Level II
Instructor Manual

Day 1
Agenda with times

Level II Training Agenda
Day 1

Welcome / Overview of Agenda

Review of Parking Lot / Ground Rules / Housekeeping

Ice Breaker “People Hunt Bingo”

Program Overview

Initial Evaluation / Consent Paperwork

Break (15 min.)

Peer Educators in the Multi-Disciplinary Team

Peer Educator Job Description

Confidentiality and Boundaries

Lunch – Noon (45min)

Communication Skills

- Verbal Communication
- Non-Verbal Communication

Break (15 min.)

Communication Skills (cont.)

- Attentive Listening

Cultural Competency

Wrap-up / Pluses & Wishes / Summary of the Day

Tab name:
Icebreaker Activity

People Hunt Bingo Ice Breaker

Sidebar items

Time Allotted
10 minutes

Participants
3-15 people

Materials Needed
People Hunt Bingo activity worksheets for all participants
Pens and pencils

Main Body

The People Hunt Bingo icebreaker is an easy "pen and pencil" way to start a community session. It also leads well into small-group activities because it shows that people bring many different backgrounds and skills to a group.

Objective
To help participants feel connected to others in the group.

Facilitator Instructions
1. Before the session, look over the activity sheet for this icebreaker and change any items to make the activity more relevant to the group.

2. Make enough copies of the People Hunt Bingo activity sheet for all participants.

3. Distribute the activity sheets to all participants.

4. Ensure that everyone has a pencil or pen.

5. Tell participants that this is an icebreaker that is similar to the game bingo. Tell them they will have 10 minutes to complete the activity.

6. Read the directions on the activity sheet aloud. Ask if there are any questions.

7. Encourage participants to move around the room as they ask each other questions.

8. Watch for any participants who may be shy or appear reluctant to mingle with the others and encourage them to get involved.

9. After several participants have finished, ask the first person who finished to re-create his or her line with the people who signed the boxes.

10. Point out how many experiences and interests people bring to the group.

Discussion Questions
This activity does not require any further discussion once everyone has completed the task.

What's Next?

Thank everyone for participating in this exercise. Share with them that, now everyone is warmed up, the group will go into a brief discussion about Peer Education programs and the roles and responsibilities of Peer Educators.

ACTIVITY SHEET #1

People Hunt Bingo

Find someone who fits the each of the descriptions below and have them initial in the box that applies to them. Each person can initial your sheet no more than two times. You "win" when you get four boxes initialed across a row, down a column or along a diagonal.

Flosses their teeth at least once a day	Has lived in Kansas City , St. Louis or Springfield for at least 6 months	Drinks 64 oz. or 8 glasses of water a day	Someone who likes to exercise
Kept a medical appointment within the last 6 months	Has at least 2 nieces or nephews	Eats 3-5 servings of fruit or vegetables every day	Has seen the Wizard of Oz movie
Has an unfinished bottle of medication in their medicine cabinet	Has had a meal at McDonald's this week	Talks with friends and family to get support	Has a Beatles CD/Album or cassette
Someone who loves a good joke	Someone who knows how to take the bus	Someone who is a good listener	Someone whose favorite color is black

Program Overview

Peer Educator Training Site (PETS)
Missouri AIDS Alliance

Project Overview

Sidebar items

Time Allotted
5 minutes

Participants
All participants in one large group

Materials Needed
None

Main Body

The first step in this training is to ensure that all participants understand the purpose of the Peer Educator Training Site (PETS) project and what will be expected of them as Peer Educators.

Objective
To introduce the Peer Educator Training Site (PETS) project to participants.

Facilitator Instructions
Gather all participants into a group and read the following introduction.

> "Nationally, the purpose of the Peer Educator Training Site (PETS) project is to learn how to build the capacity of organizations and Peers to develop and replicate HIV Peer Education programs. In Missouri, we are one of three sites participating in this larger national program, which is funded by the federal government's Health Resource Service Administration, also known as HRSA. The project is research-based, which means that on a local and national level you will help us gather information that may guide future program policies. Your input will be important in demonstrating how effective Peer support can be for engaging persons living with HIV into care.
>
> "We are excited that you have taken the second step of wanting to participate in Level II training. This week's Level II training will provide insights about HIV and the important role Peer Educators play both in helping others who are living with HIV increase their knowledge, engage in primary care and education to improve one's self-care. By the end of the training you will be ready to move onto Level III,that encompasses shadowing a Peer Educator who is already applying skills learned in working with patients in HIV primary care clinics. That trained Peer Educator will then provide reverse shadowing, which is supporting you at the site

you will be working or volunteering to ensure the transition in the role as Peer Educator is seamless

"As stated earlier, another component of the project is building capacity of organizations that provide HIV primary care. We will invite primary care clinics to an informational session to tell them about PETS: Missouri AIDS Alliance and peek their interest in incorporating a Peer program in their clinics. We will complete a needs assessment of these interested clinics to determine whether the organization has the capacity to have a Peer program and, if not, how to go about developing the necessary capacity.

Again, thank you for joining us this week for this Level II training.

Discussion Questions

Before continuing, ask the group if anyone has any questions about the training program or the PETS project in general.

What's Next?

Initial Evaluation/ Consent Paperwork

PETS: Missouri AIDS Alliance
People to People Level II Training
Summary of Data Collection Procedures

Materials

Pencils
Level II Questionnaires
Level II Peer Educator Consent Forms
Level II Peer Educator Self-Screening Forms
Level II Training Feedback Forms
Four large manila envelopes with Data Collection/Transfer Sheet

Procedures

- ***Project Overview***

    - Provide an overview of the PETS: Missouri AIDS Alliance Project using the Project Overview Script as a guide.

- ***Consent Forms***

    - Distribute **two** copies of the Level II Consent Form, a Level II Questionnaire, and a puzzle to all participants.
    - Instruct participants that if they do not wish to participate in the research they may complete the puzzle while other participants are completing the consent forms and questionnaires.
    - Review the consent form as the participants follow along with their own copy.
    - Inquire if there are any questions before asking the participant to sign both copies of the consent forms.

- ***Level II Questionnaire***

    - *At the top of the Level II Questionnaire, be sure to complete the following:*
      Site ID: *MO*
      Loc ID: *The code consists of a two letter abbreviation for the city followed by a two letter state abbreviation and ending the 1 or 2 digit number of training. This last number is used to make the distinction between two trainings occurring in the same city (e.g., SLMO1, KCMO1).*
      Date questionnaire is completed.

    - Upon completion of the consent forms and questionnaire, collect the consent forms, questionnaires, separate them and place them in two large envelopes. When all forms are collected, remind the participants to keep one copy of the consent form for themselves.
    - Complete the Data Collection/Transfer Sheet information on the outside of the envelopes. There should be one envelope for consent forms and a second envelope for the Level II Questionnaires.

- ***Level II Peer Educator Self-Screening Form***

    - At the conclusion of the training, distribute self-screening forms to each participant to complete to indicate their level of interest in Level III Training.

- Upon completion of the self-screening forms, place them in a third envelope and forward to Marilyn (American Red Cross) or Brenda (Kansas City Free Health Clinic).

- ***Level II Training Feedback Form***

  - In addition to the self-screening form, distribute training feedback forms to be completed by all training participants.
  - Feedback forms will be placed in the fourth manila envelope and forwarded to Marilyn (American Red Cross) or Brenda (Kansas City Free Health Clinic).

Peer Educators in the Multi-Disciplinary Team

Activity Template

Topic of Activity:

Peer Educators in the Multi-Disciplinary Team

Time Allotted:

30 minutes

Materials Needed:

Activity Sheets
Pencils/Pens
Prepared questions on newsprint
Markers

Goals and Objectives:

- ✓ Participants will review key aspects of a Peer Educator
- ✓ Participants will identify common qualities of peer educators
- ✓ Participants will understand the different roles we play as peer educators

Instructions:

- ✓ Explain to participants that everyone will need to complete the questions on the activity sheets
- ✓ Ask participants to form into dyads or pairs
- ✓ Participant A will ask interview B following the questions on the activity sheet
- ✓ Participant B will ask interview A following the questions on the activity sheet
- ✓ A co-facilitator will write on newsprint the answers to the questions
- ✓ Review participant answers while emphasizing the common qualities of Peer Educators
- ✓ Upon completion of this activity post on the wall to refer to during the training

Summary and Closing:

Summary common qualities based on participant feedback from the activity. Acknowledge that as we go through this training we will learn about more qualities that were not mentioned today, but are essential to being a peer educator. Now we will learn about incorporating a peer educator as part of a health care team or multi-disciplinary team.

Peer Educators in the Multi-Disciplinary Team Activity

1. What are the qualities of an effective Peer Educator?

2. What are not the qualities of an effective Peer Educator?

Curriculum Template

Topic of Curriculum Segment:

Peer Educators in the Multi-Disciplinary Team.

Time Allotted:

30 minutes

Materials Needed:

Laptop/projector

Objectives:

- To introduce participants to the concept of Multi-Disciplinary Teams
- Participants will understand the vital role that Peer Educators play on the Multi-Disciplinary Team

Instructions:

Lead the presentation using the talking points on the power point slide presentation.

Talking Points:

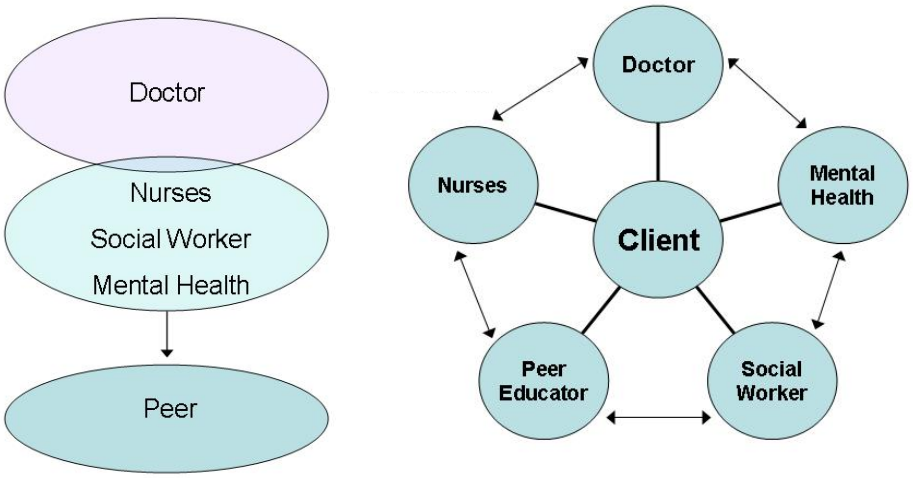
What is a Multi-Disciplinary Team?

- ✓ Multi-disciplinary teams are groups of professionals from diverse disciplines who come together to provide comprehensive assessments and consultation for a common goal (client/patient).
- ✓ Multi-disciplinary teams members do not have to be all located at the same agency/clinic, but are connected in the provision of services to the same client/patient.
- ✓ Multi-disciplinary teams are more prominent in health care-at Hospitals, Clinics and at social services agencies-Non Profit Community Based Organizations and State funded agencies.
- ✓ Multi-disciplinary teams are present in the business field and at schools but often times the title of the team is different and are comprised of professionals from diverse disciplines coming together to provide assessments for a common purpose. An example in the business field would be-a proposal to bid on a construction job where the diverse disciplines would include marketing department, sales, mechanical and electrical engineers, cad drawers etc. An example in the school setting would be-to explore resources that might assist a student function better at school where the diverse disciplines would include the school counselor, the school nurse, the home room teacher etc.

Multi-Disciplinary Team at a Hospital or Clinic

- ✓ Many teams meet at a minimum weekly
- ✓ Diverse disciplines include-social workers, case managers, physician, nurses, psychiatrist or mental health representative, peer educator and others depending on the number of disciplines/services offered at the hospital or clinic
- ✓ How the team decides which case to conference varies-some cases maybe chosen because of multiple agencies involved in providing services to the client, client is at risk of losing housing or insurance, client has not been case conferences in 6 months or the client is coming in for a medical appointment and there is suspicion of substance abuse that is affecting adherence to medications etc…
- ✓ The common goal would be to assess the patient/client needs and develop a plan with the client and the team
- ✓ All disciplines are encouraged to share information they know about the case to support a holistic assessment and explore options to provide to the case for resolution

Traditional Approach versus the Multidisciplinary Approach



Traditional **Multi-Disciplinary**

- ✓ In the Traditional Approach we see the team as being the doctors, nurses, social workers etc give direction to the Peer and so there is not much shared information to provide a holistic approach to service delivery
- ✓ The Multidisciplinary Approach we see that the Client is at the center with all disciplines including the Peer sharing information and providing a team approach to delivery of services.
- ✓ The Peer is vital to the connections between the Client and the multiple service providers.

Discussion Questions:

- ✓ What are the major differences between the Traditional Approach versus the Multidisciplinary Approach of collaborating with clients?
- ✓ What are some of the benefits to the multidisciplinary approach?
- ✓ How do you ensure that each discipline's role on the multidisciplinary team is valued?

Summary and Closing:

As you can see the Multidisciplinary Team approach is inclusive of all disciplines and each team play is valued during assessment and goal planning for the client.

Example of peer program job description

Curriculum Template

Topic of Training Segment:

Example of a Peer Job Description

Time Allotted:

20 minutes

Materials Needed:

Laptop
Projector/Screen/White Wall
Job Description Example Sheet

Instructions:

Job Description

- Reference to Resource handout titled *Peer Educator Job Description*
- Review each bullet, answer questions as they arise
- Explain that the Peer Educator job description may change depending on the Agency/Clinic focus as well as the target population that the peer program is going to reach. Example Peer Educator may work in a HIV Primary Care Clinic and work with clients who come in for their medical appointments or at a Community Based Organization peer educators assist Ryan White Case Managers in finding resources for clients.

Goals and Objectives:

- Participants will understand the educational requirements, essential functions, and physical demands of a Peer Educator in a Clinic setting

Summary and Closing:

Summary and closing are designed to re-state the main knowledge points of a segment, wrap up the discussion and to bridge to the next topic.

JOB DESCRIPTION

Title: Peer Educator	
Division: HIV Primary Care	**Status:** Part-time/non-exempt
Number of Employees This Position Supervises: 0	**Budget Size:** 0
Reports To: LaTrischa Miles	**Date:** June 19, 2006

General Summary:
The Peer Educators are integral to the Treatment Adherence Program and provide specialized services in a professional environment. Peer Educators work to encourage engagement into care and support adherence to treatment by providing client centered individual and group level skill building activities to achieve client goals.

Minimum Requirements:

- Must have a high school diploma/GED;
- Must have 1 year of experience in this or a related field;
- Must have experience in providing HIV peer education, HIV related volunteer work or completion of a leadership training program;
- Must have good interpersonal skills with the ability to relate to diverse groups of people and people on all levels;
- Must have the ability to work independently and seek guidance when necessary;
- Must have the ability to work within a multi-disciplinary team approach to health care;
- Must have good interpersonal skills with ability to relate to diverse groups of people and people on all levels.

