate boxes to voice your feelings and ideas about the workshop. Importantly, feedback also will be gathered via conversations with facilitators and fellow participants and within the group discussions.

Setting Ground Rules

Time: 20 minutes



Instructions for Facilitator: Introducing Ground Rules

1. **Explain** the objective for the session.
2. **Ask** participants in the group what group norms/ground rules would be important to them for this workshop.
3. **Explain** that examples of ground rules include the following: respect different opinions, no interrupting (speak one at a time), listening with full attention when another person speaks, avoid parallel conversations, respect timing, try to talk from a personal perspective (“I think, I feel...” rather than using “you”) avoiding generalizations, no “put downs,” all have the right to make mistakes, turn cell phones off, ensure confidentiality, etc.
4. **Solicit** participant suggestions and write all suggestions on your flip chart.
5. After all suggestions are taken, **ask the group to confirm** which suggestions they all agree should be included as ground rules and with which they are comfortable.
6. **Cross out** those suggestions with which the group does not agree.
7. **Put the flip chart paper** on the wall/in a place where it can be seen and referred to throughout the workshop.

Daily Women's Workshop Instructions

Time: 10 minutes



Instructions for Facilitator: Daily Participant Instructions

Some participants enjoy serving in different capacities during the workshop.

Each day, participants can volunteer to do the following:

- Provide a morning review of the previous day's work and give feedback;
- Review the day's agenda;
- Review the ground rules and add any additional ground rules that come up;
- Lead icebreakers and energizers and co-facilitate sessions;
- Lead feedback groups; and
- Lead and participate in training practices (such as role play) for feedback from the group.

If participants want to volunteer during the workshop in other capacities, such as leading a discussion on a particular topic, let participants know they can talk to the facilitators ahead of time to see how their contributions can be used.

Group Energizer

Time: 15 minutes



Instructions for Facilitator: Group Energizer

Explain again that **energizers** are usually used when participants have been sitting too long or in the morning when people are still not awake and flexible. Sometimes energizers include stretching. It is important for participants not to sit all day. Everyone needs to move so that blood flows throughout the body and literally provides the brain with more oxygen and energy. Breathing exercises and simple yoga techniques are also excellent to get the blood flowing. It is also important to acknowledge people's physical limitations and that not all of us, as positive people, have the same energy and physical ability.

Allow the volunteer to lead the energizer for 10 minutes.



Example Activity: Energizer: Fruit Salad

Time: 10 minutes



Instructions for Facilitator: Directions for Energizer: Fruit Salad

Directions:

1. **Set up chairs** in a circle so that there is one less chair than the total number of people in the group.
2. **Allocate fruit names** to each participant (e.g., orange...banana...mango...orange... banana...mango...orange).
3. **Call** one of the names—for example, orange—and all of the 'oranges' have to stand up and run to another seat.
4. As the caller, you also run and **find a seat**.
5. Whoever is left without a seat becomes the new caller.
6. When the caller shouts 'Fruit Salad!' everyone has to stand up and find another seat.

*Please note: If the room is too hot, or if people are not able to run, ask participants to walk.



SESSION SIX: WHY A HUMAN RIGHTS FOCUS?

Time: 1 hour 30 minutes

Materials: Flip chart, tape, markers, power point and display or projector and display screen

Prepared Materials:

Handouts: Tripoli Declaration (**Annex 5**), 'Turning the Tide' (Arabic), Human Rights Cards (English, **Annex 7**), International Community of HIV Positive Women (ICW) Series (Arabic), ICW Positive Women and Human Rights, ICW Participation and Policy Making: Our Rights



*Please note: Arabic versions of "Turning the Tide," the Tripoli Declaration, and the Human Rights Cards can be obtained from UNDP's HIV/AIDS Regional Program in the Arab States (www.harpas.org). The ICW Series can be obtained from ICW (www.icw.org); send e-mail to: info@icw.org; Arabic versions of the ICW series were completed by the Health Policy Initiative.

Objectives:

- To identify and understand human rights.
- To explore and understand rights as a requirement for human development.
- To understand the universal nature of rights.



Activity: Rights We Have from Birth

Time:



Instructions for Facilitator: Directions for Activity

1. **Put** a picture of a baby at the front of the training room (this can be cut from a magazine and put on the flip chart or on a PowerPoint, for example).
2. Break participants up into small groups of 3–4 people.
3. **Ask** the groups to consider what the baby would need to have a full life as a human being.
4. Each group should agree upon a list of needs that will be noted on flip chart paper during the small group discussion.
5. Ask each **small group** to **present** the findings of their discussion to the big group, using as a guide the list documented on flip chart paper.
6. Once all small groups have presented, a **general discussion** will take place around the input given by each group.

Discussion Notes

The facilitator will lead a discussion on the nature of human rights and how they relate to our own lives as positive women. During the discussion, **ensure** that important points are highlighted, including

- What human rights are (see glossary for a sample definition)
- The categories of rights and where they come from (see human rights cards, **Annex 7**, for examples)
- Rights that are difficult to talk about or usually avoided, such as sexual and reproductive rights (see **Annex 8** for handout on reproductive rights)

Discussion Points

You can use some of the following questions to guide the discussion:

1. Why do you think the baby needs all of those things on the list?
2. What good will these things do for the baby?
3. Does the baby deserve all of these things listed? Why or why not?
4. Are there other things that adults must have to enjoy a full life?
5. What concepts/ideas do you think can be used to refer to all of the things babies and adults need to have in order to lead a full life or to live as human beings?
*Please note: This question will change the terminology of *needs* to that of *rights* in case the latter has not yet arisen in the discussion.
6. What do you think might happen if babies and adults are deprived of these rights/things you've listed?
7. Do women and men deserve the same rights? Why or why not?
8. Do women and men enjoy the same rights? Why or why not?

Group Discussion

Review and **discuss** with participants the Universal Human Rights Cards in **Annex 7** and the Sexual and Reproductive Health handout (**Annex 8**), including the following concepts:

- The link between human rights and HIV
- The link between human rights and the law
- Right to life
- Right to privacy
- Right to information
- Right to education
- Right to work
- Right to non-discrimination
- Political and civil rights
- Rights of migrants, refugees, and internally displaced people
- Rights of vulnerable groups
- Sexual and reproductive health rights

Ask participants if they have examples of these rights being violated or upheld. Have they advocated for any of these rights in their family, community, or country? What responsibilities do PLHIV have related to these rights? Do these rights differ for men and for women in your community? If so, how?



Facilitator Background Note: International Human Rights and HIV-related Stigma and Discrimination

The concepts of stigma and discrimination—faced by women, men, and children living with HIV—are complex and can reach every part of daily life. PLHIV in MENA have faced social exclusion, home eviction, school expulsion, land loss, family rejection, and refusal of care in clinics and hospitals. PLHIV are not only stigmatized because of their HIV status, but also because HIV may be associated with behaviors that go against cultural, traditional, and religious norms and sometimes laws (e.g., injecting drug use, sex work), resulting in punishment, abuse, and marginalization justified by stigmatizing beliefs and discriminatory practices.

There are numerous instruments, declarations, guidelines, and tools created by groups as various as grassroots communities and global leaders that aim to protect and promote universal human rights for all people, including PLHIV. Further, there are declarations and guides addressing HIV specifically that have regional significance. The *Algiers Declaration* outlines rights and responsibilities surrounding HIV in the MENA Region as developed by and for PLHIV. The *Cairo Declaration*, developed in 2004 by Muslim and Christian religious leaders, also outlines rights and responsibilities related to human rights and PLHIV.⁸ The Tripoli Declaration (see **Annex 5**) delineates the rights and responsibilities of women living with HIV. At global level, at the UN General Assembly Special Session on HIV/AIDS (UNGASS), the *Declaration of Commitment on HIV/AIDS* was signed by 189 countries, including MENA countries, with specific human rights targets to be met related to HIV and AIDS. Further, the Universal Declaration of Human Rights is also used to reinforce promotion and protection of rights for PLHIV.⁹

However, what often counts most to the community, including PLHIV and someone in need of services and treatment, is the basic truth of how rights and policy translate into action. This is especially true in healthcare settings, where disclosure is necessary and a relationship of trust must be rooted in professionalism. This should include protocols that adhere to non-discriminatory practices—most notably, providing equal access to professional care for all people, regardless of HIV status, sex, or gender.

⁸ For more information, see www.harpas.org and www.unaids.org

⁹ For more information, including the complete Universal Declaration of Human Rights, go to <http://www.unhchr.ch/udhr/>



SESSION SEVEN: GENDER AND HIV

Time: 2 hours 30 minutes

Materials: Flip chart, tape, markers

Objectives:

- To review and understand basic gender-related terms.
- To start a discussion regarding the gendered implications of human rights for women and girls.



Activity: Defining Gender and Related Concepts

Time: 30 minutes

Prepared Materials:

Flip chart: Gender Terms

Objectives:

- To discuss and understand differences in key gender terms.
- To agree on common definitions and usage of key gender terms.
- To begin to discuss and understand the gendered dimensions of HIV.

(Adapted from: USAID Interagency Gender Working Group, Gender Training Modules, June 2006.)



Instructions for Facilitator

Directions:

1. **Divide** participants into 3 groups.
2. **Assign** each group one of the following terms:
 - a. Gender
 - b. Gender Equity
 - c. Gender Equality
3. **Tell** each group to take 5–10 min. to define each term. Try to divide up groups so that at least one person with some understanding of these terms is in each group to start/guide the conversation. You may need to **plan** this ahead of time.
4. When all groups are finished, **ask** each group to **write** the assigned definition on a flip chart and tape it to the wall in the front of the room.
5. Have the participants assemble around each term. **Ask** someone from the small group to **read** the definitions and **ask** the larger group for their thoughts on how it was defined.

Include the following points in the discussion:

- “Gender” refers to **socially constructed** roles, responsibilities, and expectations of males and females in a given culture or society;
- These roles, responsibilities, and expectations are **learned** from family, friends, communities, opinion leaders, religious institutions, schools, the work place, and the media.
- They also are influenced by **custom, law, class, ethnicity, and bias**.
- The definition of what it means to be male or female is learned, varies among cultures, and **changes** over time.

Display the flip chart with the definitions of key words from the small groups.

Explain to the group that these key words are defined in many different ways but, for our purposes, the following are sample definitions to keep in mind as we also discuss the region-specific meanings of each:

- **Gender** refers to the economic, social, political, and cultural attributes and opportunities associated with being female and male. The social definitions of what it means to be female or male vary among cultures and change over time.

- **Sex** refers to the biological differences between women and men. Sex differences are concerned with women's and men's physiology.
- **Gender Equity** is the process of being fair to women and men. To ensure fairness, measures must be put in place to compensate for historical, social, and structural disadvantages that prevent women and men from operating on a level playing field. Gender equity strategies are used to eventually gain gender equality. Equity is the means; equality is the result.
- **Gender equality** permits women and men equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits from development results.
- **Gender identity** refers to the gender with which a person identifies herself or himself. This can run a spectrum of masculine, feminine, and other gender identities.
- **Gender integration** means taking into account both the differences and inequalities between women and men in HIV program planning, implementation, and evaluation. The roles of women and men and their relative power affect who does what in carrying out an activity and further, who benefits.
- **Sexual orientation** is defined by the sex or gender to which a person is sexually attracted.

Ask the larger group if they have other ideas, questions, or comments, especially from a regional, country, or local perspective.

Ask a volunteer to take notes and develop a definition for each term. Pass out a draft of these definitions after the next break and agree upon a final working definition of each.



Trainer Notes: Transition Points into Next Activity

1. **Explain** to the group that both men and women can help to reduce risk factors that contribute to HIV, stigma, and related issues if they are equipped to recognize and deal with them from an informed, gendered perspective.
2. **Negative gender norms are a risk factor.** People are influenced by their own cultures and traditions, sometimes without realizing it. Everyone is taught as children and adults to behave in certain ways according to gender-based norms, but everyone should have access to the same basic rights.
3. Once we recognize these and any other norms that put people at particular risk, we can change them. Trainers, educators, advocates, program implementers, and people living with HIV in their daily lives also can help to challenge gender-based norms and stereotypes by being more aware of how gender influences behavior, including their own actions.



Activity: Sex and Gender

Time: 30 minutes

Materials: Flip chart, markers

Objectives:

- To help participants understand the difference between “sex” and “gender.”
- To recognize gender stereotypes and why they are important.



Instructions for Facilitator

Directions:

1. **Draw** three columns on flip chart paper.

2. **Label** the first column “woman” and leave the other two blank.
3. **Ask** participants to identify personality traits, abilities, and roles often associated with women in their community, region, and broader society. These may include stereotypes.
4. **Write** their suggestions in the “woman” column.
5. **Label** the third column “man” and **ask** participants to again make a list of personality traits, abilities, and roles often associated with men. These also may include stereotypes.
6. **Make sure** that participants provide examples related to HIV and/or broader issues of health.

Examples:

- Women are biologically more susceptible to HIV.
 - Women should not be seen carrying condoms in their purses.
 - Women are expected to stay home and care for children.
 - Women are unable to negotiate condom use effectively.
 - Most commercial sex workers and people who engage in sex for money are women.
 - Women are the center of the family.
 - Women hold the honor of the family.
 - Women teach their family values and rules for healthy living.
 - Women are encouraged to be chaste.
 - Women, if not tamed, have an overabundance of sexual energy they cannot discipline without the help of family, community, and traditional practices.
-
- Men can participate in certain risk behaviors that women cannot.
 - Men experience peer pressure to be sexually active.
 - Men tend to avoid responsibility.
 - Men do not like condoms.
 - Men can negotiate condom use more easily than women.
 - Men have more financial resources than women.
 - Men should protect women in all ways possible.
 - God intended men to support the health and strength of the family.
 - Men usually have multiple partners when single or married.
 - Men are the center of the family.

7. **Make sure** that both columns include both positive and negative words or phrases.
8. **Reverse headings** by writing “man” above the first column and “woman” above the third column.

9. Working down the list, **ask** participants whether men can exhibit the characteristics and behaviors attributed to women, and vice versa.
10. **Place** those attributes usually not considered interchangeable into the middle column and **label** this column “sex.”
11. **Discuss** all of the items in the “sex” column and any main issues from the other two.
12. **Stress** that stereotyped ideas about female and male qualities can be damaging because they limit our potential to develop a full range of possible human capacities, including healthy behavior choices.



Activity: Women’s Vulnerability to HIV

Time: 1 hour 30 minutes

Materials: Flip chart, markers



Instructions for Facilitator

Directions:

1. **Introduce** the topic of gender, how gender refers to both men and women and related masculine and feminine identities and, further, how gender roles can affect how one lives with HIV.
2. Group discussions (45 minutes): **Divide** women into small groups and discuss the following topic areas with each group: education, social/cultural factors, economic issues, legal issues, and treatment and care. **Ask** the groups to discuss gender factors within each topic area that affect men and women living with HIV (see bullet list that follows below and sample questions).
3. Participant groups will have 45 minutes to discuss all topic areas listed below. Participants can prioritize topics in case they do not have time to cover all areas. One person from each group will be recording answers for each category on a piece of flip chart paper or as notes, while another person will be designated as the speaker for the group to share the findings from the discussion.

4. After the group discussion is finished, both groups will report back to the larger group. (45 minutes)
5. Facilitators should **make sure** that gender is not seen as a dichotomy between men and women, but rather as in the more complex terms of gender roles and identity, including issues surrounding men who have unsafe sex with men and other at-risk groups, where appropriate. Briefly discuss the range of stigma and discrimination for each topic area, as well as other effects.
 - Education
 - Social/Cultural
 - Economic
 - Legal
 - Treatment and Care



Trainer Notes:

Below are some region-specific points to keep in mind as you navigate the discussion topics with participants. Encourage discussion of participants' knowledge of country-level policies and programming, in addition to personal experience. It is important to note that the impact of HIV-related stigma also reinforces pre-existing educational, cultural, social, legal, and treatment disadvantages, including those related to access to information and services.

- **Education**—In some cultures, boys are given greater priority for access to schooling, while girls and women do not have the same opportunities. Although in some MENA countries, the gap between girl's and boy's access to education is narrowing, illiteracy and lack of access to education remain barriers in the region, which faces the highest incidence of illiteracy among women and girls in the world. In some countries in the region, such as some Gulf countries, however, women actually have similar or higher literacy rates than men. When women have access to education, they have access to correct information and greater knowledge and are empowered to make healthy personal choices. However, access to education related to anatomy, sex, sexual reproduction, pleasure, and safety is extremely limited.

Question: What are the taboos related to certain kinds of information, especially those just listed about sex?

- **Social Relationships and Sociocultural Contexts** – In MENA, there is a culture of silence around sex and sexuality. Complex social and cultural barriers have made talking about sexuality and, in particular, women’s sexuality, pleasure, anatomy, and safety, taboo in MENA countries. If people cannot talk about sex and sexuality, discussion of HIV and AIDS is especially challenging. Social and cultural influences can be broad and varied. Gender constraints and opportunities need to be investigated in specific contexts, as they vary over time and across social relationships, partnerships, households, communities, civil society, and governmental organizations/institutions. Sociocultural context, involving ethnicity, class, race, residence, and age also influence gender constraints and opportunities.

Question: Can women talk about sex related to pleasure? When and where is it safe to talk about this subject? When and where would it not be safe to talk about this subject, and why? Can this be changed?

- **Girls and women in MENA** also face harmful traditional practices, including early marriage and female genital cutting/mutilation (FGC/M), which is widespread in several MENA countries. For example, in Egypt, more than 90 percent of women and girls over age 10 face FGM; in Yemen, more than 20 percent of the female population is affected.¹⁰ FGM creates greater vulnerability to HIV in perpetuating women’s and girls’ lack of control over their own bodies, including advocating for safer sex. FGM also creates greater physical vulnerability due to the highly injurious practices (including unsterilized instruments) often implemented by midwives, hairdressers, and barbers with cultural, traditional, and local legitimacy to perform ‘circumcisions.’ This practice often takes place just before marriage to ensure chastity. Health is further complicated during childbirth. When practices that are unhealthy for women are secured by longstanding social and cultural traditions, it is even more difficult for women to be empowered to make healthier choices and transform unhealthy norms. Further, a culture of shame often surrounds women and girls living with HIV in the region—females generally are regarded as symbols of family honor as related to sexuality and chastity. If a woman is living with HIV, she often is seen as bringing shame not only to herself, but to her family, extended family, and even the entire village. This often results in social isolation and community expulsion.

10

Where women are blamed, this can lead to:

- heightened levels of sexual and domestic violence that create both physical risk of contracting HIV and an unhealthy power relationship between abused and abuser, where women are often emotionally stripped of their ability to negotiate healthy, safe sexual relationships.
- abandonment by families and communities
- forced abortion or sterilization
- loss of jobs loss of livelihood opportunities

Question: Are the consequences different for women and men living with HIV in MENA? If so, in what way and in what context (family, community, within one's church, mosque, or workplace)?

- **Economic** –In the MENA Region, women make up the majority of people living in poverty and abject poverty. Women's access to economic power is limited, as the region also has the highest unemployment rate among women globally.¹¹ When women live in poverty, daily survival takes precedence over longer-term needs, including access to HIV information, testing, and care, all of which can be perceived as less urgent than food, water, and basic needs. Further, women living in poverty may then be forced to engage in commercial sex work, survival sex, or transactional sex, which also can put them at risk for HIV.

Question: From an economic perspective, women may often be in a position of caring for other HIV-positive people, such as their husbands and children, which could affect their ability to work in a paid position. Further, women living with HIV often lose their jobs due to their HIV status, just as men do. This in turn could lower their economic quality of life. How has this worked in your own family and community? How could this burden be shared?

- **Legal** – HIV in the MENA Region is also a human rights issue. High levels of HIV stigma and discrimination include travel policies restricting PLHIV from legally entering some countries, based on their HIV status; school expulsions; house evictions; and rejection within the community. Healthcare providers also sometimes stigmatize PLHIV and refuse to provide them with services. As a result, people who are possibly infected often do not seek the necessary tests due to shame, fear, and potential stigma and discrimination. In addition, stigma and discrimination have led to egregious human rights abuses throughout the region, ranging from domestic to state-sponsored abuse. In settings like MENA, where heterosexual transmission is a leading mode of transmission, HIV infection

11

has been associated with female sexual behavior that is not consistent with gender norms and is often criminalized. For example, commercial sex work is widely perceived as a totally unacceptable female behavior and female sex workers often are identified as vectors of infection, putting their clients and the clients' sexual partners at risk.

Women and men living with HIV are entitled to certain rights, such as the right to marry and have a home, a family, and a job, and also are responsible for protecting themselves and others. However, even where there are supportive laws, many women and men do not know about them, while other laws and policies actually prohibit access to support and basic rights. For example, marriage laws in the region can fuel women's vulnerability inside relationships in which they have little power, as most laws confirm a husband's custodial rights over his wife. Further, male supremacy within the family is reinforced under Personal Status Laws; under these laws, most women in MENA countries do not have the right to ask for a divorce or oppose polygamy, marital rape, or other forms of subordination and abuse. While some laws in the region protect women and men living with HIV, it is often difficult to translate laws into practice if they oppose strongly held beliefs, practices, traditions, and some interpretations of religion. This is especially true for those practices and cultural norms that relegate women to the private sphere and to positions subordinate to male counterparts in the family and society.

Question: What rights does a woman living with HIV have? What rights does a man living with HIV have? If they are not the same rights, why? How do these rights translate in your own life? Have you ever had to advocate for your rights in your family or community?

- **Treatment and Care** – Only 14 percent of those people in the region who need treatment are receiving antiretroviral drugs. In 2008, treatment coverage in MENA was less than half of the global average for low- and middle-income countries.¹² When provided at all, the regimens for antiretroviral treatment (ART) are limited, as are combination therapies. Treatments are not always provided consistently. Stockouts are not uncommon. In particular, many mothers living with HIV in the region do not have access to ART to prevent mother-to-child transmission. Also, HIV-positive mothers have reported refusal by hospitals and clinics to support childbirth, as well as pre- and postnatal care.

For the large majority of people in the region, voluntary counseling and testing (VCT) is inaccessible. Furthermore, as many as 90 percent of PLHIV in the MENA Region are unaware that they are positive.¹³

¹² UNAIDS. 2009. *AIDS Epidemic Update*. Geneva: UNAIDS.

¹³ Obermeyer, Carla Makhlouf. 2006. 'HIV in the Middle East.' Retrieved on October 2, 2009 from www.bmj.com

When VCT is available, necessary testing crucial to effective treatment—including CD4 and viral load—often is not. Women face added barriers to VCT and treatment, including doctors who will not treat women and girls not accompanied by a male relative; child care concerns; and limited ability and resources to travel to service centers. Further, women also may face gender-based violence after a positive test result.

Question: Is access to treatment a human right or a privilege? Who has the right to treatment in your country? Do women encounter barriers to accessing treatment? What are they? Can they be overcome? If so, how?



SESSION EIGHT: CLOSING AND EVALUATION

Time: 1 hour 15 minutes

Materials: Post-its of various colors, flip chart

Objective:

- To share feelings and feedback about the day.



Activity: Process Group Evaluation

Time: 1 hour

Directions:

1. **Ask** participants to regroup in a circle.
2. **Let participants know** that they will participate in a process group and **review** the objective above.
3. The aim of a process group is to express one's personal feelings and **ask for feedback** from the group or to share one's personal perspective—in this case, regarding the first day of the women's workshop.
4. We also learn about ourselves when we receive feedback from other people.

The co-facilitator will explain the following steps in the process group:

1. Anyone from the group can share his/her feelings and/or thoughts from the day.
2. When someone is speaking, there should be no interruptions, and everyone should focus on good listening skills.
3. To practice, the person can start his/her sentence by saying, "I feel..." Members are specifically asked to phrase sentences as "I" rather than "you" to ensure that the statement remains centered on the person's feelings. This should be done by both those requesting and providing feedback.
4. For example, a participant may say, "I feel happy to be among women living with HIV from my region for the first time, but am nervous about going back home..."
5. The facilitator then **asks** that group member if she would like feedback from the group.
6. If she answers yes, then **let her know** that feedback can be obtained from anyone in the group.
7. When another group member gives feedback, it should not be advice or solutions unless those are requested.
8. The person receiving feedback should acknowledge the feedback. The receiver can rephrase the feedback to ensure clear communication.
9. As mentioned earlier, there should be no putting down of others' values.
10. No person's question or idea is dumb.
11. It is okay to feel embarrassed.
12. No one should ask personal questions.
13. No one needs to justify her behavior.
14. Everyone in the circle has the right to participate or pass.
15. Everyone in the group should feel they have an opportunity to speak but are not forced to do so.
16. All members are asked to speak from the heart.



Trainer Notes

Often process groups can bring out different emotions that can be both intense and difficult to deal with. Be sure to focus this process group on what participants have experienced with this workshop and how they feel about the workshop themselves as a participant. It is best to have someone with counseling skills on hand.

- **Adjourn** and announce any evening events, reminding people what time we will start in the morning. Close with a song, dance, prayer, or another short activity to end the day on a positive note. (5 minutes)
- **Co-facilitators should meet** in the evening to review evaluation forms, discuss the day, and review and prepare for the next day.

DAY 2: POWER, IDENTITY, UNDERSTANDING OUR BODIES, AND SEXUAL HEALTH

Schedule

Session 1: Welcome and Review	30 minutes
Session 2: Body Mapping	1 hour
Session 3: About Sex and Sexual Health	1 hour
Session 4: The Gender Lens	1 hour
Session 5: Power in Relationships	1 hour
Session 6: Agree/Disagree/I Don't Know	45 minutes
Session 7: Young Women's Dialogues	45 minutes
Session 8: Closing and Evaluation:	30 minutes

**Please be sure to factor in time for a coffee/tea break in the morning and afternoon, as well as a lunch break and morning/afternoon energizers.*



SESSION ONE: WELCOME AND REVIEW

Time: 30 minutes

Materials: Flip chart, tape, markers

Prepared Materials:

Prepared Flip Chart: Day 2 Agenda

Objectives:

- To provide a time for participants to lead an activity and warm up the group with an upbeat and fun start.
- To review housekeeping issues and the agenda for the day.



Activity: Welcome and Review of Yesterday

Time: 30 minutes



Instructions for Facilitator

- **Select a participant to lead** warm-up exercise. (15 minutes)
- **Review** the agenda for the day. **Review** highlights from yesterday. (15 minutes)



SESSION TWO: BODY MAPPING

Time: 1 hour

Materials: Flip chart paper taped together to be as long as a person's height or, if you have it, a roll of butcher paper that is wide and long enough to fit a person lying down on the paper; tape; markers

Objectives:

- To reflect on the importance of sexual health, including reproductive health.
- To identify and discuss differences between reproduction and sexuality.



Activity: The Body Map

Time: 1 hour



Instructions for Facilitator: The Body Map

1. **Ask** participants to divide into smaller groups.
2. Each group will ask one of its participants to lie on the floor over a sheet of paper big enough to be able to outline her body.
3. Once an outline of her body is made, the participant can get up and look at the outline as well.
4. **Ask** the group to draw the reproductive and sexual organs onto the body outline drawing.
5. **Ask** the small group to discuss which organs are related to reproduction and which are related to sexuality. Are they the same? Are they different?
6. Participants **share conclusions** of their small group discussion with the broader group.

Group Discussion

- Did you all agree as to what your map has to say?
- Was there anything surprising about the reproductive organs?
- Can you imagine these organs inside of your own bodies?
- Do you think about these organs inside of you every day?
- Do you think they are important? Why?
- Are they intended only for reproduction?
- Do you think they also relate to pleasure, and if so, how?
- Are they the only organs related to pleasure and sexuality?
- Do women and men have different roles related to how their bodies are perceived or related to reproduction and sexuality? How are these roles different?
- Are there traditional practices or ideas that impact any of these organs? How, and in what way?



SESSION THREE: ABOUT SEX AND SEXUAL HEALTH

Time: 1 hour

Materials: Prepared index cards, prepared flip chart with headings: **Fact** and **Fiction**

Objectives:

- To ensure that all participants have accurate information regarding female sexuality and reproduction.
- To dispel myths about sexuality and reproduction.
- To provide an opportunity for participants to think through and discuss various issues related to sexual and reproductive health.
- To provide an opportunity for participants to discuss sensitive issues related to sexual and reproductive health and rights.



Activity: About Sex and Sexual Health

Time: 1 hour



Instructions for Facilitator: About Sex and Sexual Health

- **Ask** participants to split into smaller groups of 3–4.
- **Give** each team a stack of index cards.
- Each group must **match** the statements on the index card to the flip chart heading—either “Fact” or “Fiction,” as they see fit.
- All participants should join together and see how each statement has been placed and **discuss** those cards where there is no agreement.

Sample statements that can be listed on index cards (one statement per card):

- A woman cannot get pregnant the first time she has sex.
- A woman can get pregnant while she is menstruating.
- A woman with a sexually transmitted infection will feel ill or develop warts on her vagina.
- Contraceptive pills protect women from sexually transmitted infections like HIV and syphilis.
- A healthy woman's menstrual cycle should be 28 days long.
- Sperm can live as long as seven days inside a woman's body.
- Some sexually transmitted infections can leave women infertile.
- Extreme pain during menstruation is normal for young women.
- Jumping up and down immediately after sex will drain sperm from a woman's body and prevent pregnancy.
- All women over 21 years old who are sexually active should have an annual pelvic exam and Pap test.
- Older women usually have abdominal and pelvic pain—it is a part of growing older.
- Removing a woman's clitoris ensures that she will not be sexually promiscuous and that she will be marriageable; it ensures her honor and that of her family.
- A woman should not focus on having sexual pleasure; rather, intercourse for a woman should focus on having children and her partner's pleasure.
- Women cannot have sex with other women.
- If a woman has sex when she is married, she is safe from HIV infection.
- A woman should space the time between giving birth to one child and becoming pregnant again.



Facilitator Background Notes: Answers to Sample Statements

A woman cannot get pregnant the first time she has sex.

False. A woman *can* get pregnant the first time she has sex. The likelihood of becoming pregnant from a single act of unprotected sex varies from person to person and also depends on the stage of a woman's menstrual cycle. The probability is highest around the time of ovulation (when the egg is released) when, on average, up to one-third of women will become pregnant from having sex once.

A woman can get pregnant while she is menstruating.

True. Most women do not ovulate during their period. However, eggs may live for 2 days and sperm may live for up to 7 days inside a woman's body. The sperm and

the egg could fertilize during a woman's menstruation, but it's rare. It is important also to remember that menstrual blood can transmit HIV, so you should definitely practice safe sex during your period.

A woman with a sexually transmitted infection will feel ill or develop warts on her vagina.

False. Although some sexually transmitted infections (STIs) present symptoms, many do not. If you feel you might be at risk and are without symptoms, you should get checked for STIs by your doctor. A regular pap smear and check-up every year can ensure that any infections are detected and treated.

Contraceptive pills protect women from sexually transmitted infections like HIV and syphilis.

False. Contraceptive pills do not protect women from STIs and HIV. Contraceptive pills offer no protection against any type of STI, and women need to keep this fact in mind when using oral contraceptives. According to the U.S. Centers for Disease Control and Prevention (CDC), the only way for sexually active women to reduce the risk of HIV or other STIs is through the "consistent and correct use of latex condoms." Consistent and correct use of condoms can greatly reduce a person's risk of acquiring or transmitting most STIs, including HIV infection.

A healthy woman's menstrual cycle should be 28 days long.

True. But it does not have to be exactly 28 days. The menstrual cycle is the series of changes a woman's body goes through to prepare for a pregnancy. About once a month, the uterus grows a new lining (endometrium) to get ready for a fertilized egg. When there is no fertilized egg to start a pregnancy, the uterus sheds its lining. This is the monthly menstrual bleeding (also called menstrual period) that women have from their early teen years until menopause, around age 50. The menstrual cycle is from Day 1 of bleeding to Day 1 of the next time of bleeding. Although the average cycle is 28 days, it is perfectly normal to have a cycle that is as short as 21 or as long as 35 days. Further, for a teenage girl, a normal cycle can last up to 45 days.

Sperm can live as long as seven days inside a woman's body.

True. The normal timeframe for sperm to live inside a woman's body is two to three days. However, sperm can live inside the body for seven days as long as the conditions are favorable. For the conditions to be favorable, fertile cervical mucus must be present. Cervical mucus that has the consistency of egg whites is considered fertile and provides support for the sperm while attempting to fertilize the egg. In this type of cervical mucus, sperm can move faster and also can benefit from the protective layer that the mucus provides.

Some sexually transmitted infections can leave women infertile.

True. For example, pelvic inflammatory disease may result from nearly 40 percent of all untreated chlamydia and gonorrhea infections, causing infertility. Ectopic

pregnancy, chronic pelvic pain, and other complications also may result from untreated chlamydia or gonorrhea. These complications may be preventable if the infection is diagnosed and treated in a timely manner. This is why it is important to get regular check-ups by your doctor and visit your doctor if you think you may be at risk.

Extreme pain during menstruation is normal for young women.

False. While bloating and cramping are a normal part of a woman's period, extreme pain is not and should be addressed by a doctor.

Jumping up and down immediately after sex will drain sperm from a woman's body and prevent pregnancy.

False. There are many myths that sneezing, coughing, and jumping up and down after sex will dislodge sperm. These are all untrue; sperm are too quick and too tiny for any of these methods to work. Plus, placing objects (such as seeds or plants) into the vagina before, during, or after sex will have no effect on preventing conception. This behavior can be dangerous, as it can be harmful to the female's body.

All women over 21 years old who are sexually active should have an annual pelvic exam and Pap test.

True. Screening should start soon after having vaginal intercourse or by age 21. Beginning at age 21, women should have a pelvic exam and Pap smear every year to check for cervical cancer. Women who are sexually active should be screened for Chlamydia infection. This can be done during a pelvic exam.

Older women usually have abdominal and pelvic pain—it is a part of growing older.

False. Abdominal and pelvic pain is *not* a natural part of growing older. Any time a woman has abdominal and pelvic pain, she should see her doctor. At any age, this may be a symptom of a larger problem, such as an infection that needs to be treated.

Removing a woman's clitoris ensures that she will not be sexually promiscuous and that she will be marriageable; it ensures her honor and that of her family.

False. Removing a woman's clitoris is extremely dangerous; is physically, emotionally, and spiritually harmful; and does not impact the level of promiscuity or chastity. Women are capable and have the right to manage their sexual lives. Women have the right to keep their bodies intact and have personal control over their own bodies. Women and girls should not be mutilated or harmed in any way to control their enjoyment and ability to have sex.

A woman should not focus on having sexual pleasure; rather, intercourse for a woman should focus on having children and her partner's pleasure.

False. Sexual pleasure is the right of every woman and man. When a woman is with a supportive partner inside a healthy relationship, both she and her partner will ensure that sex is enjoyable for themselves and each other. Of course, sex can lead to childbearing, but this is not the only function of sex for a woman or a man.

Women cannot have sex with other women.

False. In any country or region, there are people who are gay, lesbian, and bisexual, even if this is not in keeping with longstanding traditions. Some men have sex with men and some women have sex with women. Sexual orientation and identity can change over time or stay the same. Furthermore, women can transmit HIV to other women, including via vaginal fluid.

If a woman has sex when she is married, she is safe.

False. According to the 2009 UNDP Arab Human Development Report, 80 percent of HIV infections among women in MENA occur within marriage.

A woman should space the time between giving birth to one child and becoming pregnant again.