Essential Functions:

- Maintain a client caseload of 5-10 HIV+ individuals
- Peer educators will provide individual contact with patients to identify and develop client directed treatment plan goals and monitor ongoing achievement of goals.
- Work collaboratively with primary care and case management staff to identify newly diagnosed patients who can benefit from peer support, by offering hope and living proof that living with the disease is possible
- Support patients in navigating the clinic system and community resources.
- Engage clients expected to start ARV regimens in an assessment of readiness for treatment, provide education on HIV medications, anticipated benefits/sides effects and importance of adherence. Assess patient needs upon onset of medication.
- Provide individual and group educational skill building opportunities to foster adherence to medications, identify strategies to improve adherence to health routines, communication with providers and additional issues to increase engagement in care and adherence to treatment ;
- Enhance engagement in care and adherence by assembling next day appointment charts, complete patient reminder and DNKA calls per Protocol and Operational Activities Manual;

- Maintain appropriate records and collaborate with primary care and treatment adherence specialist on patient concerns
- Maintain the bulletin boards in patient exam rooms and re-stock with health promotion and disease prevention literature. Participate in continuing HIV/AIDS education.
- Mentor and educate new peer educators
- Supports the mission and vision of the Kansas City Free Health Clinic; follow all clinic policies and procedures; attend individual and group supervision meetings
- Must adhere to all confidentiality policies. It is a direct violation of Clinic policy to share the names or case facts concerning any client, patient or volunteer of the Clinic with any other person with the exception of those actually involved in the care of the patient/client. Any release of confidential information to any other entity shall be preformed by authorized personnel only and shall be accompanied by proper written authorization from the patient/client;

Physical Demands/Working Conditions:

- Intermittent physical activity including walking, standing, sitting, lifting and supporting of patients.
- Incumbent will be exposed to virus, disease and infection from patients in working environment.
- Incumbent will be required to work at one of our two facilities and be responsible for their own transportation.
- Incumbent may experience traumatic situations including but not limited to psychiatric, dismembered and terminal patients.

My signature indicates that I understand that the above information is intended to describe the essential functions of the position and it is not intended to be an exhaustive list of all responsibilities, duties and skills required in order to perform the work required. I also understand that the Kansas City Free Health Clinic is an Equal Opportunity Employer and that the Kansas City Free Health Clinic is an "at will" organization and employment may be ended by either party with or without notice.

Signature and Date

Supervisor Signature and Date

Confidentiality
&
Boundaries

Topic of Training Segment:

Confidentiality and Creating Boundaries in the workplace.

Time Allotted:

45 minutes

Materials Needed:

Activity Sheets
Newsprint
Markers

Instructions:

Facilitator:

- This discussion includes a short brainstorming activity
- Elicit from the group responses to "What is Confidentiality?"
- Affirm responses
- Follow talking points

Goals and Objectives:

- Participants will gain knowledge about appropriate boundary setting with patients/clients
- Participants will understand importance of confidentiality and HIPAA laws

Talking Points

- **What is Confidentiality?**
  - ✓ Keeping information protected from unauthorized viewers
  - ✓ Ensuring that information is accessible only to those authorized to have access
  - ✓ Refers to an ethical principle associated with several professions-"privileged"
  - ✓ Trusting another person with information that will not be shared with others

- **Health Insurance Portability and Accountability Act (HIPAA)**-The federal government established this act to maintain and protect the rights and interest of the customer. HIPAA defines the standard for electronic data exchange, protects confidentiality and security of healthcare records. The privacy or confidential rules regulate how information is shared. Upon engagement of health services-pharmacy, medical visit, social services etc. the client is informed of his rights to confidentiality and the policy and procedures regarding the release of his personal health information. The client signs form stating that they received and reviewed HIPAA law.

- **Situations when data can be released without the client's permission or consent:**
  - ✓ For the purpose of reporting abuse, neglect or domestic violence to the proper social service or protective services agency.
  - ✓ To prevent serious threat to health and public safety
  - ✓ To the department of public health for health reporting purposes
  - ✓ Inform appropriate bureau during disaster relief
  - ✓ Workers Compensation
  - ✓ Food and drug administration for expected side effect to drugs of food product defects to enable product recall.
  - ✓ Correctional institution
  - ✓ To medical examiners, coroners, procurement of organ, or certain research purposes.

- ✓ Notify family members, legal guardian involved in the client's care for notifying them of a person location

- **Consequences of breaking confidentiality include:**

  - ✓ Employee reprimanded, given a warning or be dismissed from the agency.
  - ✓ The client/patient may be embarrassed
  - ✓ The client will loose trust in the peer educator and the agency
  - ✓ The client may file charges against the peer educator and the agency
  - ✓ The agency could be fined criminal penalties for disregarding HIPAA

- **What is a <u>boundary</u> and what does it mean to set boundaries?**
  - ✓ A boundary is a dividing line between you and anyone else that represents both physical and emotional limits
  - ✓ Boundaries ensure that others do not cross the line
  - ✓ Boundaries make you feel safe and healthy
  - ✓ Boundaries make others feel safe around you
  - ✓ Boundaries set relationship guidelines so people know how to behave around you.

- **Tips for setting boundaries**:
  - ✓ Clearly state what you will and will not do
  - ✓ Avoid justifying, rationalizing or apologizing for your boundaries
  - ✓ You cannot simultaneously set a boundary and take care of another's feelings
  - ✓ Set a boundary without feeling guilty
  - ✓ Be ready to enforce a boundary once it's set
  - ✓ Follow through. What we say must be what we do
  - ✓ Be prepared for people to get angry when you set a boundary

- **What to do when someone crosses your boundaries?**
  - ✓ **Inform -** Let the person know what they are doing while using I statements
  - ✓ **Request-** Let them what you want
  - ✓ **Take a stand –** Let them know that the behavior they crossed is not appreciated or is disrespectful
  - ✓ **Time Out –** Step out of the situation briefly for your safety
  - ✓ **Extended Time Out –** Stop the relationship until person changes behavior

Borrowed from: Codependence: The Dance of Wounded Soulsand, Chapter- Setting Personal Boundaries by Robert Burney

Borrowed from: The Relationship Coach Newsletter by Rinatta Paries, www.WhatItTakes.com

Activity

Title of Activity:

Confidentiality or Boundary Scenarios

Time Allotted:

15 minutes

Materials Needed:

Confidentiality and Boundaries Activity Sheets
Pencils

Objectives:

Participants will apply knowledge gained to problem scenarios that may present itself on a day today basis.

Instructions:

Introduce the activity by explaining that participants will be assigned to small groups to brainstorm scenarios where confidentiality or boundaries may have been broken.

- ✓ Pass out worksheet Level 2 Confidentiality and Boundaries Activity sheets.
- ✓ Assign participants to 4 groups by counting off 1-4 until all participants are assigned to a group.
- ✓ Assign a space in the room for each group.
- ✓ Ask participants to go to their assigned group in the respective space.
- ✓ Give each small group a piece of prepared newsprint that has a question written on it.
- ✓ As each group to appoint a reporter and a recorder
- ✓ Tell the group they will have about 10 minutes to do this activity.
- ✓ Bring the entire group back together and ask each reporter to go over his or her group's work
- ✓ Ask open-ended questions to draw out their thoughts on how a peer might be on service to a person living with HIV.
- ✓ Discuss any other brainstorming answers to all the questions.

Discussion Questions:

Summary and Closing:

Bridge

Scenario #1 **Confidentiality and Boundaries**

Read the following scenario and answer the questions that follow.

Joe receives HIV care at the Clinic at the same place where you, the Peer Educator, work. You have seen him in the clinic hallways and have acknowledged him as a client who receives services but in your mind his face is familiar to you. You, the Peer Educator, attend your apartment building's monthly tenant meeting and sitting in the room is Joe. Your eyes connect.

What do you do?

What do you say and when?

Is this a confidentiality or boundary issue?

Scenario #2 **Confidentiality and Boundaries**

Read the following scenario and answer the questions that follow.

You have been working with a client for the past 6 months and both of you decide that he is ready for graduation from the peer program. You decide to celebrate by going to lunch. Each of you pays your way, of course. You meet him at the restaurant and he brings a plant for you as a gesture of his appreciation for the work you have done together.

How do you handle this scenario?

What other issues does this bring up?

What if the gift was a $25 gift certificate payable to you for a pedicure?

Is this a confidentiality or boundary issue?

Scenario #3 **Confidentiality and Boundaries**

Read the following scenario and answer the questions that follow.

You have just finished an educational session with your client Sarah. As you are walking her out she asks, “Can I borrow $20 to buy some food for my kids to eat? I promise I’ll give it to you next week when I get my check.”

How would you handle this situation?

What else comes up?

Is this a confidentiality or boundary issue?

Scenario #4 **Confidentiality and Boundaries**

Read the following scenario and answer the questions that follow.

The Peer Program gets a referral from a case manager and you are assigned to the client, Frances Draper. The name is familiar but you are not sure that you know the person. You meet with Frances and begin the peer working relationship. Unknown to your supervisor is the fact that Frances is a member of your church and your partner contracted with Frances to clean your house.

What issues arise for you?

What are the steps you should take with this client?

Is this a confidentiality or boundary issue?

Scenario #5 Confidentiality and Boundaries

Read the following scenario and answer the questions that follow.

The Police come to the clinic and you are the first person they see, they ask if Justin Love, a clinic patient, is here because they have a warrant for his arrest.

What issues arise for you?

What do you do?

Is this a confidentiality or boundary issue?

Curriculum Template

Topic of training segment:
Verbal Communication

Time Allotted:
60 minutes

Materials Needed:
Power Point Slides
Newsprint
Pencils/Pens
Markers
Communication Situations Worksheet
Communication Situations Worksheet with scenarios cut into strips for activity

Goals and Objectives:
- To comprehend the basic concepts of communication
- To improve the participants' understanding of their own styles of interpersonal communication and how that affects their role as a peer educator.
- To understand the differences between aggressive, passive, passive aggressive, and assertive communication styles.

Instructions:

Section One – What is communication and why is it important?

1. Ask the group and briefly discuss the following question – What is communication?
2. Reinforce correct comments and make a list of participant responses on newsprint.
3. Emphasize that communication has several components. Talk about the three parts listed below and call attention to parallels with the group's responses to the previous question, what is communication.

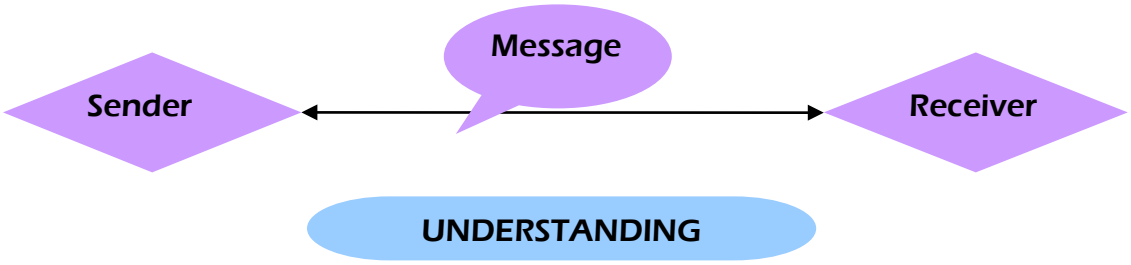
   Some key concepts of communication are:
   Sender – One who extends the message
   Receiver – One who receives the message
   Message – What is being sent (verb or non-verbal)

4. Once participants understand the first 3 concepts of communication, say the following words of greetings to the entire class. Some blank faces will reflect that participants do not understand as well as some participants may respond.

   a. **Bonjour!** *(French, hello)*
   b. **Guten tag!** (GOOTEN TOCK) *(German, good day)*
   c. **Hola!** *(Spanish, hello)*
   d. **Ni hao!** (NEE-HOW) *(Chinese, hello)*
   e. **Jambo!** (like MAMBO) *(Swahili, hello)*

5. Ask participants, "**What is missing?**" The objective of asking this question is to reinforce that in order for messages to become communication it is essential that there is ***understanding***.

6. **To reinforce**: draw the diagram below and state to have proper communication you must have a sender, receiver, message and most important understanding.



Also relate that understanding is important for the peer educator to communicate with their client as well as for the client to be able to communicate with their doctors, nurses, and others on their multi-disciplinary team.

Understanding is essential otherwise the interaction is not considered communication.
Communication can be described as an understood message between a sender and receiver.

Section Two – What are the communication styles and is there a difference?

1. Ask the group the following question:

- *What does it mean to be passive in what you say to and do with others?*

2. Allow the group to share their ideas. There is no right or wrong answers. Stay neutral and with a non-judgmental attitude.
3. Then share with the group the meaning of being *Passive.*

Being **passive** means repressing the emotions, feelings, and thoughts that we have even if by doing so we feel uncomfortable and unhappy with ourselves. Passive responders tend to act out the role of victim, making those around them feel guilty or frustrated.

4. Facilitator should demonstrate some passive communication styles that include no eye contact, low volume, hunched over body posture, etc. Thus, the demonstration will reinforce the above definition.

- *What does it mean to be aggressive in what you say to and do with others?*

5. Allow the group to share their ideas. There is no right or wrong answers. Stay neutral and with a non-judgmental attitude. Then share with the group the definition of being *Aggressive*.

Being **aggressive** means interacting with others without respect for their rights and/or feelings. Emphasize that aggressive communication can be direct and indirect. Aggressiveness may be **direct**, which may involve physical and verbal assaults. **Indirect** aggressiveness is a way of expressing anger in an unclear manner, which usually leaves others feeling nervous, guilty, or frustrated. Indirect aggressors use hostility and indifference at the same time that they say everything is fine.

- *What does it mean to be passive aggressive in what you say and do with others?*

6 Allow the group to share their ideas. There is no right or wrong answers. Stay neutral and with a non-judgmental attitude. Then share with the group the definition of being *Passive Aggressive*.

Being **passive aggressive** means displaying behavior in which feelings of aggression are expressed in passive ways as, for example, by stubbornness, sullenness, procrastination, or

intentional inefficiency. It is a defensive mechanism and, more often than not, only partly conscious. For example, people who are passive-aggressive might take so long to get ready for a party they do not wish to attend, that the party is nearly over by the time they arrive.

- *What does it mean to be assertive in what you say and do with others?*

7. Allow for discussion and for participants to share their ideas.

8. Give the definition of *Being Assertive*.

Being **assertive** means expressing what we want or believe in and is an important part of clear communication. If we say what we want or feel and explain why we have chosen a certain decisions or action, we can reduce the probabilities misunderstood.

Role play:
Facilitators: demonstrate one or more of the communication styles listed above, always starting with assertive first. The idea here is to demonstrate the "good" behavior before demonstrating "poor" behavior.

Ask the group the following questions:
What difference did you see between the two?

If time allows, let participants volunteer to role-play the communication types above, using the Communication Situations worksheet scenarios.

Activity Instructions: this is an additional activity if time permits or participants want to do it on their own.

- Review activity objectives to reinforce what participants will gain from this activity
- Divide participants into pairs. Assign a situation from the "Communication Situations Role Play" sheet to each group.
- In their small groups, have participants read the situation and decide together which response belongs to the categories listed (assertive, passive, aggressive or passive aggressive)
- Tell participants to refer to the definitions on their sheet if they need help.
- Once participants have identified each communication style for their scenario, ask them to choose on style and role play the response.
- Remind participants that doing a role play is much like acting in a play, so they are to pretend to be the person in the scenario.
- Allow 3-4 minutes to accomplish this and review as a large group.
- Remind participants that they are no longer in role.
- Facilitate group discussion by asking the following questions after each scenario/roleplay.
  - What do you think?
  - What was effective?
  - What could be improved?
  - How is this different from the assertive example?

Communication Situations Role Play Scenarios

Being **assertive** means expressing what we want or believe in and is an important part of clear communication.

Being **passive** means repressing the emotions, feelings, and thoughts that we have even if by doing so we feel uncomfortable and unhappy with ourselves.

Being **aggressive** means interacting with others without respect for their rights and/or feelings.

Being **passive aggressive** means displaying behavior in which feelings of aggression are expressed in passive ways as, for example, by stubbornness, sullenness, procrastination, or intentional inefficiency.

1. You are at a department store and you are waiting in line when another customer walks past you and asks to get checked out since she is running late. The young woman behind the counter goes ahead and helps her in spite of the fact that you were next in line. What do you do or say?

Make the statement, "Well, I guess she is late so go ahead and help her."	
You push yourself to the counter and demand to get help. "I've been waiting for the last 5 minutes, you self-proclaimed diva -wait your turn!"	
Tell the young lady behind the counter "Excuse me, maybe you did not notice, but I would appreciate if you help me since I was next in line."	
Say nothing, but sigh loudly and give the woman irritated looks.	

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2. You are at a party and everyone is drinking or getting high. Generally you prefer to enjoy a casual drink but you don't drink to excess. You have already done three alcohol shots on this particular evening and since this is your limit you don't want to drink any more. Dave, however, wants you to keep "partying." What do you say or do?

"I'll have another drink, but if something happens to me it's your fault."	
"Hey you jerk, stop bothering me. You know I don't want to drink anymore."	
"Dave, I know you want to keep partying and we can still dance and have fun, but I would feel more comfortable if I stop drinking. I have to drive home later and it wouldn't be responsible for me to drink anymore."	
"Since you are my good friend, let's go ahead and have one more, but only one."	

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3. On the job, your fellow co-worker keeps asking you to do some of her work and in the past you have often helped. You are starting to feel mistreated, however, and would like her to start pulling her own weight. What do you do or say?

"Ana, I'm flattered that you think I am competent to do this work, however, helping you all the time has got me feeling overloaded. In the future I would appreciate it if you try doing it yourself or ask someone else."	
Take Ana's extra work from her, but procrastinate and do not complete it so that her deadlines don't get met. She eventually stops asking you for help.	
"I know you don't know what to do with this extra work, Ana. I might be able to squeeze some of it in and help you out."	
"Ana, I am going to go to our boss and let her know what a lazy employee you are and tell her that you never do any or your work."	

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4. After a wonderful date with Mark you go back to his place. You start kissing and touching all over. You care about him but only want to have sex if it's with a condom. He insists that he likes it natural and just wants to feel you because he cares about you so much. What do you do or say?

"Mark, I guess since you say you care about me and we have gone out a several times it's ok to do it natural."	
"Mark, I care about you too and because I care about our relationship, I think we should use a condom."	
"You always say you care and that's great but no glove no love. I am sick and tired of you always making me feel uncomfortable."	
"Oh, great idea, genius."	

Communication Skills
Non-Verbal Communication

Curriculum Template

Topic of Training Segment:
NONVERBAL COMMUNICATION

Materials Needed:
Power Point Slides
"Feelings" Activity Cards

Time Allotted:
45 Minutes

Goals and Objectives:
- To help participants recognize and understand the various aspects of nonverbal communication

Instructions:
- Lead a discussion using the discussion questions provided making sure to cover the talking points listed with the questions.
- Prepare feelings cards before activity. Print each feeling on it's own piece of paper and place in an envelope. Participants will randomly choose their feeling card from the envelope.

Discussion Questions:
- Ask participants to identify examples of nonverbal communication.
    - Nonverbal communication may include hand gestures, facial expressions, posture, remaining silent, etc.
- Are nonverbal messages stronger when used with verbal messages?
    - Reading nonverbal communication cues provides clues to what a person is feeling and often tells us what is most important to him.
    - Nonverbal messages can enhance the sender's message making it easier to understand as well as illuminate incongruence if the verbal message doesn't match the body language.
- Do you tend to trust nonverbal messages more than verbal messages? Why?

Activity Instructions:
Tell participants they will have the opportunity to practice identifying nonverbal cues. To do this, ask participants to draw one of the Activity Cards: "Feelings". Without speaking, communicate the feeling or emotion on the card to the rest of the group. Have one participant at time get up in front of the group. For larger groups divide into smaller groups to make sure every participant gets the opportunity to do this activity.
- You may want to model the first card for the group.
- Members of the group can call out their interpretation until someone has guessed the correct answer.

Activity Cards: Feelings

- Worried
- Exhausted
- Excited
- Happy
- Angry
- Shy
- Disappointed
- Afraid
- Rejected
- Hysterical
- Nervous
- Relieved
- Intimidated
- Defeated

Summary and Closing:

Discuss as a closing:

- How can recognizing nonverbal communication cues help you in your role as a peer educator?
- Why is it important for a peer educator to be mindful of his own nonverbals when interacting with someone?

Attentive Listening

Topic of Training Segment:

ATTENTIVE LISTENING

Materials Needed:
Power Point Slides

Time Allotted:
60 minutes

Goals and Objectives:

- To increase participants understanding of listening skills in both a verbal and nonverbal way
- To help participants differentiate among listening patters and to adopt a listening style that is conducive to effective communication

Instructions:

- Lead a discussion using the brainstorm questions provided making sure to cover the talking points listed with the questions.

Brainstorm Question:

- Ask participants how a person can demonstrate listening skills using words and gestures.

Make sure the following points are covered:

- Nonverbal listening skills show a person that you are interested without really speaking. Some nonverbal listening techniques include:
  - Making eye contact
  - Nodding your head
  - Leaning forward
  - Reflecting your feelings with facial expressions
- Verbal listening skills use verbal responses to show acceptance, understanding, respect, empathy and encouragement. Some active listening techniques include:
  - Using verbal responses (“really?” “What happened next?”)
  - Commenting directly on what us being said
  - Restating the speaker’s ideas in your own words (“do you mean…?”)
  - Encouraging the person to express feelings (“I guess you must have felt…”)
  - Encouraging more information (“tell me about…”)
- Emphasize the importance of not passing judgment.

Culture and Cultural Competence: How Does it Affect What We Do?

Topic of Training Segment:

Culture and Cultural Competence: How Does It Affect What We Do?

Time: 1 hour

Materials:

- It's All About ME Activity Sheet

Objectives:

- To establish a common definition of culture.
- To understand why culture is important.
- To help participants understand what cultural competence is and is not.
- To understand how culture affects health

Overview:

This exercise will help participants look at culture from a broad view. The participants will understand how and why culture is important. It will clarify the difference among cultural knowledge, cultural awareness, cultural sensitivity and cultural competence.

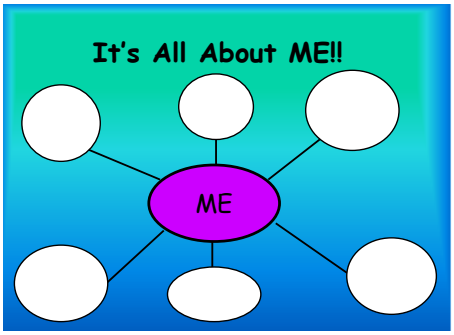
Introductions:

Open with a series of questions: What makes you special? Why do you wear your hair as you do? Why do you talk with an accent? Why do you do things the way you do? What are the powerful influences in your life?

It is the impact of your culture that leads us to our next activity Culture and Cultural Competence.

- Distribute "It's All About ME" Activity Sheet.
- Allow participants to describe what influences them, in the spaces provided.
- Discuss as a group- how what they have written makes them who they are today, topics could include religion, age, race, education, economic status.

Culture and Culture Competence Activity sheet



Social Impact

We have looked at why we are as we are; now let's talk about how we can plug these things into a broader scope.

- Discuss how outside things can affect who we are. These things shape the way we experience and view the world.
- Have participants give examples (from the slide) of how social identity can impact who we are.

What is Culture? The next two slides will help clarify the different ideas of culture.

Definition: Aspects of life shared in common by a group of people may include:

- values, norms & expectations, attitudes, beliefs
- age, gender, race / ethnicity, sexual orientation
- language, history, geography, customs, rituals
- food, clothing, music, literature, art, religion
- education and literacy, occupation, income, social class and status, leisure activities

Give examples from slides**.**

What is culture? (slide 2)
Let's look at how culture is a patchwork of influence. Here we want to continue to discuss how these items affect who we are.

What is Cultural Competence?

Now that we've formed a definition of culture, how would you know if someone is being cultural competent? Competence implies a skill. Part of cultural competence is not being judgmental; being able to adjust. It's learning more about a person's culture from resources available to you and asking them what things mean within their cultural context.

Definition of Cultural Compentence:
Having the capacity to work effectively and interact with people from cultures different from our own.

Cultural Competence Differs from

- Cultural Knowledge:
  - to be familiar with selected cultural characteristics, history, values, belief systems, and behaviors of another group.
    - **Example: Knowing that May 5th is important in the Hispanic community, but not why.**

- Cultural Awareness:
  - a general understanding of what another group is like and how it functions.
    - **Example: Knowing there's a difference and not being critical, e.g. "eating enough garlic will stop me from getting HIV."**

- Cultural Sensitivity:
  - accepting and appreciating the differences that exist between cultures without assigning judgment (good/bad, right/wrong) to those differences. This usually involves internal changes in one's attitudes and values.
    - **Example: Adapting to their circumstances, "that may be so, in addition, using a condom the correct way every time will greatly reduce the risk."**

Why Is Cultural Competency Important?

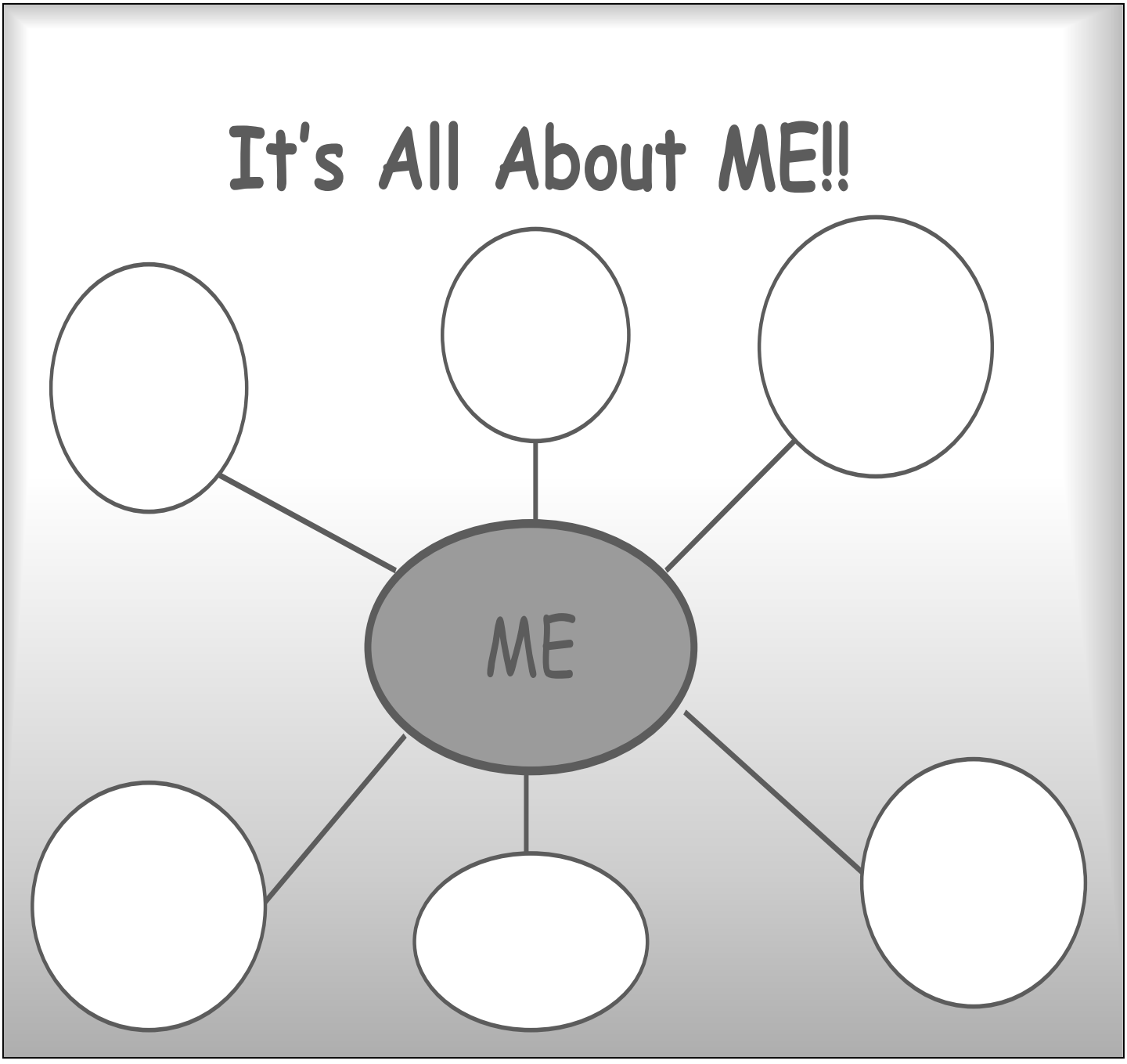
As a peer this is vitally important because we want to connect with others in a genuine way. We want to show authenticity (realness), respect, true understanding and to build trust.

Summary and Closing: Cultural Competence is on-going. It is something that we always strive towards; sometimes within the same ethic groups there may not be cultural competence. We have to constantly make ourselves aware of others around us and not be judgmental.

Topic of Training Segment:

Activity Sheet

Describe what influences who you are in the blank circles. Influences could include religion, age, race, education, economic status. Be prepared to share with the group and discuss. How has what you've written in the circles made you who you are today?