True. Having children too close together has long been associated with increased risk of various adverse health outcomes—including mortality—for infants, children, and mothers. Increasing the interval between births and delaying age at first motherhood can reduce infant, child, and maternal mortality significantly. Optimal birth spacing can save lives and improve the health and well-being of mothers and their families.



SESSION FOUR: THE GENDER LENS

Time: 1 hour

Materials: Flip chart, markers, paper, pens

Objectives:

- To explore perceptions of the “ideal” man and “ideal” women according to local culture and gender roles.
- To identify the impact these roles have in women’s and men’s lives, including the effects on vulnerability.



Activity: Ideal Images and Personal Destroyers

Time: 1 hour



Instructions for Facilitator: Directions for Activity

1. **Ask** participants to split into small groups of 3–4 people (preferably of same age—for example, under and over 30—or group them on another agreed-upon parameter).
2. **Tell** the groups to focus on the ideal image of a person their age and gender in their society.
3. **Ask** each participant to draw this ideal image related to their own age and sex, using key words if they like, to describe this image on paper.
4. **Ask** each participant in the small group to **share** and describe their picture.
5. Each group will **discuss** this particular ideal image related to their own age and sex.
6. Each group will then **discuss** how easy they find it to live up to the expectations their society has for them. **Ask** each group to describe what their ideal image is expected to say and do, or *not* to say and do.
7. Then **ask** group members to address the ideal image for men their own age.
8. After 15 minutes of **small group discussion**, **ask** participants to come back to the larger group and **share** their group's discussion with the larger group.
9. Then ask participants to **re-form the small groups** to see how easy they actually find it to live up to the expectations their society has for them.
10. After 15 more minutes, **ask** the groups to come back to the larger group in a circle again and **share** with the whole group what their real experiences are. **Encourage** participants to discuss the differences identified between image and reality.

Discussion Notes

The facilitator will **expand** on this discussion of ideal images, highlighting the following:

- It is important to note that we all have ideal images regarding how we are “supposed” to behave and look.
- There is always a gap between our images and our reality. This helps participants realize how hard it is to live up to those ideals at times.
- **Explain** that these ideals actually can be personal destroyers when we try to live up to them. For example, if people think that “a woman’s place is in the home,” this can be used as an excuse to take girls out of school early. Or the belief that men must lose their virginity by a certain age can force some youth to have a sexual début before they are ready.
- **Encourage** participants to think of some of the examples they already have mentioned and how these can be personal destroyers that can eat away at their self esteem, self image, and self worth.



SESSION FIVE: POWER IN RELATIONSHIPS

Time: 1 hour

Materials: Flip chart, tape, markers

Prepared Materials:

Prepared Flip Chart: A drawing of a ladder, pictures of people from magazines or newspapers (about 3 for each participant—minimum of 25).

*Please note: Make sure that the pictures of the people (which you will cut out ahead of time for this exercise) are diverse—different sexes, ages, socioeconomic classes, dress, races, notoriety, public profiles, perceived attractiveness, modesty, etc. Where possible, use a majority of region-specific and relevant images.

Objectives:

- To explore perceptions of power.
- To discuss dynamics of power and how they impact our lives.



Activity: Power in Relationships

Time: 1 hour



Instructions for Facilitator: Directions for Activity: The Ladder of Power

1. **Make a simple drawing** of a ladder on a piece of flip chart paper. This ladder represents the hierarchy of power.
2. **Ask** participants to select pictures of people (from magazine and paper cut outs—see prepared materials above) and place them at different levels of the ladder, according to the perceived power they have in society.
3. In the large group, **discuss** which factors are involved in our perception of power and how relationships develop based on that perception.

Discussion Notes

The facilitator will lead further discussion on power in relationships and the “ladder of power.”

- **Present** the exercise, **asking** participants to reflect on what made them choose a certain place on the ladder for one person rather than another.

Discussion Questions

- What is it that positions one person at the top of the ladder and others at the bottom?
- What made you put that person in a certain place on the ladder?
- How do we perceive that person's power?
- In what aspect of life does this person have power (personal, professional, social)?
- How can s/he show that power?
- Do different dimensions of social location play a part in the kind of power this person has (race, class, sex, age)?
- What happens if that person loses his/her position?
- On what does power depend to increase or decrease in strength?
 - Try to **introduce** the concepts of "power **over**" versus "power **with**" — which seems more useful for the whole of humanity? Why? What is the difference?
 - **Relate** this exercise to gender inequality and the construction of a society that puts people up or down the "ladder," thus conferring power unrelated to one's worth. Where should we center power?



SESSION SIX: AGREE / DISAGREE / I DON'T KNOW

Time: 45 minutes

Materials: Prepared signs/flip chart paper posted on the wall for groups of participants to stand under, according to the activity directions below. Prepare one sign that says “**Agree**” in large letters, another sign with “**Disagree,**” and a third sign that states “**I Don’t Know.**”

Objectives:

- To provide a safe, confidential forum for discussion around sensitive subjects that are sometimes taboo.
- To provide women an opportunity to discuss myths, misinformation, cultural expectations, and traditions that affect their lives.
- To clarify the rights women and men have which may conflict with traditional and cultural practices, roles, and expectations.



Activity: Agree/Disagree/I Don't Know

Time: 45 minutes



Instructions for Facilitator: Agree/Disagree/I Don't Know

1. **Explain** to participants that you will be reading a series of statements.
2. After each statement, participants should stand under the sign that reflects their opinion on the statement, showing whether they agree, disagree, or don't know.
3. **Tell** participants that, while they are encouraged to share their perspectives and discuss the statements, the exercise is not a debate and no efforts should be made to change anyone's perspective. It is a chance to share and discuss without judgment.
4. After each statement, **ask** for volunteers from each opinion group to share their perspective.
5. **Choose** the statements you feel are most appropriate to the group and **add** any others that may be interesting.
6. Use the opportunity to **correct** any misconceptions revealed during the discussions.

Discussion Points

- Sex before marriage is morally wrong.
- Anal sex is unnatural.
- A woman who has had more than three sexual partners is promiscuous.
- Oral sex between consenting adults is acceptable.
- A woman should marry the man her parents choose for her.
- A man's sexual drive is stronger than a woman's.
- After a certain point of arousal, a man cannot control himself.
- Women should enjoy sex.
- Women should have full control over how many children they have and the spacing of those children.

- It is unnatural for a woman to be sexually attracted to other women.
- If a woman gets a man sexually aroused, it is her responsibility to satisfy him.
- If a drunk woman is raped, it is her own fault.
- It is okay for a woman to be attracted to both men and women.
- A husband can force his wife to have sex.
- Teenagers should be taught about sex and provided with condoms if they decide to have sex.
- Sometimes a woman can be responsible for being raped.
- Women should have as many sexual partners as they choose.
- It is acceptable for girls to marry older men if they have parental approval.



SESSION SEVEN: YOUNG WOMEN'S DIALOGUES

Time: 45 minutes

Materials: Flip chart, markers

Prepared Materials:

Handouts: ICW's "Young Women's Dialogues" Reports and ICW Vision Paper 1 "HIV Positive Young Women" (available in Arabic, English, and French)

*Please note: You can access the ICW "Young Women's Dialogues" reports at <http://www.icw.org/node/398>; and the ICW Vision Paper "HIV Positive Young Women" at http://www.icw.org/files/VP1_young_eng.pdf.

Objectives:

- To provide a safe space for young women to reflect on the issues they are most concerned about as women living with HIV.
- To encourage young women's reflections and exchanges on their own lives and vulnerabilities.
- To promote knowledge and self-autonomy among young women to better protect their health and well-being.



Activity: Young Women's Dialogues

Time: 45 minutes



Instructions for Facilitator: Directions for Activity: Young Women's Dialogues

1. Briefly **set the framework** for discussion, explaining why this session was considered necessary.
2. If the group is too big (more than 15), propose to **split into smaller groups**, which can facilitate participation.
3. **Ask** groups to discuss the proposed issues: young women and HIV, religious and cultural beliefs, sex and sexuality. You can use the Discussion Notes questions below to start the conversation.
4. Bring the group back together and share the conclusions of smaller groups. **Continue the discussion** in the bigger group.
5. **End** by proposing to identify positive ways to address the identified issues.

Discussion Notes

- Women in the MENA Region between the ages of 15–24 are twice as likely as their male counterparts to be HIV positive. Why do you think this is the case?
- Do you feel it is worthwhile to provide this separate space for young women living with or vulnerable to HIV to access support? Why or why not?
- What kind of space is most comfortable for young HIV-positive women to discuss issues that are important in their lives and to access support?
- Identifying our realities as HIV-positive young women, how different are young women's realities and vulnerabilities from those of older women and/or men? In what ways are they different from these other groups?
- Do religious and cultural beliefs affect young women's lives in MENA? If so, how? How can these beliefs affect young women's health and rights? What do you think would help to reduce the negative impacts and increase any positive effects?

- How are sex and sexuality addressed among young women, especially those who are HIV positive? What do you think are the sexual and reproductive issues specific to young HIV-positive women?
- Is it only men who often have power over younger women? What about older women? In what ways?
- Can you identify ways in which these issues above can be addressed more effectively?



SESSION EIGHT: CLOSING AND EVALUATION

Time: 30 minutes

Materials: Post-its of various colors, flip chart

Objective:

- To share feelings and feedback about the day.



Activity: Evaluation

Time: 30 minutes



Instructions for Facilitator

- **Use** three colors of post-its—one for something they learned, one for something they liked, and one for something that needs improvement. **Group these** according to color on different flip charts for review. (15 minutes)
- **Adjourn** and **announce** any evening events, **reminding** people what time we will start in the morning. **Close** with a song, dance, prayer, or another short activity to end the day on a positive note. (15 minutes)
- **Co-facilitators should meet** in the evening to review evaluation forms, discuss the day, and review and prepare for the next day.

DAY 3: FAMILY LIVING

Schedule

Session 1: Welcome and Review	30 minutes
Session 2: HIV-positive Women Discuss Safe Motherhood	1 hour 30 minutes
Session 3: Violent Relationships	1 hour 30 minutes
Session 4: What is Love?	45 minutes
Session 5: How to Discuss Feelings about a Problem and Couple's Communication	3 hours 30 minutes
Session 6: Serodiscordant Couples Discussion	1 hour
Session 7: Closing and Evaluation	30 minutes

**Please be sure to factor in time for a coffee/tea break in the morning and afternoon, as well as a lunch break and morning/afternoon energizers.*



SESSION ONE: WELCOME AND REVIEW

Time: 30 minutes

Materials: Flip chart, tape, markers

Prepared Materials:

Prepared Flip Chart: Day 3 Agenda

Objectives:

- To provide a time for participants to lead an activity and warm up the group with an upbeat and fun start.
- To review housekeeping issues and the agenda for the day.



Activity: Welcome and Review of Yesterday

Time: 30 minutes



Instructions for Facilitator

- **Select a participant to lead** warm-up exercise. (15 minutes)
- **Review** the agenda for the day. **Review** highlights from yesterday. (15 minutes)



SESSION TWO: HIV-POSITIVE WOMEN DISCUSS SAFE MOTHERHOOD

Time: 1 hour 30 minutes

Materials: Flip chart, markers, post-it paper, pens, paper

PowerPoint (PPT) Parent-to-Child Transmission (**see below**)

Objectives:

- To advance the understanding of safe motherhood in the context of HIV.
- To promote recognition of HIV-positive women's rights to safe motherhood and related responsibilities.
- To achieve better knowledge of gender bias as it relates to parenthood.



Activity: Safe Motherhood and Women Living with HIV

Time: 1 hour 30 minutes



Instructions for Facilitator: Directions for Activity: Safe Motherhood

1. **Start** with a broad-based group discussion to assess the interests, concerns, doubts, fears, and requests from participants related to living with HIV as a woman and the wish to be a mother or the experience of being one.
2. This discussion should include the following:
 - Specific risks when future father/mother is HIV positive
 - Mother's health condition when she is positive
 - Treatment issues
 - Risks during pregnancy
 - Delivery/birth
 - Breast/formula feeding
 - Other factors to consider (emotional, social, family...)
3. You can also **provide** the PMTCT handout (**Annex 8**) in this curriculum.



Facilitator Background Notes: Pregnancy and Babies, and Mother-to-Child-Transmission

HIV can pass from an HIV-positive woman at any stage during her pregnancy, when giving birth, or during breastfeeding. We now know that most transmission occurs during birth or when a mother is breastfeeding her baby. If a woman is unaware of her HIV status, and if she is positive and nothing is done, her baby has a 1 in 3 chance of becoming HIV positive as well. If the mother has a safe delivery, takes anti-HIV drugs, and formula feeds the baby, the chance of HIV transmission can be lowered significantly, meaning that her baby has a much higher chance of being HIV negative. It is for this reason that many antenatal clinics (ANC) and maternity hospitals now offer HIV testing at the beginning of pregnancy so that support, treatment, and advice can be given to pregnant and new mothers living with HIV.

Source: 'It's My Life: A Guide for Women about HIV/AIDS' AIDS Alliance, 2006.

Discussion Notes

- It is important to separate the need for practical information around safe motherhood from the right of HIV-positive women to have children and receive the necessary support. **Discuss** the following questions:
- Do women living with HIV have the right to become mothers? Why or why not? Is there additional responsibility for HIV-positive women?
- Is parenthood seen differently in HIV-positive women and men? What are the differences?
- How do we include HIV-positive motherhood in the frame of sexual and reproductive rights?
- What is/must be the role of contraceptive methods?



SESSION THREE: VIOLENT RELATIONSHIPS

Time: 1 hour 30 minutes

Materials: Flip chart, tape, markers

Prepared Materials: Stories of violence—one story per page, translated into appropriate language (Arabic, English, French, etc.).

Objectives:

- To open the discussion up to violence in relationships and why it is important to address this topic.
- To discuss the different forms of violence.
- To note and discuss participant definitions and thresholds for violence in relationships.



Activity: Stories of Violence

Time: 1 hour 30 minutes



Instructions for Facilitator: Stories of Violence

1. **Explain** that some of these stories (see below) will be read by volunteers. The stories will present some examples of how violence affects women.
2. **Ask** the volunteers to read select stories.
3. After the readings, **ask** the readers their impressions of the stories they read.
4. **Ask** all participants what forms of violence were portrayed. Was each person experiencing violence? Were there similarities in the stories?
5. On flip chart paper, **write** down key terms as they are mentioned.
6. **Talk about** the different forms of violence and how violence against women can be
 - Physical
 - Emotional and Psychological
 - Sexual
7. **Note** differences in what participants consider an act of violence.
8. **Read** the stories of violence below and **discuss** each, including:
 - Is the narrator of the story facing violence and, if so, what kind(s) of violence?
 - How would the person telling the story be treated by her family if she lived in your country?
 - How would the person telling the story be treated in your community?
 - How would the person perpetrating the violence be treated in his family if he was living in your country? Your community?
 - How could this kind of violence be addressed in a positive way in your own community? Could it be changed? Why or why not?
 - If this person facing violence was in your family, how could this kind of violence be addressed in a positive way in the family? Could it be changed? Why or why not?



Facilitator Background Notes: Examples of Abuse

- **Physical:** Many women face beatings and violent forms of physical abuse that **can scar, bruise, break, and physically harm a woman.**
- **Emotional and psychological:** Emotional abuse can include harmful statements about a woman's appearance, her family, her choice of friends, and her interests. It also can be seen in the form of cutting off a woman or girl from friends and family or accusing her of being unfaithful, dishonest, or cunning. This kind of abuse may include control over a woman's dress, her behavior, or her choices in life. Emotional abuse also can include manipulation.
- **Sexual:** Women can be sexually abused within relationships, even marriage. Marital rape is one form of sexual abuse.

Stories of Violence:

Story 1: Teenage girl who is in an abusive relationship. She has been cut off from friends and outside activities.

"I'm a university student and have been with my fiancé for the last eight months. I used to be involved with many activities, such as going to my young women's club. I played handball and loved to go to the movies and shopping with my girlfriends. But my fiancé doesn't like me doing these things. He says he wants me 'all to himself.' It's so sweet that he loves me that much. But sometimes I also wish I could also be with my friends and playing sports, but that makes him mad and I don't want my fiancé to drop me."

Story 2: Young married woman being physically abused by her husband.

"My husband and I got married last year. Although it was an arranged marriage and I was hesitant to accept my parents' choice, we had a beautiful wedding day.

It started off quite well, but a few months ago I was late getting home from work and my husband was really angry. He wanted to know where I had been and asking who I was with. I was really surprised by his reaction. He wouldn't let it go and then started criticizing, that I wasn't cleaning the house well and that there was no dinner ready. When I suggested he could help out too, he started shouting about my disobedience and slapped me hard.

I was shocked and crying and then he was very sorry for hitting me. He said he'd never

do it again. But then a week later, he was angry and hit me again. It's been getting worse and now he wants me to quit my job, but every time he hits me he says I have done something to make him mad and that he's sorry. I am scared that his temper is getting worse and I don't know what to do. My mother says it's my duty to stay with my husband."

Story 3: Young woman who has been sexually assaulted.

"I was at a friend's birthday party and met someone. We started talking and he seemed really nice. There were a lot of people, so he asked me to step outside for a minute to get some fresh air.

He took my hand and we walked outside. There was no one around. He tried to kiss me and I said no, we have only just met. But he didn't listen to me. He just laughed and said, 'don't be such a prude.' I got scared and angry and told him to stop but he became rough and pushed me to the ground. I tried to scream and get away but he covered my mouth and held me down and raped me against my will. I am so ashamed. I know it was wrong and that he broke the law but who will believe me? Sometimes I wonder if it was my fault."

Story 4: Young married woman whose husband does not want her to study or work outside the home. She has no control over the household income and is regularly put down and insulted.