Wrap Up

"Pulling It All Together"

Topic of Training Segment:

Wrap Up

Time Allotted:

15 minutes

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Materials Needed:

Newsprint
Markers

- **Goals and Objectives:**

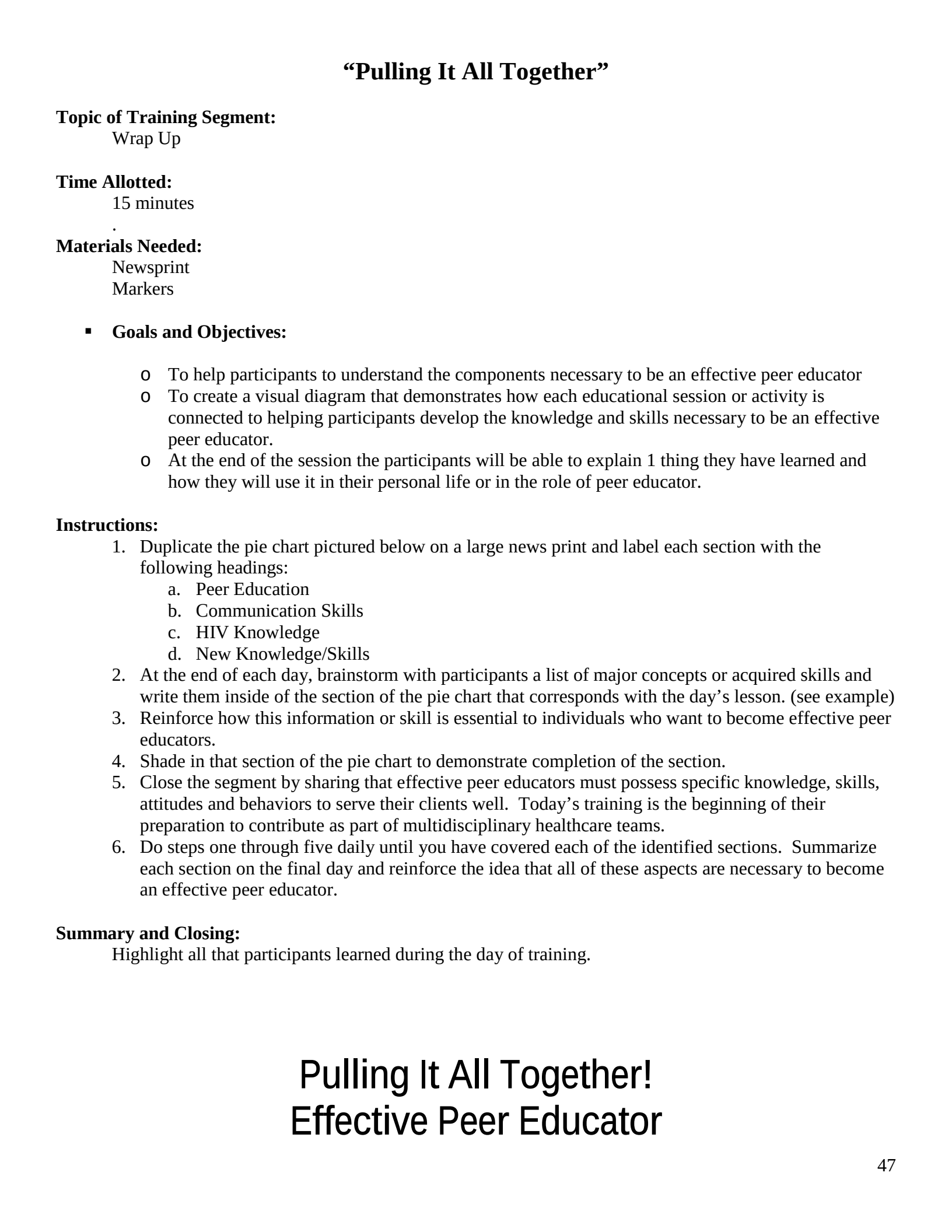
  - To help participants to understand the components necessary to be an effective peer educator
  - To create a visual diagram that demonstrates how each educational session or activity is connected to helping participants develop the knowledge and skills necessary to be an effective peer educator.
  - At the end of the session the participants will be able to explain 1 thing they have learned and how they will use it in their personal life or in the role of peer educator.

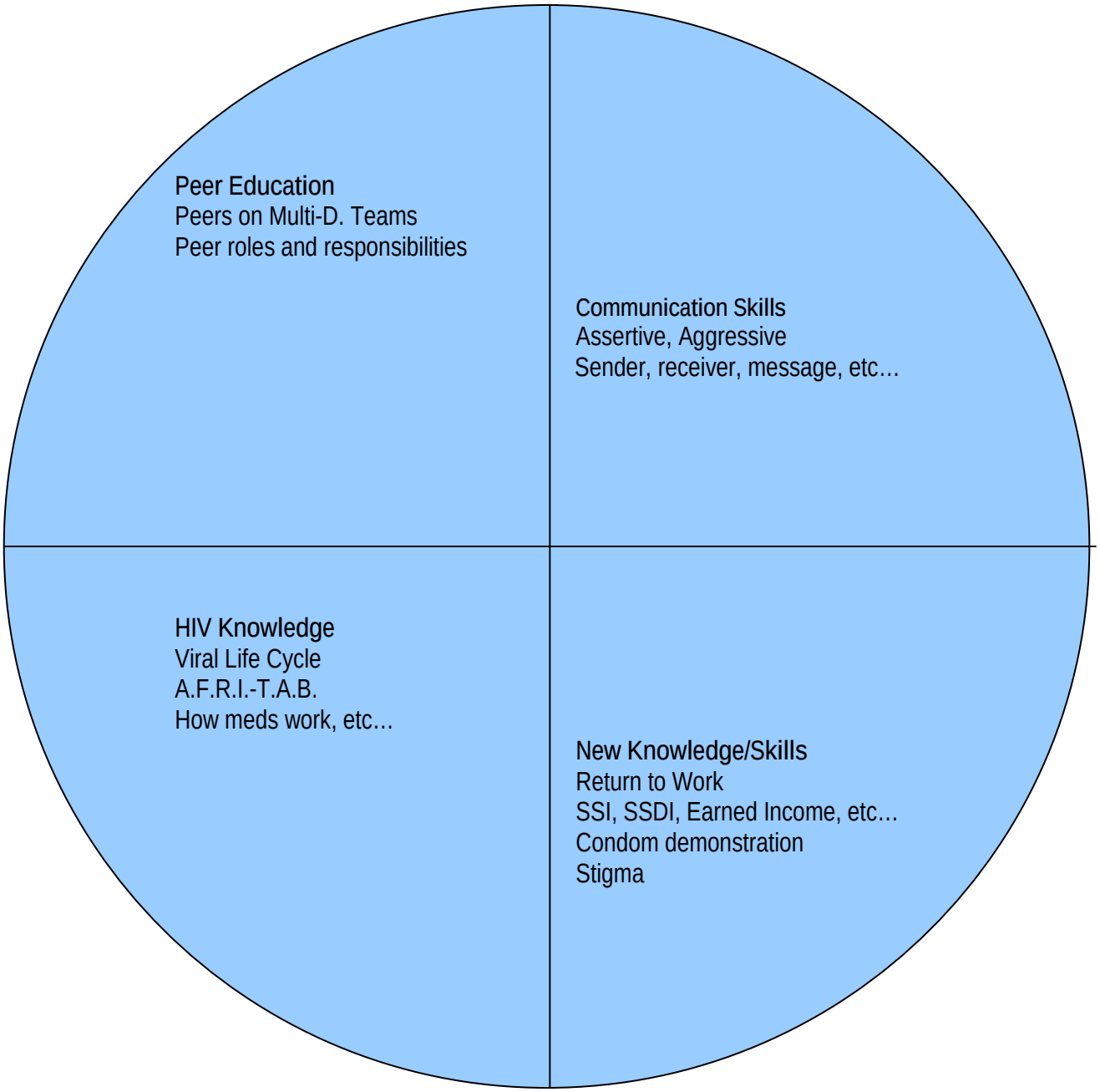
Instructions:

1. Duplicate the pie chart pictured below on a large news print and label each section with the following headings:
   a. Peer Education
   b. Communication Skills
   c. HIV Knowledge
   d. New Knowledge/Skills
2. At the end of each day, brainstorm with participants a list of major concepts or acquired skills and write them inside of the section of the pie chart that corresponds with the day's lesson. (see example)
3. Reinforce how this information or skill is essential to individuals who want to become effective peer educators.
4. Shade in that section of the pie chart to demonstrate completion of the section.
5. Close the segment by sharing that effective peer educators must possess specific knowledge, skills, attitudes and behaviors to serve their clients well. Today's training is the beginning of their preparation to contribute as part of multidisciplinary healthcare teams.
6. Do steps one through five daily until you have covered each of the identified sections. Summarize each section on the final day and reinforce the idea that all of these aspects are necessary to become an effective peer educator.

Summary and Closing:

Highlight all that participants learned during the day of training.




Peer Education
Peers on Multi-D. Teams
Peer roles and responsibilities
Communication Skills
Assertive, Aggressive
Sender, receiver, message, etc…
HIV Knowledge
Viral Life Cycle
A.F.R.I.-T.A.B.
How meds work, etc…
New Knowledge/Skills
Return to Work
SSI, SSDI, Earned Income, etc…
Condom demonstration
Stigma

Day 2
Level II Agenda

Level II Training Agenda
Day 2

Review of Day 1 / Overview of Day 2

M.A.R.S. Model

Viral Life Cycle

- Medications
- Lab Values
- Understanding Drug Resistance
- Supporting Adherence

Lunch – Noon (45min)

Wrap up Viral Life Cycle

Break (15 min.)

Prevention Education for PLWHA

Navigating the System – Resources in Your Community

Wrap-up / Pluses & Wishes / Summary of the Day

Motivation to Learn

Motivation to Learn

Topic of training segment
"Motivation to Learn"
Time allotted
30 minutes
Materials needed
Newsprint, markers, tape,
Objectives
To identify appropriate teaching methods for peer educator in peer sessions.
Introduction

Talking points

Instructions: Lead a group discussion using the following question. Then follow up with the definition of learning as indicated in the power point presentation. Discuss how each element of the MARS mnemonic enhances learning from both the client and peer educator perspectives.

Why does a peer need to understand how people learn?

The definition we are going to use today is:
Learning is the process of acquiring knowledge or skill through study, experience or teaching.

Most would agree that learning—
- Comes from study and/or life experiences
- Requires acquisition of new knowledge, skills or attitudes
- Occurs over a period of time
- Involves the process of change
- Is a life long process

Using MARS to enhance learning

The mnemonic **MARS** (motivation, association, repetition and senses) can help participants remember these four concepts that enhance learning. We will explore each of these aspects from 2 perspectives: the clients' and the peer educators'

1. **Motivation**

Client
- Comes from within.
- Motivation is related to an immediate need, problem, or deficit and is encouraged when the person finds value.

Peer Educator
- Creates an environment to encourage and connect motivation to learning
- Connect new information to the values of the person

2. **Association**

Client

- Clients learn more rapidly when they can associate the information with previous experiences or learning.
- New material draws on past experiences and is related to something the learner already knows.

Peer Educator

- Draw from the clients' past experiences and knowledge with the new necessary information.
- Relate complex ideas to everyday occurrences or their frame of reference.
- Using personal stories to connect with the clients' experiences with new information.

3. **Repetition**

Client

- Frequent reviewing, summarizing and practicing provides the repetition that helps learning and remembering.
- Repeat interactions or experiences with content reinforces learning.

Peer Educator

- Reframing and restating information multiple times and ways support clients' understanding.

4. **Use of Sense**

Client

- Clients learn more effectively when multiple senses are used.
- If clients use, see and hear new information they have a better chance of remembering.

Peer Educator

- Learning occurs more effectively when participants are actively involved in the learning process through the use of as many senses as possible.
- Examples: books, videos, personal experiences, role-play, etc.

Barriers to Learning Activity

ACTIVITY- "Barriers to Learning" group activity

Time allotted
10 minutes

Materials Needed
Newsprint, markers, tape

Objectives
To begin a group discussion about barriers to learning and what can interfere with a person's ability and/or willingness to learn.

Talking points
Many things can interfere with a person's willingness and/or ability to learn.
The purpose of this brainstorm is to list any barriers that could hinder a person's learning while using peer services.

Instructions: Lead a group brainstorm and write the groups responses on newsprint to the question listed below.

What are examples of barriers to learning?

Likely responses include:

- Financial troubles
- Stigma/shame
- Fear
- Literacy challenges
- Cultural differences between client and peer educator
- Substance use
- Language
- Mental Health diagnosis/ depression
- Attitudes about HIV/AIDS (e.g. fatalistic thinking)
- Beliefs about HIV/AIDS (e.g. fatalistic beliefs)
- Feelings of isolation
- General lack of interest

Summary
Bridge
Now let's do an exercise using MARS to build strategies to overcome barriers to learning.

Instructions: Lead a group brainstorm and write the groups responses on newsprint to the question listed below. Explain to participants that many things can interfere with a person's willingness and/or ability to learn. The purpose of this brainstorm is to list any barriers that could hinder a person's learning while using peer services.

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Likely responses include:

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- General lack of interest

Summary

Bridge

Now let's do an exercise using MARS to build strategies to overcome barriers to learning.

Meeting Diverse Barriers to Learning

Topic of training segment

Meeting Diverse Barriers to Learning

Time allotted

45 minutes

Materials needed

Newsprint
Markers
Tape
Meeting Diverse Barriers to Learning handout

Objectives

- Peer educators will understand that peers learn in different ways and at different speeds.
- Peer educators will identify ways to overcome barriers to learning.

Introduction
Talking Points

3 main ideas

- Peers learn in different ways and at different speeds.
- Peers learn through reading, completing written documents, watching videos, practicing skills and/or participating in group activities
- Peers bring to their sessions a diverse of barriers that affect their ability to learn

Instructions:

1. Ask participants to turn to Meeting Diverse Barriers to Learning worksheet in their participants' manual
2. Ask entire group for additional barriers to add to the list.
3. Divide the group into three small groups and assign an equal number of barriers to each group.
4. Have each group choose a "recorder" and "reporter".
5. Ask each group to—
    a. Decide how a peer educator could enhance learning when there are barriers to learning.
    b. Identify which of the MARS strategies is being used, if applicable.
6. Have recorder capture their group's ideas on their newsprint.
7. Have each reporter report their group's answers to the entire group.

Summary
Bridge

Activity Sheet

Meeting Diverse Barriers to Learning

Instructions: Complete the chart. In the first column are barriers to learning. In the second column, write how a peer educator could enhance learning if there that might be a barrier. Then, in the third column identify which MARS strategy is being used, if applicable. The first strategy is filled in as an example. Add barriers and strategies if time permits.

Barriers	Strategies to Enhance Learning	MARS Strategy Used
Reading Ability (Low literacy level – peer client has difficulty reading)	▪ Use simple, clear terms. ▪ Check often for understanding ▪ Use visuals when possible. ▪ Help client understand benefits of learning the new information. For example: explain how medication adherence is beneficial to health.	R S M
Cultural Background (Client is an African American Gay Man and you are not).		
Language (Client has limited English communication skills)		
Interest (Client level of interest towards medication adherence is low)		
Attitude (Client has a negative attitude toward using barrier methods)		
Active Substance Use (Client regularly uses drugs and alcohol)		

Activity Answer Activity

Meeting Diverse Barriers to Learning

Instructions: Complete the chart. In the first column are barriers to learning. In the second column, write how a peer educator could enhance learning if there that might be a barrier. Then, in the third column identify which MARS strategy is being used, if applicable. The first strategy is filled in as an example. Add barriers and strategies if time permits.

Characteristic	Peer Educator Plan: Response to Enhance Learning	MARS Strategy
Education (Familiarity and or understanding of HIV information, services, and medications)	▪ Use simple, clear terms. ▪ Check often for understanding ▪ Use visuals when possible. ▪ Help client understand benefits of learning the new information. For example: explain how medication adherence is beneficial to health.	R S M
Cultural Background (Client is an African American Gay Man and you are not).	• Use common language and experiences • Check for understanding • Use of visual aids	R S A
Language (Client has limited English communication skills)	• Check often for understanding • Use materials in both English and client's native language. • Use of visual aids	R A
Interest (Client level of interest towards medication adherence is low)	• Motivate client by outlining benefits of medication adherence. • Association – Pose questions that recall past experiences. For example, how did you feel in the past when you had a cold or stomachache and did not take any medications to alleviate the symptoms? How did you feel when you took medication like Tums or Tylenol when you were ill?	M A
Attitude (Client has a negative attitude toward using barrier methods)	• Motivate client to the benefits of using condoms, dental dams, or female condoms. • Repetition – Review and practice with penile models the correct way to put on a condom. (This creates self-efficacy and confidence so client can feel more comfortable using this skill)	M R
Active Substance Use (Client regularly uses drugs and alcohol)	• Motivate client by outlining benefits of taking care of their health • Educate on interactions between medications and substance use	M A

Viral Life Cycle

Curriculum Template

Topic of Training Segment:
Viral Life Cycle

Time Allotted:
45 minutes

Materials Needed:
Laptop with CD access (HIV Life Cycle, Educational Program by GlaxoSmithKline)
Projector with screen or blank white wall
Newsprint (with adhesive on back to stick to wall)
Markers
Participant booklet to follow lesson and video
HIV Life Cycle-The Big Picture (handout).
Medications at Work in the HIV Life Cycle (handout).

Objectives:
- Understand how the HIV lifecycle works; that is, how it enters a CD4 cell, replicates and damages the immune system.
- Understand where in the viral life cycle the different classes of medications work to slow replication.
- Begin to become familiar with terminology used in HIV treatment

Instructions:
Facilitator
- The facilitator will briefly review Level I training of HIV facts.
  - **HIV** stands for Human Immunodeficiency Virus
  - **H**-HIV is transferred only to humans; is the virus that causes AIDS, spread through humans
    I– Immune system the body's army; a collection of cells and substances.
    V– a bacterium whose survival depends on cells in the host.

    A-Acquired something specific has to happen to get it you just don't catch it like a "cold".
    I– same as above
    D-Deficiency the body's defense is weakened
    S-syndrome collection of illnesses or symptoms, infections, the presence of illnesses or symptoms
  - Without treatment, people become subject to rare opportunistic infections
  - HIV is transmitted only 3 ways:
    1. Vaginal, anal or oral sex with someone who is infected
    2. sharing needles with someone who is infected
    3. A pregnant mother to her child through pregnancy, birth or breastfeeding

  - HIV is transmitted through only four body fluids
    1. blood
    2. vaginal fluids
    3. semen
    4. breast milk

- Now that someone is infected with the HIV virus or are living with AIDS
  (assumption is that Western Blot – the confirmatory test has been done) we want our emphasis to be on treatment.
  Why treat? We want people to live a long healthy life.
  This disease is manageable. We know that the best approach to treatment is a holistic approach. Treatment is more than just drugs it encompasses body, mind and soul.
- The facilitator will tell the class that the Viral Life Cycle is the foundation of learning about HIV infection and that all other educational components regarding the disease and treatment will build on their knowledge of the Viral Life Cycle.

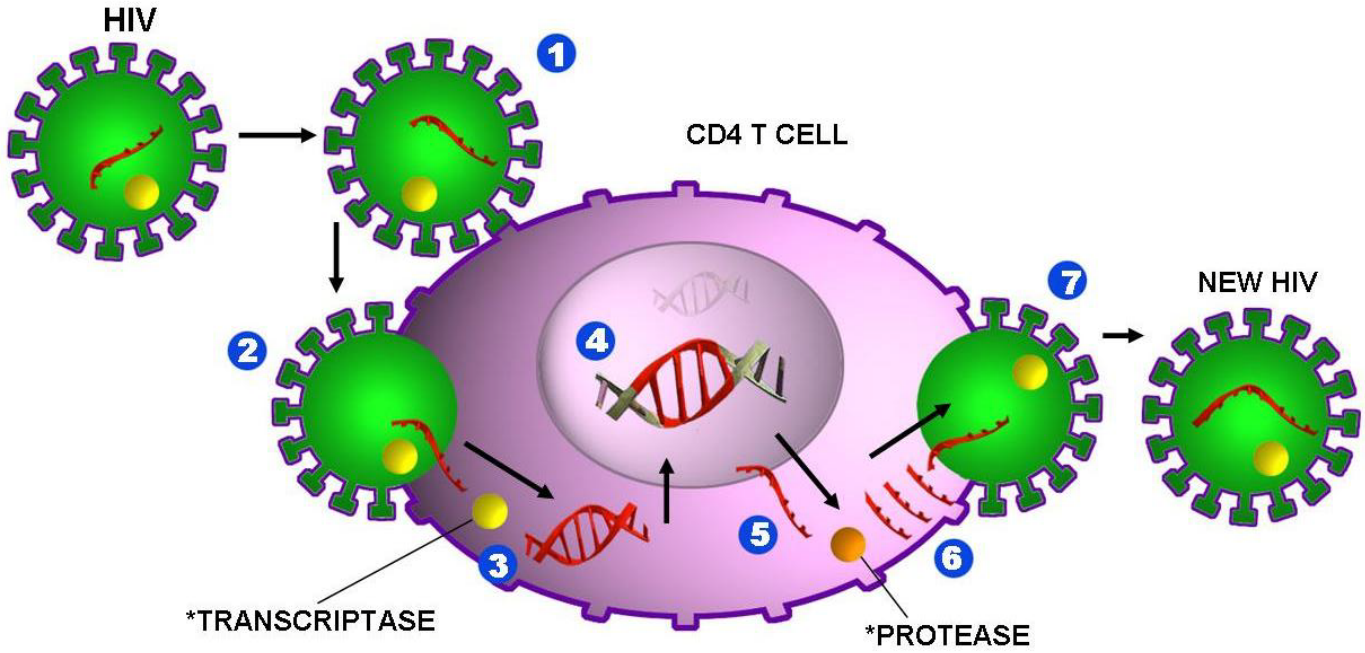
  The facilitator tells the class that HIV reproduction is a complex multi-stage process that involves several steps that must occur for the HIV virus to survive. Let's view the CD on the Viral Life Cycle which will explain the steps in viral reproduction. Keep in mind that because people learn differently and most of the material in this section is didactic we are going to use several learning methods: we will view a CD, use our power point as we go through the lecture and a HIV Life Cycle chart that you may find easy to use and later you'll be able to identify where the anti-HIV medications are working (i.e. if you're on HIV meds). So let's get started!
  (Show CD)

  Now, take out the HIV Life Cycle – The Big Picture to view the Viral Life Cycle in it's entirety. This is an example of Repetition and Senses from the MARS Model.

  Let's define some terms to make sure we are all on the same page. All of the terms that we discuss are also in your packets.

GO TO POWER POINT

HIV Life Cycle - The Big Picture



Attachment

1. HIV binds to receptors on the CD4 T-cell.

- A message is sent to the CD4 T-cell to let the virus in.

Fusion

2. Once bound, the virus is allowed to dump its contents into the CD4 T-cell.

- Included in its contents are HIV RNA and reverse transcriptase.

Reverse Transcription

3. The HIV RNA is turned into double-stranded DNA within the CD4 T-cell.

- The enzyme **reverse transcriptase* aids in this process.

Integration

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

Transcription

5. Copies of HIV DNA are made and released from the nucleus in small packages'.

- Each of the small packages' contains information for creating a new HIV.

Assembly

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

Budding

7. Once the new HIV is formed, it pushes itself out of the CD4 T-cell

- The virus steals part of the CD4 T-cell protective coating.

Definitions: (handout)

- AIDS – A result of human immunodeficiency virus (HIV) infection, which makes the immune system less able to fight infection. 2. (Acquired Immunodeficiency Syndrome) refers to the late stages of the disease of a person who is infected with the virus called HIV. A CD4 count below 200 and an opportunistic infection must be present before a person is said to have AIDS.
- Antibodies: a substance in the blood that forms when disease agents such viruses, bacteria, fungi and parasites invade the body. Although antibodies usually defend the body against invading disease agents, HIV antibodies, over time, give no such protection. 2. are a type of protein that is produced by your body when a virus enters your body.
- Antiretroviral agents: drugs that slow the pace of HIV infection by suppressing the ability of HIV to replicate. 2. are substances used against retroviruses such as HIV.
- CD4 T-Cells: A type of white blood cell essential to the body's immune system. Helps regulate the immune system and control B cell and macrophage functions. 2. Important cells in mounting the body's defense against infection. These "helper" cells not only fight infection, but recruit other immune cells to the site of infection to help kill infection-causing bacteria and viruses. The HIV virus uses the CD4 T-cells to make more HIV viruses. By doing this, HIV destroys the CD4 cell. Without CD4 T-cells, the body is not able to defend itself against bacterial and viral infections.
- Combination therapy: treatments, sometimes called "drug cocktails," involving a combination of three or more antiviral drugs that can dramatically inhibit HIV replication. 2. refers to two or more drugs or treatments used together to achieve the best results against HIV infection and/or AIDS. Combination therapy may be more effective in decreasing viral load. An example of combination therapy would be the use of two nucleoside analog drugs plus either a protease inhibitor or a non-nucleoside reverse transcriptase inhibitor.
- DNA: the chain of molecules in genes, which carries genetic information that helps cells reproduce. DNA is the main ingredient of chromosomes, which transmit genetic information. 2. The chemical make-up of living things. DNA contains 2 copies of information.
- HIV: the virus that causes AIDS. HIV weakens several body systems and destroys the body's immune system, making it easier for life-threatening opportunistic infections and cancers to invade the body. 2. A virus that can only survive in host cells. It caries with it RNA, but must make DNA to replicate.
- Host: used here to describe where a germ lives. For example, a person who has HIV is the host for the virus. 2. The animal or cell that another organism lives in. In HIV human CD4 T-cells are the host for HIV virus.
- Nucleus: The core of CD4 T-cells, it contains human DNA.
- Opportunistic infections: a variety of infections, such as Pneumocystis carinii pneumonia, that occur in people whose immune systems are weak for various reasons, including disease, such as HIV infection. 2. illnesses caused by different organisms, some of which usually do not cause disease in people with a normal immune system. Opportunistic infections of the lungs, brain, eyes, and other organs can develop in people with HIV infection.
- Protease inhibitors: (PIs) a new class of antiviral drugs. These drugs suppress HIV by blocking infected cells from making copies of HIV, which are capable of infecting other cells. 2. is a class of antiretroviral drugs that bind to and block HIV protease to prevent the production of new infectious viral particles.
- RNA: a nucleic acid found in the contents of a cell surrounding the nucleus. Some retroviruses, such as HIV, carry RNA instead of the more usual DNA. 2. The chemical make-up of living things. RNA contains only 1 copy of information and needs another copy to replicate.
- Retrovirus: A type of virus that has RNA instead of DNA as its genetic material. It uses an enzyme called reverse transcriptase to become part of the host cells' DNA. This allows many copies of the virus to be made in the host cells. The virus that causes AIDS, the human immunodeficiency virus (HIV), is a type of retrovirus.

- Viral load test: a marker that measures the amount of HIV RNA in the blood. Used by doctors to help to help make decisions about treatment. The lower the viral load, the longer a person with HIV has before developing AIDS and the longer his or her survival time. **2**. is the amount of HIV RNA in your blood. Tells you how active the virus is in your body. Higher numbers mean you have more virus in your body.

Optional: Viral Life Cycle – CD (below is the worded script from the CD)

HIV travels in the blood toward a healthy cell
HIV targets or goes after the T cell, an important part of the body's immune system.
The immune system is a group of organs and special cells that protect the body from germs and disease.
Some T cells help the immune system to work properly, other T cells act like soldiers to find, attack, and destroy infected cells.
The HIV virus gets close to the T cell in order to attach to it.
The virus will need to find receptors to land on it to get inside the T cell.
Your body makes millions of T cells, but HIV can make billions of copies of itself.
HIV attaches to receptors on the surface of the T cell (also called the CD4 cell)
Receptors are like landing pads that allow the virus to latch on to the T cell.
HIV may attach to different receptors on the T cell such as a CD4 receptor and a CCR5 receptor.
The CD4 cell itself is like a soldier that protects the body from harm.
Once attached to the T cell, the HIV virus enters the healthy cell.
HIV uses a chemical to change its genetic information, called RNA, into DNA.
DNA is the body's instruction manual.
When this change from RNA to DNA takes place, the body is forced to make HIV just like it would make other new cells such as new skin cells.
The cell is now infected which makes it hard for the immune system to fight illness.
The HIV DNA then enters the nucleus, the command center of the cell.
There the HIV DNA combines with T cell DNA this forces the T cell to make copies of the virus
An enzyme called Protease assembles all the separate parts of the HIV into new HIV virus, the new HIV is ready to leave the cell to infect other cells
The new virus is released from the T cell, it travels to infect other T cells in the immune system
Over time, HIV destroys the T cell
As more T cells die, the immune system grows weak
A weak immune system makes it hard for the body to fight germs and avoid infections.

Overview:

- Several steps must occur for the HIV virus to survive
  - Entry of virus into host cell
  - Copying RNA into DNA
  - Hiding HIV DNA in host cell nucleus
  - Multiplication of HIV virus within cell
  - Budding of virus

Write AFRI-TAB vertically on newsprint and tell the class we will use the acronym AFRI-TAB to remember the stages in the Viral Life Cycle, you'll be surprised as to how it will help you recall each stage.

Step 1. Attachment

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

Using the newsprint with AFRI-TAB tell the class this is our first acronym **A** and say
So Step 1 in our AFRI-TAB is **Attachment** and write it on the newsprint.

Step 2. Fusion

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

Go back to the newsprint with AFRI-TAB tell the class this is our second acronym **F** and say so Step 2 in our AFRI-TAB is **Fusion** and write it on the newsprint, repeat the same instructions for each step until the entire AFRI-TAB on newsprint is completed with all the steps written in.

Step 3. Reverse Transcription

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

Go back to the newsprint with AFRI-TAB tell the class this is our third acronym **R** and say so Step 3 in our AFRI-TAB is **Reverse Transcription** and write it on the newsprint.

Step 4. Integration

- Once the DNA is formed, it hides itself in the human DNA housed in the CD4 T-Cell nucleus

Go back to the newsprint with AFRI-TAB tell the class this is our fourth acronym **I** and say so Step 4 in our AFRI-TAB is **Integration** and write it on the newsprint.

Step 5. Transcription

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

Go back to the newsprint with AFRI-TAB tell the class this is our fifth acronym **T** and say so Step 5 in our AFRI-TAB is **Transcription** and write it on the newsprint.

Step 6. Assembly

- The protease enzyme in the cell combines the DNA 'packages' to create active HIV virus

Go back to the newsprint with AFRI-TAB tell the class this is our sixth acronym **A** and say so Step 6 in our AFRI-TAB is **Assembly** and write it on the newsprint.

Step 7. Budding

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

Go back to the newsprint with AFRI-TAB tell the class this is our seventh and final acronym **B** and say so Step 7 in our AFRI-TAB is **Budding** and write it on the newsprint.

Take out the HIV Life Cycle – Worksheet and together let's fill in the stages of the cycle we've just learned.

HIV

- Virus is in the bloodstream but also hides in other cells (e.g. lymph nodes)
  - Drugs don't reach these sequestered cells*
  - That's why there is no cure
  - Meds do not reach HIV in the hidden cells
- Virus destroys CD4 cells which lead to:
  - Immune suppression
  - Opportunistic infections and AIDS

*HIV hides in those cells, which are "protected" – lymph nodes, brain, reproductive Organs, not enough meds can get to those cells.

How Medications Work (Any HIV drug medications handout)

Currently, there are 5 classes of medications to fight HIV:

- Fusion inhibitors
- Reverse transcriptase inhibitors (2)
  - Nucleoside or "nukes"
  - Non-nucleoside "non-nukes"
- Integrase Inhibitors
- Protease inhibitors

Current research is aimed at medications that interfere with different steps of HIV replication. Each step represents a potential target for antiviral drug development. Let's look at our Medications at Work in the HIV Life Cycle **(handout)** and connect the dots per se - look at the stages and determine at what stage each class of medication will work.

(Additional Information-optional: All anti-HIV medications are FDA approved and have been proven safe and effective if taken properly. The physician's role is to assess their patient's condition using lab results and taking into account patients quality of life and lifestyle.

Each drug has 3 names; it starts out with 1) a chemical name that scientist refer to, 2) generic name (e.g. abacavir), 3) brand name (e.g. Ziagen) what the company calls it and ultimately the consumer).