"My husband won't let me work. He says that is his job as husband and he says he's the head of the family and besides, who would want to hire me? It's true that we have enough money for our needs but I would still like to have an interesting job as well as take care of our little daughter. My husband keeps me like a bird in a cage. We have a beautiful house but he decides what is bought and gives me a small allowance. He says it's my duty to be a good wife and to do what I am told and that he knows best how much money I need.

Sometimes I am so embarrassed buying food, as I do not have enough money to get what we need. Then when I ask for more he explodes and does not trust that I have used my allowance well. He wants to control everything I do and I feel so stupid."

Story 5: Woman forced to have sex with her husband.

"The last five years of my marriage were like a fairytale of joy and happiness. Two months ago I discovered that my husband was having an affair. We agreed that we would use condoms.

Last night he said that he is faithful now and won't use condoms anymore. I refused to have sex with him, but he demanded what he called his "marital rights." Now I don't know what to do. His is my husband. Maybe I have no right to refuse to sleep with him."

Story 6: Young woman being sexually abused by her father.

“When my mother works the night shift, daddy comes into my room and makes me touch his penis. I hate doing it, but he tells me that I will bring shame to the family if I told anyone. Besides, who would believe me? Everyone loves daddy. I feel so ashamed.”

Story 7: Woman falsely accused of adultery and afraid of being killed.

“I stayed longer at granny’s house because she was ill. I missed the bus that would take me close to home. There was one man at the bus stop when I got there, and I was glad that I knew him because it was getting late. Rain began to fall and he opened his umbrella to share with me.

Someone must have seen me because when I got home my husband accused me of being out with another man. I tried to explain but he was furious and told me that he will get me for this. We all know about wives who have been killed for being caught with another man. I am so scared.”

Story 8: Young woman being sexually harassed by a male supervisor.

“After every department meeting my supervisor asks me to stay in the room after everyone leaves. Even though he talks about work, he stands so close to me I can feel his breath, and sometimes I am right against a wall. He also calls me “sexy” or “honey” when no one else is around. It makes me feel so bad, but what can I do? He is my boss. Maybe I am just overreacting. After all, he has never touched me.”

Story 9: Young woman being emotionally and psychologically abused by her mother-in-law.

“Once I turned 17, I married my husband and moved into his apartment on the second floor of his family’s home. His parents live on the third floor and his brother lives on the third floor. Once I moved into the home, my husband’s mother expected me to clean the house, cook food, and do laundry every day according to her directions. I did not know how to cook that well but learned quickly. But, no matter how hard I tried to make everything perfect, she would criticise my work and say that I was lazy or incapable of being a good wife to my husband. Sometimes she would call me names as though she was joking, but it still hurt my feelings. One day, she found my cell phone in my purse and asked me who was calling me. My friends from school and I still text and call each other even though we are married now. I have one friend who is also my cousin who I have known since I was little, but he is a boy. Sometimes he sends me text messages. She reported this to my husband, who also questioned me. She then took away the phone and said that I did not need to call anyone and that cell phones were expensive.”

Story 10: Female Genital Mutilation

“When I was 12, my mother and father went on vacation and left me with my aunt. When they were away, my aunt decided that I should be circumcised as a favor to my mother and father. Many women do this in our village as favors to relatives with girl children, since when a girl is circumcised she can be in pain, crying and difficult to deal

with. We have a woman in our village who does the circumcision for everyone and everyone trusts her and relies on her. I did not know at first what my aunt wanted me to do; she had three women who were friends over at the time and they were all being very nice to me but then I saw the woman who performs circumcisions come into the living room. They all held me down and the woman used a sharp razor blade. I still remember the pain and crying. I fainted and woke up in worse pain and could not stop crying or bleeding. I wanted to die. My aunt tried to calm me down and told me that now I could get married and that my husband would love me more and find me more beautiful. I didn't care and wanted everything back to the way it was before my parents left. When my mom and dad got home they seemed upset with my aunt, but we never talked about it. I felt ashamed. Years afterward I still had problems going to the bathroom and later having sex with my husband and giving birth to children. Twenty years later, I still face daily pain and have to take medicine to kill the pain."



Facilitator Background Notes: Sensitivity

- Opening up the issue of violence must be done with great care and sensitivity, as some participants may find this activity difficult or upsetting. Some may or may not want to tell their stories to the group or privately to the facilitator. It is also possible that some may have not realized their experience is abusive until this particular activity. Be prepared for surprises and to assist anyone needing support. Check with a local women's organization to get information to share with participants if they need support.
- This exercise can bring up feelings and disagreements. It may remind people of experiences—as victims or perpetrators—that they may never have talked about. Reactions may include anger, sadness, shame, defensiveness, and denial. It is normal to have these kinds of feelings.
- Remind people that anger can be a powerful force for change and identify ways to use it.
- If people are denying their role in this problem, you can help them to look more closely at their reactions.
- Present some of the information and statistics about violence against women in your country, if possible. Stories need to be well adapted to the local/regional context.



SESSION FOUR: WHAT IS LOVE?

Time: 45 minutes

Materials: Flip chart, markers

Objectives:

- To explore what we mean by “love” and the implications of that meaning in daily life.
- To explore what love means as related to our vulnerability to HIV and violence.



Activity: Pair and Group Discussion: What Is Love?

Time: 45 minutes



Instructions for Facilitator: Pair and Group Discussion: What Is Love?

1. **Ask** participants to think of a word or words that mean ‘love.’ You can **write** these words on the flip chart if you like.
2. Once everyone has agreed upon one or two words or expressions meaning love between partners or lovers or between sisters and brothers, **ask** them to divide into pairs, preferably with someone with whom they have not worked before.
3. **Ask each pair** to take turns describing to each other three qualities they show to a close brother, sister, or friend whom they particularly love (start with love between friends or family members, with no sex involved) and then three qualities they expect from the same person who loves them.

4. **Call everyone back** to the full circle and **ask** participants to share their thoughts, first on qualities they show to this person and then on qualities they expect from him/her. Do they think the person they love will share the same views? In what ways might their views differ?
5. Next **ask** each pair to talk again in turn about three qualities they would show to a partner whom they love intimately and three qualities they would expect from a partner who loves them.
6. **Call everyone back** again to the full circle and **ask** them to share their thoughts, first on qualities they would show to a partner whom they love and then on qualities they expect from a partner.
7. Finally, if there are some clear differences in the qualities of love described between partners and those described for other relationships, **ask** them to define these differences more clearly and explain why these differences exist.



Facilitator Background Notes: What Is Love?

- It is important to explore the differences in relationships that involve intimacy and love; for instance, if there are formal contracts or public recognition of a relationship (such as marriage) versus a relationship that may be based on love between two people but not approved by family and society, and how that impacts the quality of that relationship.

The facilitators can help participants explore the nature of love relationships, keeping the following points in mind:

- Other questions to help facilitate the discussion include the following: Is love equal to sex or to marriage? Do they automatically go together? If they don't go together, what are the minimum levels of respect that participants think each member of the couple should show each other?
- Encourage participants to focus on their own perspectives first and on their partner's perspective only when asked to do so.
- It is likely that issues such as trust, sharing, responsibility, sex, money, and family will be mentioned. Be prepared to highlight the complexity of love.
- If polygamous marriage is common in the area, encourage participants to talk about the qualities of this kind of relationship also.



SESSION FIVE: HOW TO DISCUSS FEELINGS ABOUT A PROBLEM AND COUPLE'S COMMUNICATION

Time: 3 hours 30 minutes

Materials: Flip chart, markers, **Annex 10** handout

Objectives:

- To develop self-assertiveness.
- To show the possibility of facing someone with whom you have a problem, without antagonizing them or withdrawing from the problem.
- To practice making non-judgmental statements and using a type of discussion that opens rather than closes discussions of difficulties.
- To increase the participants' knowledge of the key elements of good communication and the importance of shared decisionmaking.



Activity: “I” Statements.

Time: 1 hour 30 minutes



Instructions for Facilitator: “I” Statements

1. Ask participants to reflect on the roles of women and men, including women having a voice in their own relationships with male relatives. Do they feel they have equal say in decisions that affect their life with their husband/partner? Father? Brother? Grandfather? Why or why not?
2. **Explain** to participants that through this exercise we can explain and demonstrate an assertive but non-aggressive way of expressing feelings about a problem.
3. **Introduce the idea** of “I” statements to the participants. Work in pairs and **ask** each of them to prepare one “I” statement relating to a current or recurring difficulty in their lives. Pairs can work together and help each other to make their statements clear.

For example:

Instead of saying: “**You** are very lazy and never do your share of the work. **You** go out with your friends instead of doing your homework. **You** do not appreciate the efforts we are putting forth for your education,” an “I” statement would be: “**I** am worried about your school marks and **I** would like us to talk to see how we can help you to improve them.”

4. **Ask** for a few examples from the participants, giving people an opportunity to comment on them and offer suggestions as to how they might be improved.
5. In what ways could the “I” statement formula be useful to participants? What do they think about it?

Group Work

1. Ask participants to pair off with a partner.
2. Explain to them that they will practice using “I” statements in a role-play exercise.
3. Review role play directions below (**Day 4, Session 4: Disclosure**).
4. Ask participants to identify three scenarios where they feel they would like to have stronger communication and a stronger voice in decision making.
5. Ask participants to alternate being the woman and being the man in the scenario.
6. When role-playing the woman, ask participants to use “I” statements in the role play.
7. After participants have gone through their role-play, ask if anyone would like to role-play in front of the larger group. Ask participants:
 - Do you think it is easy to have a say in your family as a woman? Why or why not?
 - Do you feel you have a say in your relationship with your husband/partner. Why or why not?
 - Do you feel comfortable trying this communication technique at home? Could you share it with your family and even your husband/partner?

Facilitator Notes

- This activity is a useful way of separating feelings and facts to clarify what a problem really is. **Explain** to participants that the formula may seem strange and unfamiliar but, with practice, it can become an unconscious reaction rather than a laboured response.
- It is worth **pointing out** that “I” statements can be used everywhere—at work, at the market or the shops, with friends, or at any time you feel your needs are not being met.
- “I” statements can be used for groups as well as individuals, to help them make a statement about something they feel strongly about.



Activity: Couple Communication and Shared Decisionmaking

Time: 2 hours



Instructions for Facilitator: Couple Communication and Shared Decisionmaking

1. **Discuss** with participants the following questions related to couple communication:
 - What is the goal of communication among couples?
 - What are the advantages of communicating within the couple?
 - What are the risks?
 - What are the obstacles to good communication?
 - How can you overcome the obstacles?
2. **Discuss** advice for good communication and shared decisionmaking (**Annex 9**).
 - As often as possible, **put the key words** from the conversation onto the paper or flip chart.
 - **Create small groups** for a role play exercise.
 - **Assign** each group a scenario involving a couple communication problem and have them discuss strategies for counseling (see **Annex 10**).
 - **Tell** the groups how much time they have for discussion (between 15 and 30 minutes, depending on the size of the group). Give **clear instructions** based on those provided in the handout, **Annex 10**.
3. **Ask** everyone in the group **to read** about the couple's situation. **Tasks** for the groups:
 - Identify three elements of a good strategy for the couple, based on counseling and support skills.
 - Prepare a short presentation (four to five minutes) for the entire group, summarizing the situation and giving elements of the counseling and support strategy. Explain why the strategy was chosen (if possible, write the key words or images on flip chart paper).

Adapted from: Health Policy Initiative. 2010. *Constructive Men's Engagement In Reproductive Health: A Training Of Trainers' Manual: Couple Communication And Shared Decision-making Related To Reproductive Health*.



Facilitator Background Notes: Support and Resources for Violence Against Women

Since transmission of HIV to women in MENA is often through husbands or male partners in traditional monogamous relationships, it is crucial that women become more empowered in communicating their concerns, needs and expectations with their male partners.

This type of communication may not be part of the normal roles that women have been raised to engage in. Therefore they may need additional support, resources and practice.

Further, although this is a women centered workshop, it may be useful to have a male “guest” facilitator for some part of this activity to present the male perspective. Consider if you have a local person from the support group and a counselor who are supportive of and trusted by women to share insights and discussion about relationships.

These sessions also need to be implemented with the view that the prevention of violence against women is critical (see **Annex 12**).



SESSION SIX: SERODISCORDANT COUPLES DISCUSSION

Time: 1 hour

Materials: Flip chart, markers, pens, paper

Objective:

- To develop awareness and discuss the challenges and opportunities involved in living as a serodiscordant couple.



Activity: HIV as a Bridge: Sharing Concerns and Skills in Serodiscordant Couples

Time: 1 hour



Instructions for Facilitator: Directions for Activity: HIV as a Bridge

1. Facilitators **set the scene** by talking about the challenge of living with HIV in your own body and also the challenges of having negative spouses or partners—having HIV in your life but not your body. Highlight the role of non-positive partners who—while having a relevant role as care takers, supporters, activists, etc. (especially in the case of women)—often are not taken care of or recognized by others—because they are HIV negative rather than living with HIV. How can this invisibility bring conflict to people’s lives?
2. **Ask** participants to divide into two groups (four groups if there are many people)—one composed of women living with HIV and, if enough people are present, one of women who are partners to HIV-positive people.
3. **Ask** the groups to make a list of what they have gained from sharing their status and concerns with their counterparts. The HIV-positive group can reflect on what they have learned and received from their partners. The HIV-negative group also can discuss what they have learned and received from their HIV-positive partners.
4. **Consider** that many women are infected in MENA by their husbands in traditional, married relationships. How can this be addressed?
5. **Ask** both groups to reflect on the main challenges they have identified from the serodiscordance in couples.
6. **Ask** the groups to match both lists and see what solutions, key issues, and positive outcomes they can identify.



Facilitator Background Note:

Overall, there has been little discussion about the contributions of non-positive partners in a serodiscordant couple, and often people do not make space for each person in the partnership to explore the skills, qualities, and resources needed to provide support to their partner and better understand one another. **Use** this background to help guide the discussion about HIV as a bridge. Consider the risks that women in MENA face especially regarding HIV, including married women.



SESSION SEVEN: CLOSING AND EVALUATION

Time: 30 minutes

Materials: Post-its of various colors, flip chart

Objective:

- To share feelings and feedback about the day.



Activity: Evaluation

Time: 30 minutes



Instructions for Facilitator

- **Use** three colors of post-its—one for something they learned, one for something they liked, and one for something that needs improvement. **Group** these according to color on different flip charts for review. (15 minutes)
- **Adjourn** and announce any evening events, reminding people what time we will start in the morning. **Close** with a song, dance, prayer, or another short activity to end the day on a positive note. (15 minutes)
- **Co-facilitators should meet** in the evening to review evaluation forms, discuss the day, and review and prepare for the next day.

DAY 4: STIGMA AND DISCRIMINATION, DISCLOSURE, PARTICIPATION, AND LEADERSHIP

Schedule

Session 1: Welcome and Review	30 minutes
Session 2: Naming Stigma in Your Life and Community	1 hour
Session 3: Addressing Stigma and Discrimination	45 minutes
Session 4: Disclosure, What, When, How and to Whom?	1 hour 30 minutes
Session 5: Addressing Disclosure to Our Children and Those Who Interact with Them	40 minutes
Session 6: Participation	1 hour
Session 7: Building Leadership	1 hour
Session 8: Building the Dream and Next Steps	1 hour
Session 9: Workshop Closing	45 minutes

**Please be sure to factor in time for a coffee/tea break in the morning and afternoon, as well as a lunch break and morning/afternoon energizers.*



SESSION ONE: WELCOME AND REVIEW

Time: 30 minutes

Materials: Flip chart, tape, markers

Prepared Materials:

Prepared Flip Chart: Day 4 Agenda

Objectives:

- To provide a time for participants to lead an activity and warm up the group with an upbeat and fun start.
- To review housekeeping issues and the agenda for the day.



Activity: Welcome and Review of Yesterday

Time: 30 minutes



Instructions for Facilitator

- **Select a participant to lead** warm-up exercise. **(15 minutes)**
- **Review** the agenda for the day. **Review** highlights from yesterday. **(15 minutes)**



SESSION TWO: NAMING STIGMA IN YOUR LIFE AND COMMUNITY

Time: 1 hour

Materials: Cards, colored markers (or crayons) for drawing purposes at each table, double-sided tape

*Please note: If you cannot find double-sided tape, you can use strong single-sided tape but double it over to make sure it is sticky on both sides for the exercise.

Objective:

- To develop awareness regarding the differences and potential harm of “labeling.”



Activity: Who Labels Whom?

Time: 1 hour



Instructions for Facilitator: Directions for Activity: Who Labels Whom?

1. **Distribute** cards and colorful markers or crayons to participants and **ask** half of them to draw the face of someone they know who has positive attributes. They should then write under the picture of the face the label that best describes this person, such as “honest,” “supportive,” “generous,” “famous,” or “elder.” **Ask** the other half to draw the face of someone with negative characteristics and write the label that describes them best—perhaps “selfish,” “thief,” “coward,” or “liar.” If someone shows discomfort with drawing, they can simply write the word, or vice versa if they don’t want to write. Be sure to **keep an eye out** for those who may have trouble writing.
2. Next, each person explains the quality or characteristic reflected in the face she drew.
3. **Gather** the cards, **mix** them up, and **keep** them, putting them aside.
4. **Ask** participants to greet each other as they normally do.
5. Then **regroup**.
6. **Ask** participants to pick one card (keeping the cards face down so they cannot identify which card they are picking). **Make sure** that participants do not get their own card or know which one they choose.
7. Once they have chosen a card, **make sure** they do not see it at all and **stick it** on their forehead using the double-sided tape.
8. **Ask** participants to go around greeting everyone again, but this time according to the drawing the person carries on their forehead. If for example, one participant is greeting another with the “liar” label, she should show dislike of liars in her face and body language as she greets that person—it’s okay to play this up a little.
9. When everyone has finished their various greetings, **regroup in a circle** and **start a discussion** on the difference between the first set of greetings and the second. How were they different? How did these differences make each person feel?
10. Then let participants look at the cards they were wearing.
11. Go around the circle, **ask** each participant to share her “label” and how she felt.



SESSION THREE: ADDRESSING STIGMA AND DISCRIMINATION

Time: 45 minutes

Materials: Flip chart, markers, pens

Objectives:

- To further explore the impact of stigma in people's lives.
- To identify possible differences of stigma and discrimination in men and women.



Activity: Group Discussion

Time: 45 minutes



Instructions for Facilitator: Directions for Activity: Group Discussion

1. **Ask** people to split into small groups to identify examples of stigma and discrimination at different levels in their lives and society—at family, local, and national levels—and how it is expressed differently toward women and men.
2. Each group will select a person to present on its behalf.
3. Join together and **present** the small group discussion and findings.
4. The broader group discussion should **include** specific issues regarding stigma and discrimination.



Facilitator Background Notes: We All Stigmatize

We stigmatize when we say things such as “she was promiscuous” and “he deserves it,” and do things such as isolating people when they get sick or excluding them from decision-making.

Forms of stigma:

- **Moral judgments**—Blaming people for their “behavior.” Others may assume that the person living with HIV has had many sexual partners or has engaged in immoral, criminalized, and/or marginalized behavior, such as drug use. This can be especially problematic for women or for women and men living in conservative households.
- **Physical and social isolation from family, friends, and the community**—Forcing others to eat alone. Enforcing a rule of no visitors, no physical contact, and separation—“us” versus “them.” This type of stigma is based on ignorance and fear of HIV and AIDS.
- **Self-stigma**—People blaming and isolating themselves as a reaction to stigmatization from society—internalizing the shame and blame from society.
- **Stigma by association**—Stigmatizing family members or orphans of PLHIV; this affects the family’s status. This also can be expressed in many ways that people living with HIV experience, such as gossiping, name-calling, violence, and condemnation.

The main causes of stigma include the following:

- Insufficient knowledge, misbeliefs, and fears about HIV transmission
- Moral judgments about people
- Fears about death and disease
- Lack of recognition of stigma

The effects of stigma include the following:

- Being chased from the family, house, work, rented accommodation, or organization
- Dropping out of school (resulting from peer pressure—insults)
- Depression, suicide, drug use, alcoholism
- Loss of rights and decisionmaking power

Source: *Understanding and Challenging HIV Stigma: Toolkit for Action*. International AIDS Alliance, Brighton, 2006.

For more information about Stigma and Discrimination, see: Morrison, Ken. *Breaking the Cycle, Stigma, Discrimination, Internal Stigma and HIV*. Washington, DC: Health Policy Initiative, Task Order 1: 2006. Available at: http://www.policyproject.com/pubs/generalreport/Breaking_the_Cycle.pdf



SESSION FOUR: DISCLOSURE: WHAT, WHEN, HOW, AND TO WHOM?

Time: 1 hour 30 minutes

Materials: Flip chart, markers and pens

Objectives:

- To reflect on the impact of stigma on a woman's ability to disclose.
- To understand the barriers to safe disclosure.
- To explore the relationship between disclosure and the right to confidentiality.



Activity: Disclosure: What, When, How, and to Whom

Time: 1 hour 30 minutes



Instructions for Facilitator: Disclosure: What, When, How, and to Whom

1. **Introduce** the issue of disclosure to participants. It is better to present it as both an internal and external process that is not limited to telling others about one's serostatus. **Highlight** that disclosure starts with the person reflecting on the point of disclosure and the consequences.
2. This should bring the group around to **discussing** the right to confidentiality and the need to disclose as a continuum that is different for every person, and even for the same person in different situations. For example, there could be different responses among and with healthcare providers, family, workplace, schools, and the media.

3. **Ask** participants to split into pairs. Each pair will take 5 minutes to discuss what and to whom each one is going to disclose. Alternatively, the facilitators can provide each pair with a previously defined situation so that they can role play the disclosure. **Review** role play general guidelines below this section to prepare.
4. Each pair then will practice role playing, one person disclosing and the other playing the part of the person receiving the disclosure.
5. Each pair will have another 5 minutes to discuss how they felt disclosing and being disclosed to.
6. **Bring** everyone back together. **Ask** if 1–2 couples want to reproduce their role playing for the larger group.
7. **Facilitate** a general discussion about identified barriers, feelings, how stigma is related, and the role of rights. **Make sure** that the discussion also addresses gendered differences and risk and includes the different reactions to disclosure women and men face, possible violent reactions, and safe spaces for disclosure.
8. **Close** this session in such a way as to calm any feelings of urgency to disclose, highlighting the need to follow one’s own heart and trust in decisionmaking about the right time, person, and place for disclosure.
9. For more information, see for example:
WHO. Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes, A Review Paper. WHO; and Southern Africa AIDS Trust: Geneva. 2004. and Counseling Guidelines on Disclosure of HIV Status, SAT, Harrare.

Discussion Questions

- How was it to think about the actual fact of disclosure?
- What kind of things came to your mind?
- Do you think disclosure is a right or a duty? Why?
- What is involved in disclosing?
- Do we have to disclose everything to everybody?
- What do we disclose to whom, when, and how?
- How can we decide?
- What is the relationship between disclosure and confidentiality? Where are the boundaries of both? Are they mutually exclusive or can they be combined?



Facilitator Background Notes: Role Play Overview

Role play scenarios may offer opportunities to provide information on many topics, such as stigma and discrimination, basic facts about HIV, advocacy and human rights, behavior change communication and education, psychosocial support, testing, treatment and care, disclosure, gender issues, family issues, and community issues.

Explain that a role play is an interactive method that can be used effectively in HIV education and support. It can also be used to practice methods of disclosure in a safe and supportive space.

Explain that many workshop and training programs use role plays to illustrate challenges and model important skills. Effective role play engages the hearts and minds of the audience and can put the actors in “someone else’s shoes,” creating empathy and change.

Review the general steps described below and adapt for two willing volunteers to practice a disclosure role play. This can be, for example, between a husband and wife, two sisters, or a woman living with HIV and her five closest family members.
Role Play Basic Guidelines:

1. **Prepare** the actors so that they understand their roles and the situation.
2. Try to have gender balance in the role play (even if the workshop is all women, some can play men or boys). It is okay to have a man play a woman and a woman play a man, as we also can learn about the opposite sex and different gender identities from role play.
3. **Set the stage** so the observers know what the situation involves.
4. Create enough space for the performance so that all participants can see what is presented.
5. **Encourage** role players to speak loudly so that the whole audience can hear the dialogue.
6. If the role play goes on for too long or seems to get stuck, invite the players to stop so that everyone can **discuss** the situation.
7. **Observe** the role play.
8. **Thank** the actors and ask them how they feel about the role play; be sure that they get out of their roles and back to their real selves.
9. **Share** the reactions and observations of the observers.
10. **Discuss** different reactions to what happened.
11. **Ask** participants what they have learned. Do these lessons feed into any broader participant learning principles?
12. **Ask** the learners how the situation relates to their own lives.
13. **Ask** the actors in the role play what they learned. Did they experience increased empathy or understanding from playing the role? Were they able to work through solving a difficult situation, such as disclosure?
14. **Summarize.**



SESSION FIVE: ADDRESSING DISCLOSURE TO OUR CHILDREN AND THOSE WHO INTERACT WITH THEM

Time: 1 hour

Materials: Flip chart, markers, pens

Objectives:

- To reflect on when and how to disclose to children (about both the parents' and the children's serostatus).
- To facilitate participants' preparedness to talk with their children about HIV status.
- To promote participants' acknowledgment of possible factors involved in disclosure of HIV status (one's own and a child's).



Activity: Disclosure Dialogue with Children

Time: 1 hour



Instructions for Facilitator: Dialogue with Children

Discuss the complexity of disclosure in the case of children, with the following diverse scenarios:

- HIV-positive children who do not know about their status;
- HIV-negative children who know about their parent's/relative's status;
- HIV-positive children's serostatus disclosed to others (school, relatives, other children...)

Facilitation addressing these sensitive issues needs to be planned carefully, as the process of disclosure has many implications for the mother, father, the children, and the rest of the family. The facilitator needs to review the process for this discussion carefully and advise all participants regarding the need to have mutual support throughout the session. The facilitators then can ask participants to divide among themselves into self-selected small groups for the small group discussion below.

Small Group Discussion Questions

- How do we relate to our children in day-to-day life? Is conversation a usual activity we do together?
- Why do we feel we should disclose to our children?
- How much do our children know about HIV?
- What are the differences between disclosure with younger children versus adolescents?
- Do we have any kind of support for our children in preparation for the disclosure?
- Explore the meaning and consequences of disclosure.
- Are we prepared for questions about our mode of transmission (sex, drug use) and/or theirs?
- Are we prepared to deal with feelings of fear, guilt, loss, anger, or taboo related to ways of transmission and to having the virus?

- When and how do we disclose a child's status to the school? Is it necessary? Why? Is a process in place?

Once the small groups have discussed these issues, **return** to the larger group to obtain feedback regarding participants' discussions, experiences, and suggestions related to disclosure and children. This may include discussions around the differences between disclosure among women and men, as well as planning for a child's future.



SESSION SIX: PARTICIPATION

Time: 1 hour

Materials: Post-it notes, GIPA Session Notes/MENA Sub-Regional Curricula

Prepared Materials: ICW Participation Tree

Objectives:

- To reflect on what participation means in our context.
- To explore with participants the level and quality of participation at both personal and organizational levels and the greater and more meaningful involvement of people—especially women—living with HIV.



Activity: The Participation Tree

Time: 1 hour



Instructions for Facilitator: The Participation Tree

1. **Check** that everyone has heard of GIPA (greater involvement of PLHIV). You can reference the Health Policy Initiative's Sub-Regional Curricula for a presentation on GIPA, if needed.
2. **Describe** the GIPA principle, its origins (Paris Declaration, 1994), and the evolution from GIPA to MIPA (meaningful involvement of PLHIV).
3. **Describe** the International Community of Women Living with HIV (ICW), how it operates in the MENA Region, and how participants can join.
Answer any questions.
4. **Pass out** the ICW Participation Tree (see poster and accompanying explanation below).
5. Using these tools, **explain** the components of the Participation Tree from the roots to the fruits of meaningful participation. **Relate** these plant concepts to GIPA/MIPA principles and women's participation.
6. **Ask** participants to split into smaller groups and **provide** them with a copy of the tree and post-it notes. **Ask** them to discuss examples from their experience that reflect different levels of participation in their community, organization, support group, network, etc.
7. **Ask** participants to write some of those examples on post-it notes and stick them on the corresponding part of the tree according to the level of participation involved.

Discussion Questions

- What are some of the experiences of your group with issues that fit certain sections of the tree?
- What are some of the barriers to achieving the greater or more meaningful involvement of women living with HIV?
- Where do these barriers come from?
- Are there any internal barriers from within the HIV-positive community?
- What are the challenges that networks/agencies of positive people face in trying to ensure the participation of their members?
- How can these be overcome?



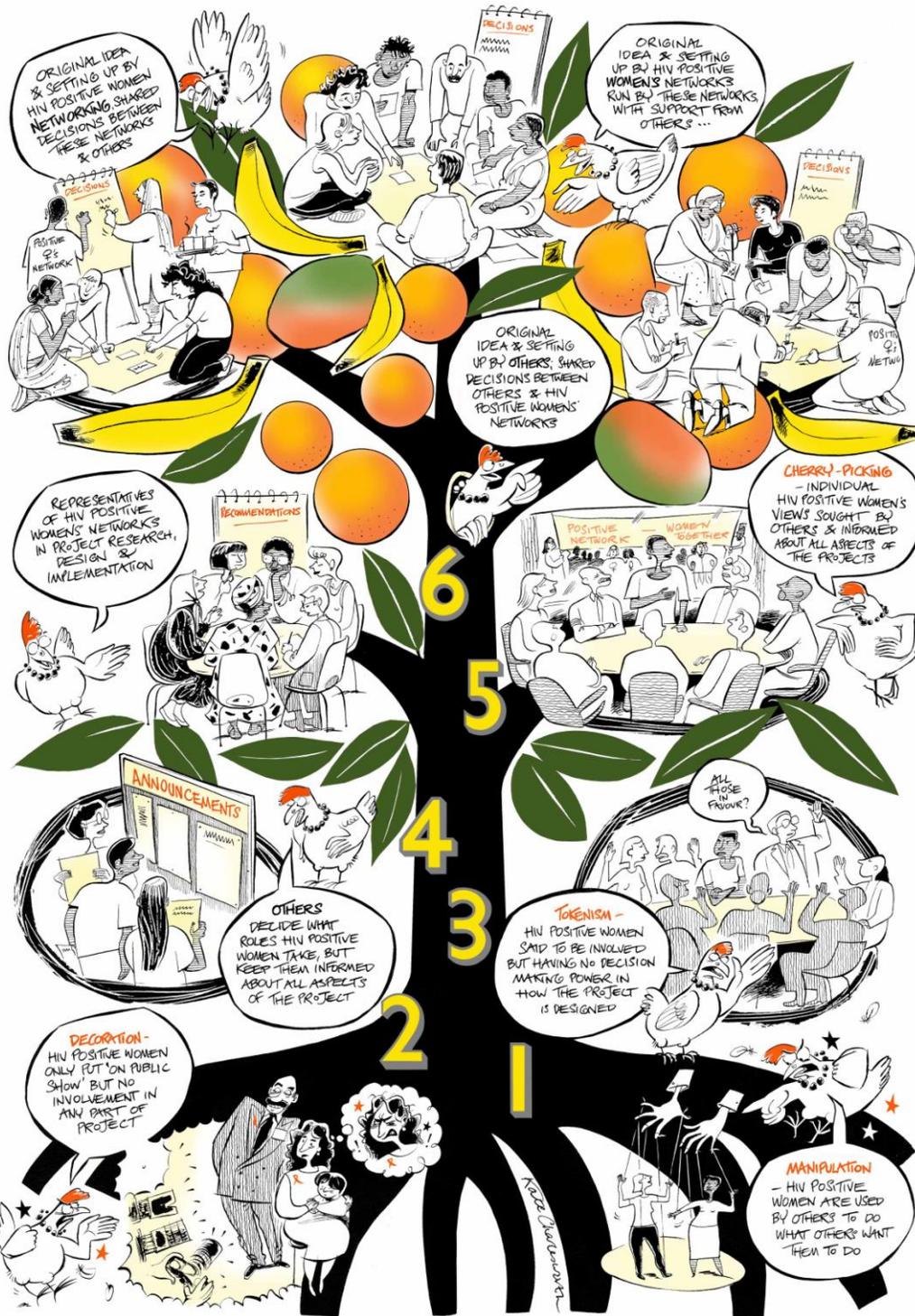
Facilitator Background Notes: Explanation of the Participation Tree

Near the base of the trunk, decisions are made solely by others. Women and girls living with HIV have no role in decisionmaking. Further up the trunk, decisions are made by others with advice from HIV-positive women. At the top of the tree, where you will find the fruit, there is more sense of the real working partnership between HIV-positive women and our organizations and others.

ICW believes that when HIV-positive people are involved in all levels of decisionmaking in an organization, that organization is better able to respond to the concerns of people living with HIV/AIDS. For example, HIV-positive women and girls are best placed to understand the barriers they face in accessing care, treatment, and support and so are the best people to consult on the development, design, and delivery of better ways of making treatment and care available to positive women and girls around the world. Working together in creative, interactive, and participatory ways, and with others who work directly with community members and other relevant groups, will enable us to create 'services to fit people' rather than 'people to fit services.' Without this, we believe that preventing women and girls from accessing treatment and care will not be addressed adequately, and HIV-positive women and girls will continue to get sick and die.

It is now more than 10 years since the GIPA principle of Global Involvement of HIV-positive people was adopted at the Paris Summit. While widely accepted in theory, our practical experience has been that the views and voices of HIV-positive people—especially positive women and younger people—still tend to be overlooked or ignored. To mark the 10th anniversary of GIPA, therefore, ICW commissioned political cartoonist Kate Charlesworth to produce the "Tree of Participation" to try to convey what we mean by "meaningful participation." This tree has been adapted by ICW from Roger Hart's ladder of participation of children, 1997, UNICEF. Please feel free to use this tree, distribute it among your colleagues, display it in your offices, and use it in your talks. We would appreciate it if you would credit ICW for its production.

IS YOUR ORGANISATION



BEARING FRUIT?



SESSION SEVEN: BUILDING LEADERSHIP

Time: 1 hour

Materials: At least one blank sheet of paper per participant (and a few extras), pens/pencils, flip chart, markers

Prepared Materials: Two pieces of flip chart paper—one with the header **Good Leader** and the other with the header **Bad Leader**.

Objectives:

- To explore and understand the qualities of leadership.
- To define good leadership as a group.



Activity: Good Leader/ Bad Leader

Time: 1 hour



Instructions for Facilitator: Good Leader/Bad Leader

Facilitators will ask participants to think of a leader they admire and one they dislike and write down three qualities they feel make these people good or bad leaders. Discussions will explore what makes an effective leader and how to avoid negative leadership.

1. **Ask** participants to think of a leader they admire (e.g., mother, community leader, celebrity, politician) and write down three qualities that make this person a good leader.
2. **Ask** them to think of a leader they dislike (a dictator, a mean teacher) and write down three qualities that make that person a bad leader.
3. **Allow** about 10 minutes for this and then **ask** participants to share what they have written. **Record** these qualities on the flip chart paper under the column “Good Leader” or “Bad Leader.”
4. **Propose** that participants discuss the similarities and differences in the qualities they described. Was anything surprising? Are there any similarities in the qualities of a good and bad leader? Do the leaders we do not admire have qualities similar to those we do admire? Do we find any differences between male and female leaders? How can we avoid becoming bad leaders? What can we do to be effective leaders?



SESSION EIGHT: BUILDING THE DREAM AND NEXT STEPS

Time: 1 hour

Materials: At least one sheet of drawing paper per participant (and a few extras), pens/pencils, colored markers, flip chart, markers

Objectives:

- For participants to set goals and develop a plan for their community/region.
- For participants to develop their strategic planning skills.