Two explanations have been provided for each medication class; a detailed explanation, and a short version. The detailed explanation is provided and can be used as additional information to address questions in more detail. The short version has been written to provide a simple explanation to be used more in teaching.)

- Fusion inhibitors

  The drug blocks entry of HIV into cells by inhibiting fusion of the virus and the cell.

(at what stage would this medication work? – Attachment which is Step1 in our AFRI-TAB).

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

  - Efuvirtide (Fuzeon®)
    (*Additional information optional: a white or off-white powder that must be reconstituted with sterile water before injecting under the skin. Vials of Fuzeon come in a "kit" with bottles of sterile water and syringes. This drug must be taken with other anti-HIV drugs, and has shown effective when used with a protease inhibitor boosted with Norvir as part of the HIV regimen. No food restrictions and it needs to be stored at (77 F), if stored in refrigerator, it must be used*

within 24 hours and brought back to room temperature before injection. Approved March 2003.)

(short version –What does it do? - blocks the lock on the door, it keeps the virus from entering)

Talking point why isn't this medication prescribed first?

1. It's an injection
2. It's not always the best drug
3. Just like other HIV drugs one can build up resistance if not taken as prescribed.

Fuzeon is the only medication metabolized by the liver, it is not expected to have any significant drug interactions and similar to other HIV drugs one can build up resistance if not taken as prescribed.

Types of Fusion Inhibitors

- Efuvirtide (Fuzeon®)

Fusion Inhibitor Side Effects

- Skin reactions or Injection site reactions (ISRs). ISR's might appear as mild slight redness that can include itching, swelling, pain hardened skin, or hard lumps that might last up to a week
- Pneumonia
- Allergic reactions are possible
- Common Side Effects: headache, pain and numbness in feet or legs, dizziness, and loss of sleep.
- Good agent for people with kidney or liver problems because it has no known interactions with other HIV medications, no long-term side effects.

LABS

- **(Fusion) or Entry Inhibitors**
  - **Complete Blood Count (CBC)**
    - Red Blood Cell count
    - Hematocrit and Hemoglobin
    - White Blood Cell count
    - Platelets
  - **Lymphocyte tests**
    - CD4 count
    - CD4%
    - CD8 count CD8 percentage and T-cell ratio
  - **Blood Chemistry Panel tests**
    - Liver function
    - Kidney function
    - Pancreatic function
    - Lipid profile
      - Fasting
      - Blood sugar

Non-nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

Question: At what stage would this medication work? – Reverse Transcriptase

The drugs attach to the reverse transcriptase enzyme, they bind on a different site than the Nukes. It sits on the reverse transcriptase and does not let it do its job, but a single mutation will ruin the relationship. This class is very unforgiving.

- Inhibit reverse transcriptase, the enzyme responsible for turning HIV RNA into DNA. Binds to a different site on the Reverse Transcriptase enzyme.
- Prevents the virus from replicating-making copies.

What does it do? Short version: sits on Reverse Transcriptase and keeps it from working

Types of Non-nucleoside Reverse Transcriptase Inhibitors

- Delavirdine (Rescriptor®)
- Nevirapine (Virmune®)
- Efaviren (Sustiva®)

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) Side effects

- Easily resistant (loose the entire drug class). Considered the unforgiving class of medications.
- Rash
- Headaches, Nausea, Vomiting
- Fatigue, Elevated Liver Enzymes
- Insomnia, Peripheral Neuropathy,
- Lypodystrophy
- Skin discoloration, ingrown toenails.
- Increased Triglycerides-Sustiva
- False positive tests for Marijuana

LABS- italicized items are significant tests for that particular drug

- **(NNRTIs) or NON-NUKES**
  - **Complete Blood Count (CBC)**
    - Red Blood Cell count
    - Hematocrit and Hemoglobin
    - White Blood Cell count
    - Platelets
  - **Lymphocyte tests**
    - CD4 count
    - CD4%
    - CD8 count CD8 percentage and T-cell ratio
  - **Blood Chemistry Panel tests**
    - ***Liver function***
    - Kidney function
    - Pancreatic function
    - ***Lipid profile***
      - ***Fasting***
      - ***Blood sugar***

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

Question: At what stage would this medication work? – Reverse Transcriptase

The drugs inhibit reverse transcriptase which is an enzyme that HIV needs in order to infect cells. It messes up the translation.

- Inhibit reverse transcriptase. The mechanism of action is the same as the NNRTIs, however, these medications are structurally different. The drug binds to the enzyme at a different place other than the NNRTI's.

What does it do? Short version: fake it out, messes up the translation.

Types of Nucleoside Reverse Transcriptase Inhibitors

- Lamivudine (Epivir®)
- Zidovudine (Retrovir®)
- Abacavor (Ziagen®)
- Emtricitabine (Emtriva®)
- Didanosine (Videx®)
- Tenofovir (Viread®)
- Stavidome (Zerit®)

Nucleoside Reverse Transcriptase Inhibitors (NRTIs) Side Effects

- Pancreatitis
- Lactic Acidosis
- Increased Triglycerides - Zerit
- Lipoatrophy – alteration of fat deposits Zerit & Retrovir (AZT) may also be linked to other drugs
- Anemia, Liver Dysfunction, "Drunkenness, Odd Dreams, Hallucinations
- Central Nervous System Disturbances
- Common Side Effects- headaches, fevers, fatigue, upset stomach, vomiting, diarrhea, rash, nausea

LABS- italicized items are significant tests for that particular drug

- **(NRTIs) or NUKES**
  - ***Complete Blood Count (CBC)***
    - ***Red Blood Cell count***
    - ***Hematocrit and Hemoglobin***
    - ***White Blood Cell count***
    - ***Platelets***

  - **Lymphocyte tests**
    - CD4 count
    - CD4%
    - CD8 count CD8 percentage and T-cell ratio

  - **Blood Chemistry Panel tests**
    - ***Liver function***
    - ***Kidney function***
    - Pancreatic function
    - Lipid profile
      - Fasting
      - Blood sugar

***(<u>Additional information – optional test</u>: HLA-B5701 (Abacavir HSR) – a hypersensitivity reaction** test used to detect whether an individual has genetic markers that exhibit sensitivities to Ziagen. Studies show that abacavir HSR is highly associated in whites. (73% were white, 9% black, 10% Hispanic and 8% Asian (primarily Thai). Their mean age was 40.9 years, and 24% were female))*

Integrase Inhibitors

Question: At what stage would this medication work? – Integration

Integrase Inhibitors are the newest class of HIV drugs and little is known about their potential side effects, especially metabolic side effects. It's impossible to know the long term side effects of a drug until many patients have been on it for many months. It is reasonable to assume that integrase inhibitors may have some unanticipated side effects, but based on these and other studies, they seem unlikely to cause the same effects on fat and cholesterol we have seen with earlier protease inhibitors. As more patients are on the drug there will be more extensive human data available.

(Additional information – optional:

- *Block viral DNA and keeps HIV from binding to the host cell DNA.*
- *Prevents viral replication.*

Types of Integrase Inhibitors

- Raltegravir (Isentress®)

There is one other candidate for this class of drugs that is not yet approved.

Integrase Inhibitors Side Effects

- Common Side Effects-headaches, fevers, fatigue, upset stomach, vomiting, explosive diarrhea, rash, nausea

It is impossible to know about potential side effects at this time. As more patients are on the drug, there will be more data available.

LABS - there are no significant tests for this particular drug that are reviewed that have been identified.

- **Integrase Inhibitors**
  - **Complete Blood Count (CBC)**
    - Red Blood Cell count
    - Hematocrit and Hemoglobin
    - White Blood Cell count
    - Platelets
  - **Lymphocyte tests**
    - CD4 count
    - CD4%
    - CD8 count CD8 percentage and T-cell ratio
  - **Blood Chemistry Panel tests**
    - Liver function
    - Kidney function
    - Pancreatic function
    - Lipid profile
      - Fasting
      - Blood sugar

Protease Inhibitors (PIs)

Question: At what stage would this medication work? – Assembly

Protease inhibitors are the most complex with regard to drug interactions, dosing and restrictions.

(Additional information – optional: These drugs block the protease enzyme. When new viral particles break off from an infected cell, protease cuts long protein strands into the parts needed to assemble a mature virus. When protease is blocked, the new viral particles cannot mature. PI's can tolerate more mutations- 95% adherence is always best.)

- Prevent the piecing together of HIV DNA small packages.
- Prevents a new HIV from forming.

What does it do? Short version – PI meds stop the scissors from working because it stops protease from cutting and arranging DNA - it up holds onto it, pulling it all together into a cut and paste format to make more virus.

Types of Protease Inhibitors

- Fosamprenavir (Lexiva®)
- Indinavir (Crixivan®)
- Saquinavir (Invirase®, Fortovase®)
- Lopinavir/ritonavir (Kaletra®)
- Atazanavir (Reyataz®)
- Nelfinavir (Viracept®)
- Tipranavir (Aptivus®)

Protease Inhibitors Side Effects

- Increased Cholesterol and Triglycerides
- Lipodystrophy
- Onset or worsening of Diabetes
- Liver toxicity, Kidney Stones
- Increased bleeding in Hemophiliacs
- Common Side Effects-headaches, fevers, fatigue, upset stomach, vomiting, explosive diarrhea, rash, nausea
- Yellowing of eyes

LABS- italicized items are significant tests for that particular drug

- **Protease Inhibitors (PI's)**
  - **Complete Blood Count (CBC)**
    - Red Blood Cell count
    - Hematocrit and Hemoglobin
    - White Blood Cell count
    - Platelets
  - **Lymphocyte tests**
    - CD4 count
    - CD4%
    - CD8 count CD8 percentage and T-cell ratio
  - **Blood Chemistry Panel tests**
    - Liver function
    - Kidney function
    - Pancreatic function
    - *Lipid profile*
      - *Fasting*

– *Blood sugar*

(short version – PI meds interrupt the process. PI's stop the scissors from working because it stops protease from cutting and arranging DNA - pulling it all together into a cut and paste format to make more virus).

Long Term Complications include: we might need to move this based on the pp slide deck

- Once Daily Regimen
  - Atripla (Efavirenz/Emtricitabline/Tenofovir Disoproxil Fumarate ®) – daily
    - Side Effects- related to class of drugs
    - e.g. It has Sustiva so there might be odd dreams.

- Hyperglycemia (Slide 99)
  - Increased blood sugar levels

- Lactic Acidosis
  - Rare
  - Potentially fatal
  - High levels of Lactic acid in the blood

- Decreased Bone Mineral Density
  - Avascular Necrosis of the hip joint where the blood supply is decreased in your hip joint bone therefore there is decreased nutrients in the area
    1. Not clearly understood
    2. Drug Therapy include Calcium and Vitamin D
    3. Weight Bearing Exercises

- Slide 100 is a table that correlates classes of Medications with long term complications related to HAART

Adverse Reaction	NRTIs	NNRTIs	PIs
Lactic Acidosis	++	--	--
Lipid Changes	--	+	++
Insulin Resistance	--	--	++
Fat Redistribution	+	--	++

- Lipid Abnormalities-Cardiovascular Risk (Slide 94)
  - Increase in LDL (cholesterol). Goal for LDL is to be less than 200
  - Increase in Triglycerides
  - Increased risk of stroke
  - Increased risk of heart attack
  - The slide shows 1. Normal Artery Lining (red is normal blood flow)
    2. Shows some plaque build-up (the yellow is fat build up)
    3. Shows a block artery

  - Other non-HIV risk factors include age, smoking , obesity and family history
  - Lifestyle Change
  - ASA, diet, exercise, medications

    (Doctors will usually start an anti-cholesterol medication to treat Hyperlipidemia and encourage changes in diet/exercise habits)

- Lipodystrophy (Slide 95 and 96)
  - Redistribution of body fat
  - Visceral fat deposits
  - Buffalo hump
  - Crix belly
  - Peripheral wasting (Slide 97)
  - Consider switching therapies as it is potentially reversible
  - Plastic surgery for irreversible cases

Goal of Therapy:

- Suppress HIV VL to <50 copies/ml for as long as possible
- Improve quality of life
- Preserve medications for future use
- Restore immune function
-

Slide is 104 are General Guidelines that providers use to assess when to start HAART.
Should probably add slide information

Principles of HAART (Slide 105)

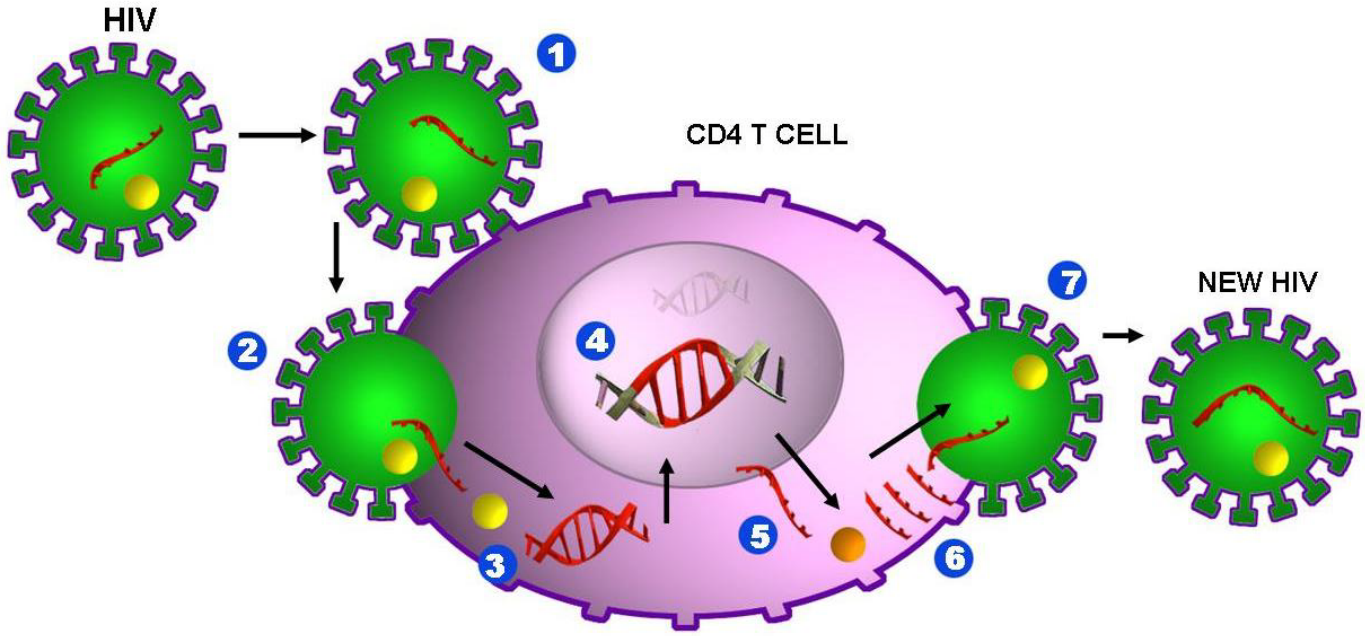
- HIV virus has 1 goal: replication
- Triple-drug therapy
  - "Attack" virus in several *different* ways
  - Slow down viral replication
  - Allow immune system to 'recover'

Risks and benefits of delayed treatment (Slide 106)

- Benefits
  - Client readiness
  - Avoid negative effects on quality of life
  - Delay development of drug resistance
  - Preserve future drug options
- Risks

- Possible irreversible immune depletion
- Possible greater difficulty suppressing viral replication
- Untimely Death

HIV Life Cycle - Worksheet



A_____ **F**_____ **R**_____ **I**_____ **T**_____ **A**_____ **B**_____

1. HIV binds to receptors on the CD4 T-cell.
   - A message is sent to the CD4 T-cell to let the virus in.
2. Once bound, the virus is allowed to dump its contents into the CD4 T-cell.
   - Included in its contents are HIV RNA and reverse transcriptase.
3. The HIV RNA is turned into double-stranded DNA within the CD4 T-cell.
   - The enzyme reverse transcriptase aids in this process.
4. Once the DNA is formed, it hides itself in the human DNA housed in the CD4T-cell nucleus.
5. Copies of HIV DNA are made and released from the nucleus in small packages'.
   - Each of the small packages' contains information for creating a new HIV.
6. The protease enzyme in the cell combines the DNA 'packages' to create active virus.
7. HIV is formed, it pushes itself out of the CD4 T-cell
   - The virus steals part of the CD4 T-cell protective coating.