Activity: Building the Dream

Time: 1 hour



Instructions for Facilitator: Building the Dream

Participants are asked to relax and imagine a future gender situation in their communities. They then create a road map from their community's current reality to their final vision. This exercise helps participants develop practical steps to move from vision to reality.

1. **Invite** participants to sit or lie on the floor (if appropriate) and relax for awhile with their eyes closed.
2. **Encourage** them to take deep breaths and relax their minds and bodies completely.
3. **Guide** participants to think about their communities. **Ask** them to think of why they love their community and what their ideal community would be like to live in regarding gender equality. This time they should not try to be realistic, but rather allow their minds to dream a wonderful future for their communities.

4. **Ask** participants to open their eyes. Whenever they are ready, they can split into small groups (4–6). Taking turns, everyone describes their individual dream in the small groups.
5. After listening to all of the dreams, the group explores the similarities in the dreams and discusses the differences. The challenge for the group is to build a dream that contains everything they have heard.
6. **Ask** each group to choose a member to present their dream to the whole group.
7. Everyone listens and appreciates. Once again, the big group explores the similarities and differences in the dreams. The group then tries to build a common dream for the whole community.

Once the dream is set, participants choose 3–5 priority actions they will develop in the next year (or whatever timeframe they decide) to advance the fulfilment of the common dream.

8. Participants then put 3–5 concrete actions they will take to address each priority action in the short term (3–6 months).
9. Participants identify key partners and alliances they can make related to each priority area.
10. They then designate a person in the group who will be responsible for particular actions related to key priority areas.
11. Participants agree on a way to follow up and monitor progress with actions and priorities; for example:
 - A weekly phone call with some selected point people in the group;
 - A weekly e-mail to those who have e-mail and another means to have regular contact with those without e-mail;
 - A regular time when the group would like to reconvene face to face on a monthly basis (or whatever timeframe the group chooses); and
 - A way that the group will notify partners of their planned activities and of the support needed to reconvene and move forward with their priorities.

Facilitator Notes

- Encourage participants to be as inclusive as possible. It is not about choosing one person's dream but rather about being able to incorporate the dreams of all participants into one while maintaining an open mind.



SESSION NINE: WORKSHOP CLOSING

Time: 45 minutes

Materials: Flip chart, markers, computer, projector, display screen, adapter plug, feedback box

Prepared Materials:

PPT: Feedback PowerPoint

Prepared Flip Chart: What Is Feedback?

Handout: Final Evaluation (Evaluation Template – **Annex 13**)

Objectives:

- To review the workshop objectives in light of what has been accomplished today.
- To provide a consistent period of time to gather feedback from the day's activities, make announcements, and present a conclusion.



Prepared Flip Chart or PPT: What Is Feedback?

- Feedback is non-judgmental
- Feedback is constructive
- Feedback is specific
- Feedback provides alternatives
- Feedback is received non-defensively



Instructions for Facilitator: Closing Discussion

1. **Ask** participants to sit in a circle.
2. **Ask** a volunteer to read from the flip chart or PowerPoint slide above.
3. **Provide** a brief summary of the topics covered during the workshop.
4. **Ask** the participants to think back on the workshop's activities and discuss some of the central themes.
5. **Thank** all participants for their time, energy, and commitment.
6. **Provide** a final evaluation form (Evaluation Template – **Annex 13**) and **ask** participants to fill it out. They should not put their names on the evaluation. They can return the evaluation to a designated person or table.

End of Women's Workshop: Goodbyes and Departures

*Please note: Many times workshops end with a group photo, song, or time for final comments and thanks. Based on your participants, you can choose a way to end the workshop that best bonds the group.

GLOSSARY OF TERMS

Case study—A written description of an example situation that is used for analysis and discussion.

Co-training—A situation in which two (or possibly more) trainers work together to design and conduct a training session.

Disclosure—When a person living with HIV informs other(s) about his/her HIV status. HIV serostatus disclosure is usually defined as disclosure to a sexual partner before sex, delayed disclosure (after sex), and no disclosure to both current and recent past (in the last year) sexual partners. Broadly, disclosure also can refer to disclosure to other people in the person's life, including family members, friends, and colleagues.

Energizer—An activity often used when participants (in a training or other setting) have been sitting for too long.

Essentialism—The view that people have some inherent essence or characteristics and qualities that define them (i.e., women are naturally more caring and nurturing than men).

Evaluation—Using strategies to assess participants' achievement of learning objectives and the success of the training.

Expectations—What participants expect from the training (e.g., what skills participants expect to learn and how they expect to use these skills when they return home). These expectations should help define training goals.

Gender—Refers to the economic, social, political, and cultural attributes and opportunities associated with being female and male. The social definitions of what it means to be female or male vary among cultures and change over time.

Gender analysis—Refers to the socioeconomic methodologies that identify and interpret the consequences of gender differences and relations for achieving development objectives, as well as the implications of development interventions for changing relations of power between women and men.

Gender assessments—Involve carrying out a gender analysis of organizations' programs and their ability to monitor and respond to gender issues throughout the program cycle.

Gender-based constraints—Factors that inhibit either men's or women's access to resources or opportunities of any type. These can be formal laws, attitudes, perceptions, values, or practices (cultural, institutional, political, or economic).

Gender bending—Adopting clothing, body language, and/or behavior that challenges and undermines conventional gender norms and expectations, thereby drawing attention to the fluid nature of both femininity and masculinity.

Gender equality—Permits women and men equal enjoyment of human rights, socially valued goods, opportunities, resources, and the benefits from development results.

Gender equity—The process of being fair to women and men. To ensure fairness, measures must be put in place to compensate for historical, social, and structural disadvantages that prevent women and men from operating on a level playing field. Gender equity strategies are used to eventually gain gender equality. Equity is the means; equality is the result.

Gender identity—The gender to which a person identifies themselves. This can cover a spectrum of masculine, feminine, and other gender identities.

Gender integration—Means taking into account both differences and inequalities between women and men in HIV program planning, implementation, and evaluation. The roles of women and men and their relative power affect who does what in carrying out an activity and, further, who benefits.

GIPA—The Greater Involvement of Persons Living with HIV/AIDS is a basic principle that has been incorporated into national and international program and policy responses worldwide and adopted as a model of best practice in the response to HIV. This principle aims to realize the rights and responsibilities of persons living with HIV, including the right to self determination and participation in decision-making processes. GIPA goals include improving the quality and impact of the HIV response through meaningful engagement of people living with HIV and through their participation and leadership. GIPA also encompasses a broad and dynamic process that must be linked to social movements, organizations, networks, support groups, and individuals to ensure meaningful involvement.

Goal—Broad statement of purpose of what we would like to be true. A goal may depend on many objectives for its achievement. Further, it may not be precisely measurable.

Human rights—Rights and freedoms generally recognized as belonging to every individual by virtue of the fact that she or he is a human being. Human rights are rooted in the concept that all people are created by God, giving them innate dignity, regardless of ability or any perceived value to society. These rights and freedoms can exist as shared, justified moral norms; natural rights usually supported by universally agreed upon reasons; legal rights at the community and/or national level; or international law. The Universal Declaration of Human Rights signed in the aftermath of World War II in 1948 by the UN General Assembly is one of the main modern expressions of the concept. It states, “All human beings are born free and equal in dignity and rights.”

Icebreaker—An activity often used among members new to a group, issue, or setting. Icebreakers serve as a means of introduction. Along with introducing new participants to each other, icebreakers also introduce new subjects to participants.

Inputs—Those resources provided to implement objectives and reach a goal. In the case of training, inputs include trainers, participants, training materials, funding, and location.

Needs assessment—Identifying knowledge and skill needs, as well as the learning expectations of participants.

Objectives—Time-bound actions taken to reach a goal. They can be a specific statement of the ideal situation that will exist at the completion of a particular task—a future fact, a statement of exactly what the learner will be able to do at the end of the training, or a precise element or unit of work that will contribute toward reaching a goal—one of the steps toward the goal. They may be related to other objectives, but each is measured against itself; must be precisely measurable (results can be seen and measured); and must answer the following questions: what, how much or how many, when, where, who, with whom, and how often? Objectives also are described as “SMART,” an acronym standing for: Specific, Measurable, Attainable, Relevant, Time-Bound.

Outputs—Outcomes of trainings, including trained participants, objectives met, and workshop products, such as visual aids.

PMTCT—HIV infection from an HIV-positive mother to her child during pregnancy, labor, delivery, or breastfeeding is called mother-to-child transmission (MTCT). PMTCT refers to *prevention of mother-to-child transmission* of HIV. PMTCT efforts include (1) primary prevention of HIV among parents-to-be (e.g., through Behavior Change Communication); (2) prevention of unintended pregnancies among HIV-positive women (e.g., through family planning); (3) prevention of transmission from HIV-positive women to their infants (e.g., through provision of ART); and (4) follow-up for and linkages to long-term prevention, care, and support services for mothers, their children, and their families (PMTCT-Plus).

To benefit from PMTCT interventions, women need access to adequate antenatal, delivery, and postnatal care, which includes

- Early access to antenatal care (before 34–36 weeks);
- Voluntary counseling and testing;
- A minimum package of antenatal care that includes vitamin supplementation and screening for and treatment of anemia and sexually transmitted infections (to reduce both sexual and mother-to-child transmission of HIV);
- Delivery care by a skilled attendant, including optimal obstetric practices that may reduce the risk of transmission; and
- Counseling on infant feeding and care practices and support of mother’s infant feeding choice. (WHO. 2010. *PMTCT Strategic Vision 2010–2015*.)

Process—Use of resources to implement objectives, including training methods, facilitation, skills, and participation.

Role play—An activity where two or more individuals enact parts in a scenario related to a training topic.

Sex—Refers to the biological differences between women and men. Sex differences are concerned with women’s and men’s physiology.

Sexual and Gender-based Violence (SGBV)—This has been defined by the UN Population Fund Theme Group (1998) as “any harmful act that is perpetrated against a person’s will and that is based on socially ascribed [gender] differences between males and females.” The World Health Organization defines **sexual violence** as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work.”¹⁴ The scope of the definition is expanded to include forced sex, sexual coercion, and rape of adult and adolescent men and women, as well as child sexual abuse. The definition also includes

- The use of physical violence or psychological pressure to compel people to participate in a sexual act against their will, whether or not the sexual act is consummated.
- A sexual act (whether attempted or consummated) involving a person who is incapable of understanding the nature or significance of the act, of refusing, or of indicating his or her refusal to participate in the act (e.g., because of disability, the effect of alcohol or other substances, or intimidation or pressure).
- Abusive sexual contact.

Sexual orientation—A person's sexual orientation is defined by the sex or gender to which they are sexually attracted.

Small group discussion—An activity that allows learners to share their experiences and ideas to solve a problem among a small group of people.

Social construction—Recognizes that many categories of being are not “natural” but are socially constructed. Because of this, these categories are unstable and are continually restabilized through various social processes.

Stigma and discrimination—Stigma refers to a cluster of negative attitudes and beliefs that motivate a person to fear, reject, avoid, and discriminate against people living with HIV. Many people living with HIV also face self-stigma, a state of mind in which their own stigmatizing thoughts and negative feelings about living with HIV also can have a negative psychological impact. Discrimination is an act that expresses stigmatizing thoughts and feelings. These can range from social exclusion and stereotyping to human rights abuses. Stigma and discrimination often are stated together as a term because stigmatizing feelings and their expression in discriminatory practices go hand-in-hand.

Transgender—A general term applied to a variety of individuals, behaviors, and groups involving tendencies to deviate from the normative gender roles. Transgender is

¹⁴ WHO. 1997. ‘Violence against Women: A Priority Health Issue. Geneva: World Health Organization, (document WHO/FRH/WHD/97.8).

a gender identity (self-identification as woman, man, neither, or both) not matching one's assigned sex (identification by others as male, female, or intersex, based on physiological make-up). Transgender does not imply any specific form of sexual orientation; some may consider conventional sexual orientation labels inadequate or inapplicable to them. The precise definition for transgender remains in flux.

Violence against women—Has been defined by the UN General Assembly, Declaration on the Elimination of Violence against Women (1993) in Article 1: “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.”¹⁵

¹⁵ For more information, see full text: UNGA. 1993. *Declaration on the Elimination of Violence against Women*. Available at [http://www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.RES.48.104.En](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En).

ANNEX I: INTERPRETER CONFIDENTIALITY AGREEMENT

I, _____, as an interpreter, will be permitted to have access to participants' information in order to perform interpretation and translation work related to **investing in PLHIV leadership in the Middle East and North Africa Region Women's Workshop**.

I agree to keep all information that I learn about the participants from these trainings confidential. I understand that I may not discuss or disclose any information related to any participant to anyone outside the workshop setting. I further understand that I may learn personal information about a participant and/or his or her family that is private. I understand that it is my duty and responsibility to preserve and protect this privacy and confidentiality. I understand that this duty will extend after I am no longer working at the workshops. I also understand that information relating to persons who are participating at the workshop is also privileged and must be kept confidential. By placing my signature below, I hereby indicate that I understand and agree to maintain the privacy of the participant(s)' personal information.

WITNESS:

INTERPRETER:

By: _____
Date: _____

By: _____
Date: _____

ANNEX 2: SUBJECT RELEASE FORM/PHOTO CONSENT FORM

I would like permission to take your picture or video on behalf of:

(Enter company name, NGO, or other organization/group being represented above)

I would also like permission to include your picture (or video) in an internal report or PowerPoint presentation, publications of limited distribution, or a password-protected website. Any information provided in this document and/or website or with your picture will not misrepresent you. Please read the statement below. If you agree with the statement, please sign your name and include today's date.

- Yes, I agree to have my picture taken, and I understand that the photo may be used in a limited-distribution document or on a password-protected Internet site for educational purposes.

Signature: _____

Date: _____

ANNEX 3: WOMEN'S WORKSHOP PARTICIPANT CRITERIA

Participants should have the following:

1. Some experience in conducting or attending HIV-related programs in the home country. For example: support group work, advocacy work, or NGO work.
2. Some links with other HIV-positive community members and vulnerable groups in the home country, especially women and girls.
3. A commitment to sharing information with others, including PLHIV and, if possible, key stakeholders, to strengthen HIV policies, programs, and support.
4. Some experience with, or a strong interest in, awareness raising, outreach, and support to women and girls, as well as male engagement.
5. A basic understanding of human rights related to HIV in home country — understanding of policies a plus.
6. An appreciation for participatory training styles and a commitment to developing awareness and applying what will be learned at the workshop.
7. Access to a means of regular communication. Computer literacy with regular Internet access is an advantage.
8. Demonstrated commitment to diversity and gender equity.
9. Interest in participating in a cross-cultural training environment.
10. An openness about living with HIV, pending restrictions in the home country, local community, and family.
11. Ability to work on a team, including any proposed work on national-level activities.

ANNEX 4: WOMEN'S WORKSHOP AGENDA

WOMEN'S WORKSHOP OVERVIEW AGENDA

Day	Morning	Afternoon
Day 1		
Introduction, Human Rights, Gender Terms, and Key Concepts	Introductions	Why a Human Rights Focus?
	Training Expectations, Goals, and Objectives	Gender and HIV
	Review Agenda and Logistics	Closing and Evaluation
	Participant Baseline Questionnaire	
	Setting Ground Rules	
Day 2		
Power, Identity, Understanding Our Bodies, and Sexual Health	Welcome and Review of Day 1, Housekeeping, and Agenda Overview	Body Mapping About Sex and Sexual Health
	The Gender Lens	Agree/Disagree/I Don't Know
	Power in Relationships	Young Women's Dialogues
		Closing and Evaluation
Day 3		
Positive Parenthood, Our Relationships	Warm-up, Review from Day 2, Housekeeping, and Agenda Overview	What Is Love? How to Discuss Feelings about a Problem Sero-discordant Couples Discussion
	HIV-positive Women Discuss Safe Motherhood	Closing and Evaluation
	Violent Relationships	
Day 4		
Stigma and Discrimination, Disclosure, Participation, and Leadership	Warm-up, Review from Day 3, Housekeeping, and Agenda Overview	Addressing Disclosure with Our Children and Those Who Interact with Them
	Naming Stigma in Your Life and Community	Participation Building Leadership Building the Dream and Next Steps
	Addressing Stigma and Discrimination Disclosure: What, How, When, and To Whom?	Workshop Closing

ANNEX 5: THE TRIPOLI DECLARATION



The Tripoli Declaration of Women Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic

We, the Muslim and Christian women religious leaders in the field of AIDS in the Arab States, meeting in Tripoli (Libya) from the 4-7 Gumada Al-Awal 1427 H, 28-31 May 2006 as part of an initiative of the United Nations Development Programme and its HIV/AIDS Regional Programme in the Arab States (HARPAS), hosted by the NGO "Wattassimo for Charity": Declare our endorsement of the Cairo Declaration for Religious Leaders", and affirm that women religious leaders are enjoying a considerable degree of awareness of the threat of HIV/AIDS and we have committed to increasing awareness of its underlying causes and of its destruction of our societies. Thus, we will focus in this Declaration on issues related to both women and children, in view of their vulnerability to HIV infection in our Arab societies, and we have agreed the following:

First: To protect women from HIV infection by:

- Advocating the importance of the implementation of religious laws to facilitate prevention, protection and treatment of HIV/AIDS
- Promoting woman's right to protect themselves from HIV infection
- Working on putting an end to all forms of confiscation of the self-evident God-given right of women to choose or refuse situations that might expose them to HIV infection
- Promoting and reinforcing women's psychological, economic and social status to reduce their vulnerability to HIV infection
- Ensuring women's right to legitimate and safe sexual relations
- Advocating the enactment and implementation of laws that protect women from sexual abuse and exploitation
- Emphasizing the importance of reaching out to vulnerable groups; especially commercial sex workers and drug users, and advocating the importance of designing up-to-date programmes based on our cultures, traditions and religious values to help in rehabilitating and protecting these vulnerable groups
- Calling upon the media to abide by ethical codes regarding the material they present and to avoid misuse of images of women in commercials, video clips, T.V serials and superficial movies, and encouraging the media to promote virtue
- Denouncing of all forms of violence against women along with harmful customs and traditions that contradict religious laws, and fostering a culture that encourages dialogue within the family
- Asserting women's right to benefit from health services and information related to HIV
- Appealing to governments and civil society to facilitate access to free medication for women living with HIV/AIDS and to establish a regional fund to help these women and all those affected by it
- Organizing awareness campaigns aimed at providing precautionary information to both medical and non-medical institutions regarding use of equipment that may transmit the virus
- Improving women's status during conflicts and migration, and in refugee and internal displacement situations
- Urging concerned Arab, African and Asian authorities to hold scientific workshops to ascertain the true causes of the spread of the epidemic, to find solutions, and to encourage scientific research on other issues related to HIV
- Preparing comprehensive programmes to combat poverty in our countries and transform needy families into independent and productive ones; as well as encouraging wealthier States to support and fund HIV/AIDS projects in poorer states
- Establishing and activating funds to support young people who want to get married

Second: To protect children from HIV infection by:

- Protecting children from the sex trade and taking all available media, educational, economic and legal measures to prevent such practices
- Advocating the development and implementation of a law dealing with the sexual abuse of children
- Emphasizing the importance of age-conscious sex education in school curricula in order to protect children from HIV infection
- Emphasizing the importance of enacting and implementing laws that forbid child labor under all circumstances, as it may lead to severe consequences, including HIV infection
- Addressing issues related to street children, homeless children and orphans
- Putting an end to the genital mutilation of young girls and the associated psychological and physical damage (which includes the possibility of exposure to HIV infection)
- Improving the match between the content of school curricula and the requirements of the labor market to empower young people and help them avoid unemployment
- Instituting developmental projects that address unemployment and help fill the free time of young people, girls and women, and especially the right of girls and women to take part in activities such as sports and related activities.