How Medications Work Activity

Activity Template

Topic of Training Segment: **Viral Life Cycle-"How Medications Work"**

Time Allotted:
20 minutes

Materials Needed:
Handout – HIV Antiretroviral Agent – Drug Chart
Handout – Medications at Work in the HIV Life Cycle

Objectives:
- Participant will identify the 7 stages in the Viral Life Cycle (AFRI-TAB).
- Participants will be able to identify the 5 different classes of HIV medications
- Participants will become familiar with HIV terminology used in HIV treatment
- Participants will understand why HIV medications are used in combination and why one must be adherent to meds for them to work.

(talking point)
Now that we've gone through the Viral Life Cycle, the 5 classes of medications and we've showed you where those medications work at slowing replication of the virus at all stages. Let's pull out the HIV drug medications chart and check off the medications that you currently take.

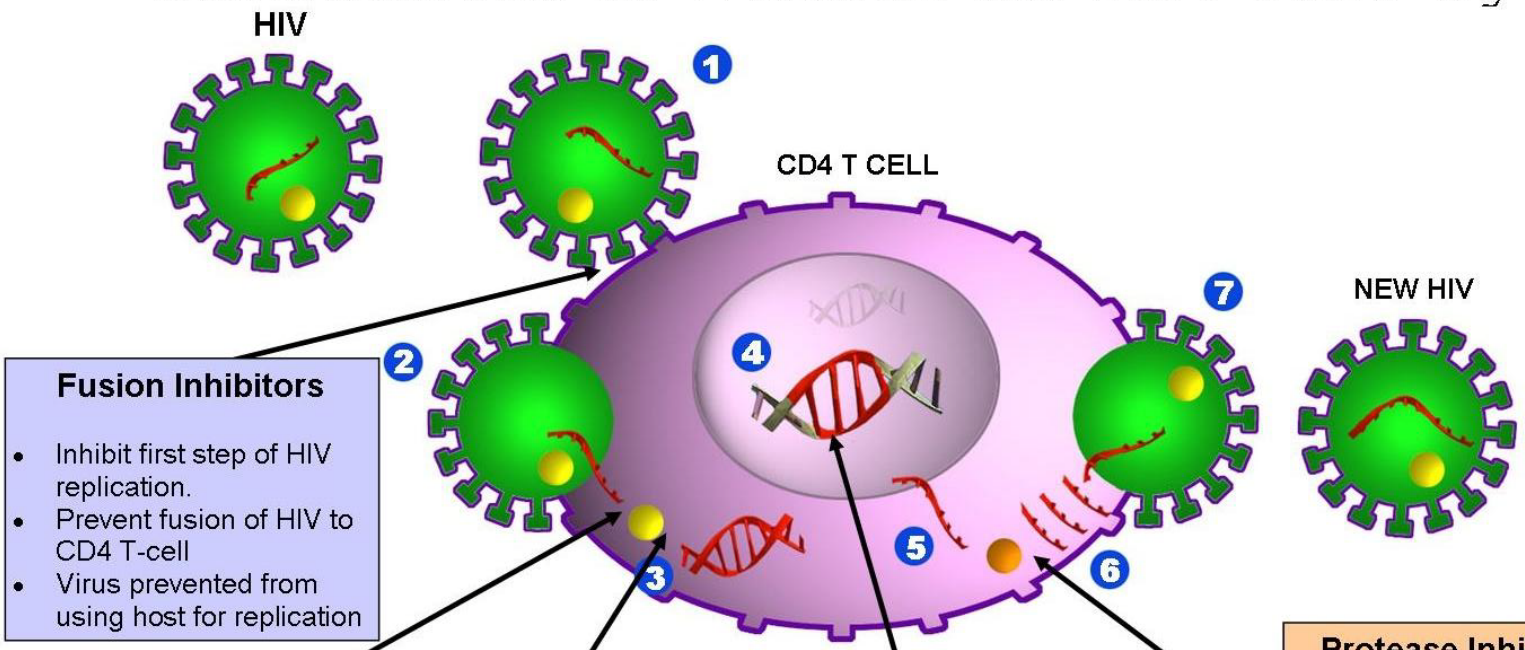
Instructions:
The facilitator will:
1. Give each participant two handouts; HIV Antiretroviral Agent – Drug Chart and the Medications at Work in the HIV Life Cycle.
2. Participants (specifically participants on HIV medications) will be asked to look at the list and put a check beside the medications they are currently taking.
3. The participant will then identify the stage where their medications are working the Viral Life Cycle (AFRI-TAB) their medications are working.
4. 3-4 participants will be asked to volunteer to give the following information from the drug chart:
    i. name of HIV medications they are taking;
    ii. identify which of the 5 classes the medications are in;
    iii. identify the stage where their medications are working.

Discussion Questions:
- What happens when one forgets to take medications?
- What happens if some medications are taken and not others?
- Are there certain levels of medications that must be maintained in the body?
- Since the fusion inhibitors block the door to the cell, why isn't this drug prescribed first?
- There are a number of medications now approved by the FDA, are there other meds on the way for people that have taken everything and nothing works – have no options?

Summary and Closing:
- In closing what has been learned in this lesson will color everything in each of the other lessons that will be taught regarding treatment. Now with this knowledge you have power to influence those that you work with to be adherent to their regime or if they are not on meds to explain the role of the different classes and how it is significant to treatment.

Bridge: We've covered a lot of detailed and technical information that we've taught a number of different ways. During the training we will continue to build on the information learned each day. This is a layered approach and by day 3 we will put it all together in role plays.

Medications at Work in the HIV Life Cycle



Fusion Inhibitors

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

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

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

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

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

Integrase Inhibitors

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

Protease Inhibitors

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

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

Side Effect	Possible Treatments
Fat Redistribution-Lipodystrophy, Lipatrophy and Lipadiposity	Currently there are no treatments that have been proven effective for body-shape changes. Switching regimens might be an option. Serostim-reduces fat buildup not FDA approved for Lipodystrophy. Liposuction Sculptra-Injection of fat or fat substitutes
Fatigue, tiredness, weakness, lack of energy	Discuss with doctor, change in diet, rest and sleep.
Nausea, vomiting	Antiemetics-Compazine, Zofran Eat small meals, Eat bland foods (low in fat and high in starch/carbohydrages) Relax before meals, eat slowly
Loss of appetite due to nausea and vomiting	Antiemetics-Compazine, Zofran Megace to treat anorexia. Marinol to stimulate appetite Some people opt for marijuana
Diarrhea /watery stools	OTC-Imodium AD, Kaopectate, Metamucil, Lomotil These meds work best if taken 30-45 minutes before taking medications that cause diarrhea. Dietary change using the BRATT diet-Bananas, Rice (white), Apple juice or sauce and Toast and Tea (herbal) Drink water to combat dehydration.
Gas and bloating	Dietary changes by eliminating gas producing foods such as broccoli, beans, vegetable skins. OTC-Gas-X
Heartburn/acid reflux	Dietary changes-avoid foods that are spicy or fatty, vinegar, peppermint, pickles, alcohol, caffeine (soda, tea, coffee, chocolate), citrus fruits and juices (orange, grapefruit, lemon, tomato) Avoid aspiring, ibuprofen that irritate the stomach OTC-Mylanta, Maalox, Tagamet, Zantac, Pepcid
Liver damage	Discuss with doctor-possibly change in ARVs Decrease alcohol consumption
Kidney stones	Possible change in medications, Increase in water intake,
Fungal Infections	Anti-fungal such as Monistat, prescription-Diflucan
Skin rashes/Stevens-Johnson Syndrome	Consult with doctor, antihistamines-Benadryl Good skin moisturizer if dry skin
Peripheral Neuropathy	Consult with doctor-change in ARVs Anti-inflammatory meds-Ibuprofen Applying topical creams-Ben Gay Prescribed Medications-Neurontin
Muscle decrease or weakness, muscle pain or joint pain	Anti-inflammatory drugs-Tylenol
Anemia	Procrit and Epogen. Doctor may want to change medications

Understanding Lab Values

Curriculum Template

Topic of Training Segment: **Making Sense of Lab Values**

Time Allotted:
45 minutes

Materials Needed:
Laptop
Projector with screen or blank white wall
Markers
Participant booklet to follow lesson and power point

Objectives:
- Understand the importance of having regular lab work done by knowing what specific HIV test results mean such as viral load, CD4, resistance tests.
- Understand what CD4 percentage and T-cell ratio indicate and review other significant subset tests.
- Understand what CBC and blood chemistry tests are performed and why they are checked.
- Understand the importance of having cholesterol, triglycerides, blood pressure and glucose levels tested and how they may relate to HIV treatment adherence and care.

Power Point Presentation: Making Sense of Lab Values in HIV

If you are living with HIV, lab tests are one of the most important ways you and your healthcare provider can monitor your health.

Doctors Use Lab Tests to Monitor Your Health
- Lab tests:
  - Detect the presence of disease-causing organisms (e.g. bacteria, viruses, parasites) that may be related to HIV
  - Tell when to treat, how to treat, and if treatment is working
  - Identify the development of side effects related to treatment
  - Detect other infections and problems associated with HIV infection

Step 1: Lab Basics

Confirm your personal information:
- Name
- Age
- Gender
- Social security number

Ask about anything you do not understand

Step 2: lab timeline

So what are the baseline lab tests your doctor will want you to take? These are the most common, but they are not the only tests your doctor may want you to take.

- A complete blood count or CBC

- A CD4 T-cell count and percentage
- A drug resistance test (this may not be required by your physician)
- A viral load test
- A chemistry panel

There are also a number of other tests that your doctor will probably order as a baseline measurement—to be able to keep track if things change. As time goes on, these other tests will be ordered periodically, or if your doctor suspects a problem.

We'll discuss each of these tests in more detail in a moment.

Periodic labs Occasional tests/vaccines

- After the baseline lab tests have been taken, your doctor will ask you to take them again periodically. Now what does that mean? To begin, generally every quarter, or about every 3 months throughout your treatment, your doctor may want to perform the lab tests listed here:
  - Viral load test
  - CBC
  - CD4 T-cell count and percentage
  - A lipid profile for cholesterol and triglycerides
  - A fasting blood sugar test for diabetes

  Your doctor may also want you to take these additional tests:
  - Liver function tests, because many HIV/AIDS meds are processed by the liver
  - Kidney function test, because many HIV/AIDS meds are excreted by the kidneys
  - Hepatitis A, B, and C
  - HIV resistance (if your therapy fails to lower the viral load or achieves only suboptimal suppression)
  - Toxoplasma antibody IgG (which tests for a blood-borne illness that people can get from cats)
  - CMV IgG

  Beyond blood tests, these additional screenings may be done:
  - Pap smear, including a vaginal pap smear for women, and an anal pap smear for men and women
  - Full sexually transmitted disease or STD screening
  - Chest X-ray
  - PPD skin test for tuberculosis

  Your doctor may also want to make sure the following vaccines are up-to-date:
- Pneumococcal vaccine (if not given in the last 5 years)
- Tetanus/diphtheria toxoid (if not given in the last 10 years)
- Hepatitis A & B vaccines
- Flu vaccine

Labs (3-4 months)

- CBC values
  - Red blood cell count
  - Cells that carry oxygen
  - White blood cell count (different types) make up the immune system-fight infection

- CD4
  - One of the white blood cells (Lymphocyte) that tell other white blood cells to attack HIV
- Drug resistance testing
  - Genotype
- HIV infection within 2 years of diagnosis –resistance profile
- Viral load
- Chemistry panel
  - Liver function
  - Kidney function
  - Lipid profile
    Fasting – 1 yearly
    Blood sugar

Lab Values

The CBC or complete blood count lab value tests is a report of the red blood cell count.

- One of the most commonly used blood tests
- Examines blood components including red and white blood cells
- Blood components are made in bone marrow, which can be affected by HIV
  HIV/AIDS and antiretroviral agents

The CBC is a very important gauge of your overall health, so it is one of the most commonly used blood tests for monitoring HIV and AIDS. The CBC examines the components of your blood, including your red and white blood cells. Why are these lab values important? For two reasons:

- First, because these cells are produced in the marrow of your bones
- Second, because your bone marrow can be affected by HIV and AIDS and antiretroviral agents

Lymphocyte tests

- CD4 is a WBC called Lymphocyte
  - Counts the number of CD4 T-cells
- Normal CD4 count (helper T-cell count)
  - 600-1500 cells/mm3 is normal for healthy adults
  - Children's counts are much higher
    Less than 200 cause increased risk of opportunistic infections. Lower the CD4 drops, the more risk
- CD4%
  - More consistency than a single measurement
  - Less than 30% means some level of immunodeficiency (weakened immune system

What about ups and downs?

- CD4 T-cell counts can vary according to:
  - Type of test
  - Time of day
  - Current or recent infection
  - Stress
  - Fatigue

CD4 Percentage

- CD4 accounts for 30%-60% of all the immune cells
- Usually does not vary as much as the actual CD4 measurement
- Some providers might consider starting antiviral therapy when the CD4% is <15-17 even if CD4 remains > 350 copies

Viral load

- One of the most important tests you will take about every 3 months
- Often considered the critical marker in the management of HIV and AIDS
- Measures the amount of HIV in your blood

Chemistry Panel

This is an example of a chemistry panel. The chemistry panel is probably the most substantial portion of your lab results, because it provides a lot of information about how your body is doing. Specifically, the chemistry panel indicates how your major organs are working. The chemistry panel provides information on your heart, liver, kidneys, muscles, and bones.

Liver Function Tests

- Most HIV medications are processed through the liver
- Conditions that affect your liver can also affect your meds
- Tests used to monitor liver function are:
  - ALT, also known as SGPT
  - AST, also known as SGOT
  - Bilirubin
  - Alkaline phosphatase

Kidney tests

- HIV can cause kidney damage
  - So can diabetes and cardiovascular disease
- Many HIV meds are cleared from the body by the kidneys
- In people with reduced kidney function, the doses of some HIV meds may need to be adjusted
- Tests for kidney function include:
  - Blood Urea Nitrogen (BUN)
  - Creatinine

Lipids

- HIV, and some HIV meds, can increase lipid levels
- People with high levels of LDL cholesterol and triglycerides are at a greater risk for:
  - Cardiovascular (heart) disease
  - Heart attack
  - Stroke
- Factors that can increase the risk of elevated lipids include:
  - Family history of cardiovascular disease

- High blood pressure
- Smoking

- Things you can do to decrease the risk include:
  - Eat healthy
  - Exercise
  - Quit smoking
  - Appropriate lipid-lowering drugs

- Cholesterol - Types of fat in the blood
  - Triglycerides - <150 (related to amount of sugar intake)
  - Cholesterol - <200
    - LDL (lethal) – bad cholesterol <100
    - HDL (healthy) – good cholesterol >60
- Abnormal ranges put one at risk for cardiovascular events and pancreatitis Many HIV medications effect cholesterol

Blood sugar levels

Glucose is sugar and is broken down in your body to provide your cells with energy. High blood sugar may be a sign of diabetes, which can lead to a variety of cardiovascular and other health problems. High blood sugar levels eventually cause damage to your eyes, nerves, kidneys, and heart. Some HIV medications, including protease inhibitors, can increase blood sugar levels. High blood sugar can also mean that your pancreas is not making enough insulin, which enables your body to keep blood sugar levels in balance. Your age, diet, and weight can also play a role in developing diabetes.