Source: UNDP Regional HIV/AIDS Programme in the Arab States: www.harpas.org.

ANNEX 6: WOMEN'S WORKSHOP PARTICIPANT BASELINE QUESTIONNAIRE

This questionnaire can be administered ahead of time over the phone or during the workshop. If conducted during the workshop, facilitators should be sure to identify literacy levels of participants and personally help those who may need aid in answering the following questions:

I. Participant Profile

Name: _____

Organization: _____

Country: _____

E-mail: _____

On a scale of 1–10, how comfortable are you with reading and writing? _____

Languages (speak, read, and write): _____

Sex: _____ Age: _____

Family members (you do not have to name them but, for example, you can state, "daughter, age 14" or "son, age 5"). Please be sure to include all wives, your husband, and parents, if you also live with them:

Dietary preferences: _____

Physical needs: _____

How long do you think you have been living with HIV?

II. Experience

What types of community, national, regional, and/or global HIV-related activities are you involved in (this can include for example, a support group, NGO, or networking with other women living with HIV)?

Have any of these activities been directed specifically toward women and girls living with HIV? If so, please explain.

What kind of information do you think you need related to women, gender, and HIV? Why?

What do you feel are your strengths as a woman living with HIV?

What do you feel are your opportunities for growth?

How have you been able to use other forms of HIV-related support and information in your own family life and work? What has been most useful? Why? What has not been so useful? Why?

III. Curriculum Topics

Gender

What do you think are the important issues that we need to address in the training related to differences between men and women?

How do you think living with HIV affects women?

How do you think living with HIV affects men?

Are there any specific topics that this workshop should address?

What topics do you think were most helpful during the last workshop or meeting you attended:

<i>HIV Basics</i>	Not	Somewhat	Very
<i>Nutrition and Exercise</i>	Not	Somewhat	Very
<i>Disclosure</i>	Not	Somewhat	Very
<i>ARVs and Treatment</i>	Not	Somewhat	Very
<i>Pregnancy</i>	Not	Somewhat	Very
<i>Healthy Living</i>	Not	Somewhat	Very
<i>Relationships, Marriage, and Family</i>	Not	Somewhat	Very
<i>How to Create Support Groups</i>	Not	Somewhat	Very
<i>How to Network in the Region</i>	Not	Somewhat	Very
<i>Human Rights</i>	Not	Somewhat	Very
<i>Advocacy</i>	Not	Somewhat	Very
<i>Religious Leaders</i>	Not	Somewhat	Very
<i>Improving Community Support</i>	Not	Somewhat	Very
<i>Process Groups</i>	Not	Somewhat	Very
<i>Stigma</i>	Not	Somewhat	Very

Other

What are the 3–4 issues that are currently most important in your life?

What kind of knowledge, skills, and capacity do you need to address the issues that you described in the question above?

What are some steps that your local community has taken to improve the lives of women and girls living with HIV?

IV. PMTCT

Risk factors that influence mother-to-child transmission of HIV include (*circle the most appropriate*):

- a. Maternal clinical condition
- b. Maternal immune system
- c. Mode of delivery
- d. Viral load
- e. Duration of rupture of membranes
- f. All of the above
- g. Both a. and d.

Name two (2) antiretroviral drugs given to HIV-positive pregnant women to reduce the risk of mother-to-child transmission.

V. Stigma and Discrimination

What is the difference between stigma and discrimination?

What are some of the causes of stigma and discrimination against women living with HIV in the Middle East/North Africa Region?

What do you think the effects of stigma and discrimination are on a woman or girl living with HIV in our region?

VI. Other Barriers

Can you name barriers women and girls living with HIV face related to disclosure?

Can you name some barriers that women and girls living with HIV face related to accessing support?

Can you name some barriers that women and girls living with HIV face related to accessing important HIV information?

Can you name some barriers that women and girls living with HIV face related to treatment access?

Other Comments:

Thank you for your time and feedback.

ANNEX 7: UNDP HUMAN RIGHTS CARDS

<p>KNOW YOUR UNIVERSAL HUMAN RIGHTS</p>  <p>With every Right, there is a Responsibility</p> 	<p>WHAT IS AIDS?</p> <p>AIDS is the Acquired Immune Deficiency Syndrome, which is caused by the Human Immunodeficiency Virus (HIV). Discovered in the early 1980s, HIV is transmitted from person to person through unprotected sex, transfusion of infected blood, sharing of contaminated needles and from mother to child during pregnancy, birth or breastfeeding.</p> <p>By the end of 2005, 39 million adults and children were living with HIV and AIDS. More than 4 million people were infected with HIV in 2005, and almost 3 million died of AIDS-related illnesses.</p>	<p>THE LINK BETWEEN HUMAN RIGHTS AND AIDS</p> <p>Respect for human rights is critical to preventing the spread of HIV, and reducing AIDS-related stigma and discrimination.</p> <p>"Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS."¹</p> <p>Millennium Development Goal 6 includes the target of halting and beginning to reverse the spread of HIV/AIDS by 2015.²</p> <p>"A human rights-based approach to development insists that women and men have equal access to development health, an education, employment and adequate housing."³</p> <p><small>¹ United Nations General Assembly Special Session, Declaration of Commitment on HIV/AIDS, June 2001. ² Millennium Development Goals, the Millennium Declaration, September 2000. ³ Kemal Derviz, UNDP Administrator, Human Rights Day Statement, December 2005.</small></p>
<p>THE LINK BETWEEN HUMAN RIGHTS AND LAW</p> <p>The law tells us what rights we enjoy, as well as our duties.</p> <p>In order for human rights to be respected and enforced, they must be recognized in law.</p> <p>When human rights are recognized and protected by law, people are free to live healthier, happier and more fulfilling lives. In order to claim human rights, one has to know what rights are recognized by the legal system of one's country.</p> <p>"We should have laws to protect us so that we can enlighten society and erase the stigma attached to HIV/AIDS."¹</p> <p><small>¹ A person living with HIV from Sudan.</small></p>	<p>RIGHT TO PRIVACY</p> <p>Everyone has the right to privacy. The right to privacy is a fundamental human right that is vital to the concept of human dignity.</p> <p>"No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation."¹</p> <p>"States... should ensure privacy and confidentiality and ethics in research involving human subjects..."²</p> <p><small>¹ Article 17 of the International Covenant on Civil and Political Rights, 1976. ² HIV/AIDS and Human Rights International Guidelines (Guideline 5), OHCHR, UNAIDS, 1998.</small></p>	<p>WHAT THIS RIGHT MEANS TO YOU</p> <p>The right to privacy means that you have the right to keep your HIV status to yourself and you cannot be forced by any means to have a blood test without your informed consent.</p> <p>Your doctor cannot inform your family of your status without your consent. However, you are responsible for informing your sexual partner(s) of your status and for not engaging in behaviour that may put others at risk of infection.</p> <p>This right is important because without it, people who might be HIV positive are less likely to seek counselling, testing or treatment out of fear of stigmatization.</p>

RIGHT TO LIFE

Everyone has the right to life. "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services..."¹

Human rights are universal, indivisible, interdependent and interrelated, therefore the right to life is linked to the right to food, the right to adequate housing and the right to a healthy environment.

¹Article 25 of the Universal Declaration of Human Rights, 1948.

WHAT THIS RIGHT MEANS TO YOU

The right to care, support and treatment means that States must ensure access to services for sexually transmitted infections, means of prevention such as male and female condoms, clean injection equipment and life prolonging treatment such as antiretroviral therapy.

With respect to the integrity and dignity of the human body, drugs and therapeutic tests such as vaccines cannot be tested on individuals without their informed consent.

African leaders committed themselves to "... protect those not yet infected, particularly women, children and youth..." and to "the strengthening and development of special youth programmes to ensure an AIDS free Generation."¹

¹Article 23 of the Abuja Declaration, endorsed by African Head of States, April 2001.

RIGHT TO INFORMATION

Everyone has the right to information. "Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds..."¹

"States should enact legislation to provide for the regulation of HIV related goods, services and information..."²

"States shall take all appropriate measures ... to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning."³

¹Article 19 of the International Covenant on Civil and Political Rights, 1976.

²HIV/AIDS and Human Rights International Guidelines (Guideline 6), OHCHR, UNAIDS, 1998.

³Article 12 of the Convention on the Elimination of all Forms of Discrimination Against Women, 1981.

WHAT THIS RIGHT MEANS TO YOU

You have a right to the most up-to-date information on HIV prevention, counselling and treatment in your native language.

States are obliged to ensure that appropriate and effective information on methods to prevent HIV transmission is developed and disseminated for use.

Adults and children have the right to information about HIV that will empower them to protect themselves from infection.

You also have the right to exclusive access to your medical records. No one can demand access without your explicit informed consent.

RIGHT TO EDUCATION

Everyone has the right to education. "Education shall be directed to the full development of the human personality ... and shall strengthen the respect for human rights and fundamental freedoms."¹

States shall "make primary education compulsory and available free to all... make higher education accessible to all ... ensure that the child has access to information and material ... aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health."²

¹Article 13 of the International Covenant on Economic and Cultural Rights, 1976.

²Articles 28 and 17 of the Convention on the Rights of the Child, 1989.

WHAT THIS RIGHT MEANS TO YOU

Schools cannot refuse to educate you if you are living with or affected by HIV. You also have the right to an education about healthy practices that help to prevent HIV infection. You should not be asked to take a mandatory HIV test in order to apply to any school or university, nor should you be forced to disclose your HIV status to your school or university.

Schools have a responsibility to educate all students about HIV and how it is transmitted, and to challenge AIDS-related stigma and forbid discrimination.

RIGHT TO WORK

"Everyone has the right to work, to free choice of employment, to just conditions of work and to protection against unemployment."¹

Just and favourable working conditions bar any form of discrimination. This includes "any distinction, exclusion or preference made on the basis of race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation."²

No one should lose his job because of positive HIV status.

¹Article 23 of the Universal Declaration of Human Rights, 1948.

²Convention concerning Discrimination in respect of Employment and Occupation, ILO, 1958.

WHAT THIS RIGHT MEANS TO YOU

You have the right to safe and healthy working conditions, as well as the provision of health care services.

You have the right to access social insurance, which includes life and medical insurance, the right to have access to treatment and information about HIV, the right to compensation if you have been infected with HIV at work, and the right to fair and equal payment.

States should ensure that you are allowed to work as long as you can carry out the functions of your job. You have the right to keep your HIV status confidential, as long as you do not engage in behaviour that puts others at risk of infection.

RIGHT TO NON-DISCRIMINATION

Everyone has the right to dignity. "Everyone is entitled to ... rights and freedoms... without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."¹

The 1999 Commission on Human Rights Resolution reiterated that "discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term "or other status" in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS."²

¹Article 2 of the Universal Declaration of Human Rights, 1948.

²Resolution 49/1999 of the UN Commission on Human Rights.

WHAT THIS RIGHT MEANS TO YOU

You should not be discriminated against because you or someone close to you is HIV positive.

"States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV or AIDS and people with disabilities from discrimination in both the public and private sectors."¹

"We may have different religions, different languages, different coloured skins – but we all belong to one human race."²

¹ HIV/AIDS and Human Rights: International Guidelines (Guideline 5), OHCHR, UNAIDS, 1998.

² Kofi Annan, United Nations Secretary General, June 2000.

POLITICAL AND CIVIL RIGHTS

"The right of peaceful assembly shall be recognized ... Everyone shall have the right to freedom of association with others..."¹

"The family is the natural and fundamental group unit of society and is entitled to protection by society and the State... the right of men and women of marriageable age to marry and to found a family shall be recognized."²

"Every citizen shall have the right and the opportunity ... to take part in the conduct of public affairs ... to have access, on general terms of equality, to public service in his country."³

¹Article 21 of the International Covenant on Civil and Political Rights, 1976.

²Article 23 of the International Covenant on Civil and Political Rights, 1976.

³Article 25 of the International Covenant on Civil and Political Rights, 1976.

WHAT THIS RIGHT MEANS TO YOU

You can create or join NGOs, support groups, clubs, volunteer networks or any other types of organizations.

You are free to advocate for your human rights. You have the right to freedom of expression, which includes freedom to receive or give out information or ideas. You cannot be separated or isolated from other people involuntarily.

You have the right to actively participate in society and exercise all of your rights as a citizen such as voting, being elected and receiving government services. You have the right to marry and have children, bearing in mind that you are responsible for informing your partner of your HIV status, because he or she has the right not to be infected.

THE RIGHTS OF MIGRANTS, REFUGEES AND INTERNALLY DISPLACED PEOPLES

"Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State Concerned."¹

"The Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals."²

¹Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 2002.

²Article 23 of the Convention Relating to the Status of Refugees, 1951.

WHAT THIS RIGHT MEANS TO YOU

Thousands of people fleeing conflict and civil unrest, or who are simply seeking a better life, move from place to place every day, regardless of national boundaries. This increased mobility can contribute to the spread of HIV, and migrants, refugees and internally displaced persons may be particularly at risk. It is therefore critical that universal human rights of displaced and mobile populations are recognized, no matter where they live, or what their nationality is.

THE RIGHTS OF VULNERABLE GROUPS

Vulnerable groups including intravenous drug users, sex workers, men having sex with men, and groups whose behaviour is criminalized, are often socially excluded, with less access to information, support, care and treatment.

As a result, many may be unable or unwilling to exercise their rights to confidential counselling, testing or treatment related to HIV. Their universal rights must be recognized and respected so that they are empowered to protect themselves and their loved ones and to live the healthiest lives possible.

As stated by religious leaders in the Arab States: "We emphasize the importance of reaching out to vulnerable groups which are more at risk of being infected by HIV and/or spreading it."¹

¹The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic, December 2004.

WHAT THIS RIGHT MEANS TO YOU

Vulnerable groups are entitled to exactly the same universal human rights as anyone else. You have the right to information, confidential counselling and education that can help you to protect yourself and your loved ones from HIV infection.

You have the right to privacy, meaning that your personal practices, HIV status and health records may not be disclosed to anyone without your explicit consent.

You have the right and responsibility to protect yourself, your family and your sexual partners from HIV by taking necessary precautions such as using clean injection equipment or male/female condoms.

INTERNATIONAL INSTRUMENTS

- The United Nations Charter, 1945
- The Universal Declaration of Human Rights, 1948
- The International Covenant on Civil and Political Rights, 1976
- The International Covenant on Economic, Social and Cultural Rights, 1976
- The Convention on the Elimination of all Forms of Discrimination Against Women, 1981
- The Convention on the Rights of the Child, 1989
- The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 2003
- The African Charter on Human and Peoples' Rights, 1981
- The World Conference on Human Rights, 1993
- The International Conference on Population and Development and the Cairo Plan of Action, 1994

Other important international instruments: The Denver Principles, 1983; The Ottawa Charter for Health Promotion, 1986; The Paris Declaration, 1994; The Abuja Declaration, 2001; The Declaration of Commitment on HIV/AIDS, 2001; The Millennium Declaration.

WEBSITES

- www.unaids.org
- www.who.org
- www.unesco.org
- www.unfpa.org
- www.unodc.org
- www.wfp.org
- www.undp.org
- www.unicef.org
- www.ilo.org
- www.worldbank.org
- www.unhcr.org

Developed by the UNDP HIV/AIDS Regional Programme in the Arab States: <http://www.harpas.org>



United Nations Development Programme
HIV/AIDS Group, Bureau for Development Policy
304 East 45th Street
New York, NY 10017
T: 212 906 3688 F: 212 906 5023
www.undp.org/hiv

ANNEX 8: SEXUAL AND REPRODUCTIVE HEALTH RIGHTS



SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

1. The right to life should be invoked to protect women whose lives are currently endangered by pregnancy.
2. The right to liberty and security of the person should be invoked to protect women currently at risk from genital mutilation, or subject to forced pregnancy, sterilisation or abortion.
3. The right to equality and to be free from all forms of discrimination should be invoked to protect the right of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to sexual and reproductive health.
4. The right to privacy should be invoked to protect the right of all clients of sexual and reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers.
5. The right to freedom of thought should be invoked to protect the right of all persons to access to education and information related to their sexual and reproductive health free from restrictions on grounds of thought, conscience and religion.
6. The right to information and education should be invoked to protect the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.
7. The right to choose whether or not to marry and to found and plan a family should be invoked to protect all persons against any marriage entered into without the full, free and informed consent of both partners.
8. The right to decide whether or when to have children should be invoked to protect the right of all persons to reproductive health care services which offer the widest possible range of safe, effective and acceptable methods of fertility regulation, and are accessible, affordable, acceptable and convenient to all users.
9. The right to health care and health protection should be invoked to protect the right of all persons to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
10. The right to the benefits of scientific progress should be invoked to protect the right of all persons to access to available reproductive health care technology which independent studies have shown to have an acceptable risk/benefit profile, and where to withhold such technology would have harmful effects on health and well-being.
11. The right to freedom of assembly and political participation should be invoked to protect the right to form an association which aims to promote sexual and reproductive health and rights.
12. The right to be free from torture and ill treatment should be invoked to protect children, women and men from all forms of sexual violence, exploitation and abuse.

Adapted from International Planned Parenthood Federation Charter on Sexual and Reproductive Rights

This poster was made possible through the support of Department For International Development (DFID).



Supporting community action on AIDS in India
Kushal House, Third Floor, 39, Nehru Place, New Delhi - 110019
www.aidsalliance.org, www.aidsallianceindia.net

ANNEX 9: PREVENTION OF MTCT

Prevention of MTCT involves the following:

1. Prevention of primary HIV infection

Decreasing the number of mothers infected with HIV is the most effective means for reducing MTCT. HIV infection will not be passed on to children if parents are not infected.

2. Prevention of unintended pregnancies among HIV-positive women

In MENA, the risk of MTCT is exacerbated by unintended pregnancies. A major cause of unintended pregnancy is the limited access to family planning services. Stockouts of contraceptive supplies also present a problem—this includes condoms, which also help prevent HIV. In addition, HIV-positive women on highly active antiretroviral treatment (HAART) may be more vulnerable to unintended pregnancy because, while HIV might suppress fertility, HAART reduces viral loads and is likely to increase fertility.¹⁶ In developing countries, maternal mortality is nearly double in HIV-positive women compared to those who are not infected.

3. Prevention of HIV transmission from HIV-positive women to their infants

Specific interventions to reduce HIV transmission from an infected woman to her child include VCT, antiretroviral prophylaxis and treatment, safer delivery practices, and safer infant-feeding practices.

4. Provision of treatment, care, and support to women living with HIV and their infants and families

If a woman is assured that she will receive adequate treatment and care for herself, her children, and her partner/husband, she is more likely to accept VCT and, if HIV-positive, interventions to reduce MTCT. Other services also may be needed, such as palliative care, nutritional support, reproductive health—which, importantly, includes family planning and counseling—and psychosocial support. Further, children whose mothers are infected with HIV are at higher risk than other children for illness and malnutrition and so should be included in comprehensive care.

¹⁶ Population Action International. 2007. *Family Planning—A Crucial Intervention for HIV-positive Women*. Available at www.populationaction.org/Publications/Fact_Sheets/FS35/Summary.shtml#notes

5. Promotion of safe breastfeeding practices

In resource-constrained settings, some healthcare providers suggest exclusive breastfeeding.¹⁷ Exclusive breastfeeding may provide benefit by protecting the infant's intestinal mucosa, thus providing a better barrier against HIV, and by diminishing the mother's risk for breast-health problems, which are associated with increased breast milk viral load.¹⁸ However, it is important to check with your health care provider regarding what kind of breastfeeding practice is best for your circumstance, including formula based options mitigate HIV transmission.

6. Risk reduction during pregnancy and delivery

Many MENA women can plan delivery to take place in an antenatal care (ANC) setting, supported by healthcare staff. ANC improves the general health and well-being of mothers and their families. By integrating PMTCT services into essential ANC services, healthcare programs can improve care and pregnancy outcomes. This can ensure that both delivery and treatment are provided to limit HIV transmission. For example, interventions in Somalia are being supported to incorporate midwives into safer delivery practices for mothers who are HIV positive.

7. Antenatal care

This improves the general health and well-being of mothers and their families and is a main source of healthcare for women of childbearing age. By integrating PMTCT services into essential ANC services, healthcare programs can improve care and pregnancy outcomes for clients. Antenatal interventions can reduce the risk of MTCT and can support women living with HIV to have healthy, longer lives and care for their children to adulthood. When mothers die prematurely, children face much higher rates of vulnerability themselves, including illness and death. ANC should include the following in PMTCT programs:

- Health information and education
- Education about safe sex and HIV
- Confidential VCT for HIV
- Partner HIV testing and counseling
- Interventions to reduce the risk of MTCT

¹⁷ In South Africa, a 2007 study was conducted in which pregnant women were enrolled in a nonrandomized cohort study to assess HIV transmission and infant survival by type of infant feeding. They received single-dose nevirapine, counseling about feeding options, and postnatal home visits by counselors. The feeding options were exclusive breastfeeding, starting from birth; replacement feeding (nonhuman milk, with or without solids); and mixed breastfeeding (breast milk plus nonhuman milk, other liquids, or solids). For more information, see full article: Coovadia, H., et al.2008, "Mother-to-Child Transmission of HIV-1 Infection during Exclusive Breastfeeding in the First 6 Months of Life: An Intervention Cohort Study." *The Lancet* 369(9567): 1107–1116.

¹⁸

- Infant-feeding counseling and support
- Support for safe motherhood, including malaria and TB treatment
- Diagnosis and treatment of STIs

ANNEX 10: COUPLE'S COMMUNICATION HANDOUT

Source: "Constructive Men's Engagement in Reproductive Health: A Training of Trainers' Manual," *Couple Communication and Shared Decisionmaking Related to Reproductive Health*. Health Policy Initiative, 2009.

Advice for communication

- Express yourself (the first step is talking)
- Listen (listen well to the other person)
- Consult/ask (asking questions demonstrates respect for the other person)
- Understand/sympathize (exploring differences in order to see the commonalities)
- Use body language (gestures) as well as words

Means of Communication

Advice + Behavior + Reason

- "I feel bad" + "when you ignore my mother" + "because she is important to me."
- "I don't like" + "when you leave me to go the health care center alone" + "because I only want to avoid problems with my pregnancy and have a healthy baby."

It's important to include all three elements in a statement. Often someone will demonstrate that they are not happy without explaining why.

Decision

- Have time and a quiet, private place
- Agree on the decision that needs to be made
- Sum up the aspects and their affects
- Weight the options: advantages and disadvantages
- Consider feelings and concerns

Killer bees (elements that harm good communication)

- Assuming
- Avoiding
- Criticizing
- Blaming
- Being on the defensive

Benefits and risk of working on couple's communication

- Benefits: more exchanges, increased understanding, shared differences, and clarity of differences
- Risks: time, misunderstanding, and annoyance

Advice from a mother to her children

There are three essential things in life: laughing, dreaming, and sweating. Communication is like this: you need to be patient, begin with the positive, let people express themselves, and finally see how this translates into action.

ANNEX 11: SCENARIOS FOR EXPLORING STRATEGIES TO IMPROVE COUPLE COMMUNICATION AND DECISIONMAKING

Scenario A

Neighbors tell you in confidence that there are problems at home with a couple. They believe the husband hits his wife.

The couple comes to your support group and you speak with the wife. She admits her husband yells at her often but has never hit her. She also admits that he does not want to wear a condom but she would prefer that he did. She is HIV negative and he is HIV positive.

Have everyone in the group read the couple's situation.

Tasks:

- Identify three elements of a good strategy based on counseling and support skills for the couple.
- Prepare a short presentation (four to five minutes) for the entire group, summarizing the situation and giving elements of the counseling and support strategy. Explain why the strategy was chosen (if possible, write the key words or images on flip chart paper).

Scenario B

A man and a woman you know in your support group have a good relationship on some days but the husband is very jealous. When he is jealous, he accuses his wife of cheating on him with other support group members who are men. As a result, his wife does not speak during any meetings and never leaves his side. She has made some friends in the support group who are women, but he does not feel comfortable with her speaking to even the women. The husband has also said he would leave his wife, and threatened to do this several times. They have two children.

Have everyone in the group read the couple's situation.

Tasks:

- Identify three elements of a good strategy based on counseling and support skills for the couple.
- Prepare a short presentation (four to five minutes) for the entire group, summarizing the situation and giving elements of the counseling and support strategy. Explain why the strategy was chosen (if possible, write the key words or images on flip chart paper).

Scenario C

Mona and Mohammed have been married for three years and have two children. Mohammed is anxious to have a big family and another child right away. Mona wants to take a longer time to have their next child, and only wants to have three children. Mona is not only facing pressure from Mohammed, but also his family as well as her family. Mona has an older sister who is respected in the community who also supports Mona's choice to space her births further apart and to have a smaller family.

Have everyone in the group read the couple's situation.

Tasks:

- Identify three elements of a good strategy based on counseling and support skills for the couple.
- Prepare a short presentation (four to five minutes) for the entire group, summarizing the situation and giving elements of the counseling and support strategy. Explain why the strategy was chosen (if possible, write the key words or images on flip chart paper).

ANNEX 12: VAW-ICW-GCWA FACT SHEET



Violence against HIV positive women

International Community of Women Living with HIV/AIDS (ICW)
and the Global Coalition on Women and AIDS (GCWA)



International Community of Women Living with HIV/AIDS (ICW)
International Support Office, Unit 6, Building 1
Canonbury Yard, 190a New North Road,
London N1 7BJ, United Kingdom
Tel: +44 20 7704 0606 Fax: +44 20 7704 8070 www.icw.org
(ICW is co-convening agency for the ACTS arm of the GCWA -
<http://womenandaids.unaids.org>)

This fact sheet frames key issues and advocacy messages based on the findings of our project work on violence against women. Two other fact sheets on access to care, treatment and support and sexual and reproductive rights are also available from ICW.

Definition of “violence against women:”

The term "violence against women" (VAW) means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, VAW encompasses but is not limited to the following:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non- spousal violence and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and
- Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Other acts of VAW include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy. Acts of VAW also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.¹⁹

¹⁹ Definition of Violence against women from the Beijing Platform for Action 1995.

Already high levels of VAW are compounded by HIV/AIDS. However, most of the research conducted to date has focused on violence and its role in transmission. Here we consider the connection between violence and gender for women that are already HIV positive.²⁰

The link between HIV and violence against women:

- Assaults, battery and the rape of children, especially girls, are reported to be frequent occurrences, and they perpetuate the spread of HIV directly (in the case of rape) and indirectly through promoting intra-familial fear that might prevent disclosure by a positive partner to a negative partner or prevent negotiation of safer sex. Certain situations such as conflict, migration and sex work can exacerbate the impact of violence on HIV positive women.
- Social tolerance of VAW prevents women from discussing the issue, leaving or confronting an abusive situation or seeking help. Discrimination associated with HIV heightens such tolerance.
- Women may fear to leave an abusive relationship for fear of what will happen to the children if they have no child-custody rights.
- Women are often the first member of a household to discover their status, through ante-natal testing. This can result in blame, violence and rejection from partners or in-laws, family, friends and community. *'When I was diagnosed I had a partner. The relationship became more violent – he said I brought a new problem into the family. The violence became more, he had other relationships. You get told off because you have HIV.'* (ICW member Swaziland)
- Exposure to re-infection by refusal to wear condoms, or the violation of a woman's reproductive rights (e.g. if a woman is forced or coerced into pregnancies and childbirth that she is not willing to undergo) can endanger her life due to HIV-related complications.
- Internalized stigma and discrimination may mean that people living with HIV feel ashamed of themselves and of their status. This can undermine their confidence to leave or confront an abusive situation. *'He says "you have AIDS anyhow so you can't compete with me. I have to have a life. You have HIV and won't be around. So understand my other relationships.'"* (ICW member South Africa)
- Myths and misconceptions and attitudes around HIV promote VAW. For example, the belief that you can be cured by having sex with a virgin has led to a high incidence of rape of young girls.

²⁰ The Global Coalition on Women and AIDS has produced an Issue Brief on violence against women, the focus of which is on vulnerability to HIV and examples of work addressing the issues. See: <http://womenandaids.unaids.org/themes/docs/UNAIDS%20VAW%20Brief.pdf>.

Accessing services:

- Violence and fear of violence can lead to women feeling fearful to seek care, treatment and support.
- Fear of disclosure due to the threat of violence or abandonment by partners, can be a barrier to accessing treatment, especially where women have to travel a long distance to reach health services, hospitals or clinics, and may need husbands' permission to make or pay for the journey. The result can be that women seek help at the last minute when they are really sick.
- Fear of disclosure may prevent a woman from accessing available PMTCT programs, and using safer infant feeding options, as a woman who doesn't breastfeed her child may be suspected of being HIV positive.

Information and experiences of services:

- Many women do not know where to find information about VAW nor where to report incidences or seek help.
- Services are often limited with no referral systems in place to ensure that appropriate counselling, treatments, advice and legal remedies are available.
- There are generally no shelters or safe houses for women.
- The police often do not take the issue seriously, particularly, rape in marriage. *'I was nearly raped twice and the police said 'but he did not penetrate you – why are you here? He put it in such a way that made me feel guilty – you were out late'. 'Going to the police and being on trial is like being raped again' (ICW member Swaziland).*
- Marital rape is not recognized as a legal issue in most countries.
- The culture of blame and discrimination against women living with HIV that exists within society also permeates health care settings. Therefore, the onus is placed on women to avoid violence by modifying their behavior. *'I put on weight from the treatment and could not wear my [wedding] rings so I was abused. The counselor said – "You must wear your rings." I am worried about being shot to death! She says you must go back.'* (ICW member South Africa)
- HIV positive women also face pressure to abort, be sterilized or take contraceptives in order to access treatment services – all of which are forms of VAW.

Recommendations:

Given the limited information and analysis on the links between HIV, gender and violence we firstly emphasize the need for research to address the following questions:

- How are local communities (i.e. families, community traditional, civic and faith leaders) coping with HIV/AIDS and violence? What strategies have they adopted to address violence and its links to HIV/AIDS?
- How do young women understand and define the concept of violence in their lives? What responses do they make and what opportunities do they have for addressing this violence? How do poverty and culture combine to open up or close down their options? More specifically, how do child custody laws and practices affect women's responses to violence; what role does access to or lack of access to property/land/livelihoods play?
- How does being perceived as being HIV positive, or disclosing a positive serostatus, affect women's experiences of sexual and other forms of violence?
- How do HIV/AIDS and other public services, policies and programs address issues of VAW? How do they contribute to VAW, including through mass and routine testing?
- How do services that deal with violence address the issues of women who are already HIV positive?

In the mean time we urge policymakers and programmers to consider:

- VAW and its relationship to HIV as rooted in unequal gender relations, gender hierarchies and poverty, and not just within a public health framework;
- The implications for VAW of public health policies relating to HIV/AIDS, including HIV testing, treatment and partner notification policies;
- The implications for VAW of legislation which has relevance to gender relations, such as legislation related to equality within marriage, domestic relationships, child custody;
- Future directions for public services (legal/justice, medical and social), in relation to VAW and HIV/AIDS;
- The need to recognize differences in needs/approaches in different contexts – drawing out comparisons while avoiding “one size fits all” solutions;
- The need to increase the broad understanding of the complexities of VAW, including physical, sexual, psychological, financial and institutional violence;
- Supporting safe spaces for HIV positive women to share histories and seek mutual support. We also feel that if HIV positive women have the space and time together they can break down the barriers to discussing hidden or taboo areas. This could help challenge aspects of 'internalized' acceptance of male violence and male 'right' to sexual access to women, or, for example, the necessity of genital mutilation in order to attract a husband.

ANNEX 13: EVALUATION TEMPLATE

Logistics

Please give your feedback on the following:

- Hotel:

- Location:

- Service:

- Meals:

- Coffee Breaks:

- Your Room:

- Meeting Room:

Workshop Content

Please provide your feedback on the following:

Overall, what were the strengths of this workshop?

Overall, were there any weaknesses of this workshop? If so, what? How could the workshop be improved?

Please use the table below to rate each one of the sessions.

					
Session 1	Relevance				
	Facilitation/Speakers				
	Comments				
Session 2	Relevance				
	Facilitation/Speakers				
	Comments				
Session 3	Relevance				
	Facilitation/Speakers				
	Comments				
Session 4	Relevance				
	Facilitation/Speakers				
	Comments				
Session 5	Relevance				
	Facilitation/Speakers				
	Comments				
Session 6	Relevance				
	Facilitation/Speakers				
	Comments				
Session 7	Relevance				
	Facilitation/Speakers				
	Comments				
Session 8	Relevance				
	Facilitation/Speakers				
	Comments				
Session 9	Relevance				
	Facilitation/Speakers				
	Comments				
Session 10	Relevance				
	Facilitation/Speakers				
	Comments				
Session 11	Relevance				
	Facilitation/Speakers				
	Comments				

					
Session 12	Relevance				
	Facilitation/Speakers				
	Comments				
Session 13	Relevance				
	Facilitation/Speakers				
	Comments				
Session 14	Relevance				
	Facilitation/Speakers				
	Comments				
Session 15	Relevance				
	Facilitation/Speakers				
	Comments				
Session 16	Relevance				
	Facilitation/Speakers				
	Comments				
Session 17	Relevance				
	Facilitation/Speakers				
	Comments				
Session 18	Relevance				
	Facilitation/Speakers				
	Comments				
Session 19	Relevance				
	Facilitation/Speakers				
	Comments				
Feedback Group	Relevance				
	Facilitation/Speakers				
	Comments				