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

Discussion Questions:
- All of the labs appear to be very significant to people living with HIV. Are their any labs discussed more significant than any others that an HIV positive person should know?
- Should I ask my healthcare provider for a copy of my lab results?
- What tools are available to track my test results?

Summary and Closing:
- If you are living with HIV, as you can see there are numerous lab tests usually done quarterly that can be confusing, mind boggling thereby leaving HIV+ people spinning.
- It is important to remember that your healthcare provider often welcomes the opportunity for you to take an active role in your care by asking questions about your lab results to understand what they mean and more importantly what you can do to make a lifestyle change to make a difference in some of those results.

Bridge:
- Now we will do a matching activity to categorize the lab tests with which type of blood tests taken.

“Test Tubes”
Lab Value Activity

Activity Template

Topic of Training Segment:
"Test Tubes"

Time Allotted:
10 minutes

Instructions:
Facilitator
The facilitator will:

- Give each participant a copy of the activity sheet;
- Ask each participant to match the test name(s) with the type of test most likely being taken.
- This activity can be completed individually or together as a class.

Materials Needed:
Handout – Test Tube

Objectives:

- Participant will be able to identify the test name with the blood test most likely being performed.
- Participants will be able to match the 5 most comprehensive laboratory test used to monitor health.
- Participants will become familiar the types of laboratory tests to monitor a person's HIV care and treatment.
- Participants will understand why laboratory tests are significant in monitoring the health and how these tests can be used to manage care.

Discussion Questions:

- What happens when one is not adherent to doctor visits to have these laboratory test performed?
- How often should a person take laboratory tests if they have just started medication or are starting a new regimen?
- Are all of these tests performed each time labs are drawn?
- Will the tests show different results or possible blips if an HIV positive person is sick and has labs drawn?
- Does a person have to fast before having labs are drawn?

Summary and Closing:

- In closing the good news is that people are living longer with HIV, the bad news is that people are living longer with HIV and are seeing different problems as long-term progressors such as heart disease. Some of the HIV medications may cause some of the elevations in glucose, cholesterol, triglycerides and being monitored frequently and following or charting lab results to watch for changes is extremely helpful. The benefits of taking medication certainly outweighs the risk. Watching those lab values is important stuff.

Bridge:
It's been a long day, we've covered a lot of detailed and scientific information. Now let's break for a few minutes.

“Test Tubes” Activity

Instructions: Match the question on the left with the most likely answer on the right.

Question	Answer
What is the most important test HIV infected people routinely take?	Liver
What determines when to treat, how to treat and if treatment is working?	Lipid Panel
In people with reduced kidney function, doses of some HIV medications may need to be adjusted. Tests to monitor this vital organs function are called _____ function tests.	Baseline
After someone first learns of their HIV infection, the doctor will want them to take several lab tests to get a _____	CBC
HIV medications are processed through this organ; therefore _____ function tests are performed to monitor its condition since it affects medications.	Kidney
One of the risks of HAART is a greater chance of serious drug-related problems, including heart disease. What tests are used to monitor this risk factor?	Lab Tests

Understanding Drug Resistance

Topic of Training Segment:

Understanding Drug Resistance

Time Allotted:

60 minutes

Materials Needed:

TV/VCR
Video- HIV Resistance. What It Is…..And What You Can Do About IT (17 minutes)
Laptop
Projector

Instructions: (These will be power point slides)

View video
Review scenarios in video:-

A. Jose

- New on medications.
- Works in construction.
- Wants to take all his medications at once.
- "Organize it so it works for me"
- "Every dose, every day, every time"
- "Nothing to it but to do it".

B. Christy

- Mutant strain or Wild type strain
- Resistance to therapy
- Re-assess with genotype testing
- She is not agreeing to a new therapy maybe because she will do some research on medications and resistance before starting another medication therapy.

C. Warren

- Has a new job
- Stigma of his sexual orientation and being HIV positive
- Options to help with adherence-Christopher (his partner) and his new watch
- Realistic fears of feeling sick from side effects to medications.

Follow the slide presentation and utilize the presenter slide notes.

Goals and Objectives:

- Participants will understand the concept of drug resistance
- Participants will understand when and what types of drug resistance testing is available

What are the goals of HIV therapy?

1. Slow the progression of HIV
2. Restore the function of the immune system
3. Improve a person's quality of life

The Provider and patient would consider combination therapy. To remind you there are 5 classes of drugs that are used in HIV therapy:

Nucleoside reverse transcriptase inhibitors (NRTIs)

Non-nucleoside reverse transcriptase inhibitors (NNRTIs)
Protease inhibitors (PIs)
Entry inhibitors (EIs)
Integrase Inhibitors

These ARVS interrupt the HIV replication process and help preserve the health of the immune system. Therapy with a combination of three or more antiretroviral drugs is usually required for effective treatment of HIV infection.

What Is HIV Drug Resistance?

- HIV drug resistance means that the virus can adapt, grow, and multiply in the presence of drugs.
- HIV is considered to be drug resistant when a drug or class of drugs is no longer effective against it.

What Causes Drug Resistance?
HIV replicates very rapidly and makes many mistakes (mutations) in the process. However, HIV doesn't have the ability to correct these mistakes. This results in mutant viruses that can be resistant to one or more of the drugs used in HIV therapy. These mutant viruses continue to make copies of themselves, further reducing the effectiveness of an individual's HIV therapy.

How Common Is Drug Resistance?
Recent data indicates:

- 3 out of 4 people currently taking HIV drugs, treatment failure is linked to drug resistance
- 1 in 4 newly infected individuals is already resistant to at least one HIV class of drugs.

Why Is Drug Resistance Testing Important?

- Gives provider a complete picture of therapy options (when used with treatment history, VL and CD4 labs
- Helps avoid unnecessary drug side effects and medical costs associated with taking drugs that are not likely to work.
- Helps with development of an effective treatment plan

How Is Drug Resistance Tested?
A blood sample is taken and sent to a laboratory where one or both types of resistance testing — phenotypic and genotypic are performed.

Phenotypic testing is performed by testing a sample of a person's HIV against all of the available antiretroviral drugs. By directly measuring the ability of HIV to grow in the presence of these drugs, the laboratory can determine which drugs will work and which are no longer good options. The activity of a person's HIV in the presence of the antiretroviral drugs is compared to the activity of a control strain of HIV that is known to be susceptible to all drugs. This comparison determines how well a drug is likely to work.

Genotypic testing is performed by identifying genetic mutations, or changes in genes, in an individual's HIV that are known to be associated with drug-resistant HIV. Once the mutations have been identified, a computer is usually used to interpret the results for the healthcare provider.

What Do Drug Resistance Test Results Look Like?
The report forms used for Monogram's resistance tests include genotypic and/or phenotypic drug resistance information for all of the approved nucleoside reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), and protease inhibitors (PIs).

Please refer to your participant books for copy of a Genotype test results.

- **When Should Drug Resistance Testing Be Used?**

Before therapy begins

Because drug-resistant strains of HIV can be passed from one person to another, resistance testing can be used to evaluate drug resistance in recently infected or newly diagnosed people. The results can help a healthcare provider work with an individual to design a targeted treatment plan that is more likely to be effective for a longer period of time. By using information about how resistance develops when certain drugs are used, healthcare providers can design combinations of drugs that will preserve more treatment options if therapy failure occurs later on down the road. For facilitator notes

Following treatment failure

When a person no longer benefits from his or her HIV therapy (treatment failure) and viral load is increasing, drug resistance testing can help determine which drug or combination of drugs is no longer effective. A treatment plan can then be developed that is more likely to slow HIV replication. For facilitator notes

Throughout therapy

Drug resistance testing can also be used during the course of an individual's therapy. Periodic testing when HIV is detected in plasma can help gauge therapy effectiveness and drug resistance, so that treatments can be altered as needed. For facilitator notes only

How to Prevent Drug Resistance?

In addition to working with their healthcare providers and using drug resistance tests as appropriate, people living with HIV can fight drug resistance by:

- **Taking HIV drugs every dose, every day and every time.** If people under HIV treatment skip their medications, stop taking them or don't stick to their schedules, it becomes easier for the virus to develop resistance.
- **Not sharing needles or having sex without a condom with someone else who has HIV.** This way, HIV-positive people avoid exposure to additional, drug-resistant strains of the virus.

Summary and Closing:

- Drug Resistance is the body saying no to these medications are not working to reduce replication of the virus, therefore the medications are not working for me.
- It is important to understand how to reduce chances of drug resistance-Medication adherence and safe sexual behavior.
- Drug resistance testing is available-Phenotype and Genotype testing and is prescribed based on a mutual decision between the provider and patient, as well as exploring cost effectiveness of procedure.
- Drug resistance testing is done before, during and throughout the ARVs medication adherence journey.

Adherence:
Barriers and Strategies

Curriculum Template

Title of Activity:

Adherence: Barriers and Strategies

Time Allotted:

60 minutes

Materials Needed:

- Projector with screen or blank white wall
- Laptop

Objectives:

- Participants will understand what adherence means.
- Participants will be aware of common reasons for adherence challenges
- Participants will understand common side effects
- Participants will walk away with strategies for managing side effects

Instructions:

- Follow the power point presentation on Adherence-Barriers and Strategies.
- Use slide notes as a reference during presentation

Adherence-Barriers and Strategies

(These will go into power point slides)

What is Adherence?

- Adherence refers to how closely you follow a prescribed treatment regimen.
- Partnership between the patient and doctor/provider.
- It is a skill to be learned
- Client must be able to do the following to be adherent to their therapy:
  - Understand the regimen
  - The Who, What, When, Where, Why? of treatment
  - Believe they can adhere
  - Remember to take medications
  - Integrate medications into current lifestyle
  - Problem-solve changes in schedule and routines

Why is Adherence so important?

- Adherence affects how well anti-HIV or Anti-Retroviral (ARVs) medications decrease viral load and increase CD4 cells
- Skipping medications allows for replication of the virus
- Prevents drug resistance-development of HIV strains that are resistant to your medications you are taking now and potential drugs you maybe prescribed in the future

Questions/Problems to ask a client to assess medication adherence:

- What is the reason you are taking this drug?
- How do you take this medication?
- Are you taking this medication with food?
- Where did you receive information about this medication?
- What do you use to help you remember to take your medication?

- What do you do when you miss a dose?
- What problems have you encountered while taking this medication?

Client factors that affect adherence:

- Knowledge of treatment regimen
- "Fits" with lifestyle
- Stage of disease, level of wellness
- Support system
- Belief in HAART effectiveness
- Fear
- Ability to control side effects
- Mental health
- Substance abuse
- Stigma
- Believing the drugs were ineffective
- Denial of HIV status

What tools can peers use to support adherence with clients?

- Self-monitoring (pill boxes, tracking booklets)
- Pharmacy automatically refills medications
- Location of pill boxes
- Create individual adherence plan
- Develop problem-solving skills
- Habit building/cueing (integrating adherence into daily routines)
- Reinforcement (accountability coach, reviewing lab values)
- Incentives (better health, staying in relationships, connecting to values)
- Electronic reminders (Cadex watches, pagers, cell phones)
- Research on the medication options and a lengthy discussion with your doctor
- Reduced pill burden
- Scheduling medications based on dietary requirements, such as taking them at snack times or when your stomach is empty
- Scheduling particular dates monthly on the calendar to request refills of medications
- Planning ahead if you are going to be out of town to ensure you have sufficient medications

There is no **gold** standard or consensus on the best interventions to promote adherence to PLWHA

Resources for Peer Educators and Clients

- Informed and skilled providers
- Continuous client education
- Continuous support
- Multidisciplinary team approach to healthcare

Environmental Factors That Effect Adherence

- Transportation
- Housing
- Food
- Drug treatment
- Mental health service
- Social network
- Child care

- Addressing cultural norms

Non-adherence can take many forms?

- Not having prescription filled
- Taking an incorrect dose
- Taking medication at wrong time
- Missing doses
- Stopping therapy too soon
- Taking OTC medications that interfere with prescribed medication

Discussion Questions:

- What are some of the common side effects you have experienced?
- What strategies have you used that has not been mentioned during this presentation?

Summary and Closing:

- As you can see there are common side effects that patients experience with the medications.
- Not everyone will experience the same side effects and to the degree that another person will
- It is important to have open communication with your provider as you decide treatment options
- Become knowledgeable about the possible medications you will be prescribed and the side effects, that way you will know what symptoms to track.

Bridge

- We will now do an activity to practice how to problem solve with a patient strategies for managing side effects from ARVs

Adherence Strategies Activity

Activity Template

Topic of Training Segment:

Adherence Matters

Time Allotted:

- 30 minutes
- 3-15 people

Materials Needed:

- Newsprint
- Markers
- Masking tape
- Prepared Scenario activity sheet.

Instructions:

- Introduce the activity by explaining that the participants will be assigned to small groups to brainstorm ways a patient on ARVs can manage side effects
- Assign participants to 3 groups
- Assign a space in the room for each group
- Ask participants to go to their assigned group in the respective space
- Assign 1 scenario to each group
- Give each group a sheet of newsprint and markers
- Instruct each group to appoint a recorder and a reporter
- Tell the group they will have about 5 minutes to do this activity
- Instruct each group to brainstorm answers to scenarios and write their answers on the newsprint
- Bring the entire group back together and ask each reporter to go over his or her group's work
- Ask open-ended questions to draw out their thoughts on how a peer might be on service to a person living with HIV.
- Discuss any other brainstorming answers to all the questions.

Goals and Objectives:

- Participants will understand common side effects of the different Anti-HIV drug classes
- Participants will be able to offer clients options to manage drug side effects

Summary and Closing:

- Ask participants if they now understand some common side effects of ARVs, how to problem solve ways to manage the effects to achieve greater than 90% adherence to medications.
- Explain to participants that strategies to managing side effects will be different with different patients based on their daily routines, ability to manage side effects and patient's past experiences with ARVs.
- Inform participants that managing side effects if possible if there is an open working relationship between provider and patient, knowledge about drugs and side effects is understood and there is a plan to manage the side effects.

Bridge

Adherence Matters Activity Sheet

Scenario A

Joe is a 32 year old who started medications 3 weeks ago. The Peer Educator gives Joe a call to see how he has adjusted to his medications. Joe tells the Peer Educator that he was prescribed Sustiva and Truvada. He reports that he is taking his medications faithfully. The peer educator asks Joe if he has been experiencing any side effects since starting the medications. Joe reports that he had mild dizziness and vivid dreams.

Scenario B

Carmen is a 36 year old who has been prescribed Viramune, Zerit and Epivir. Carmen states that she had only missed 1 dose of medications since starting them 6 weeks ago. Carmen reports that she had been experiencing some tingling in her feet and her boyfriend thinks that her face is thinning. She is not sure what she should do.

Scenario C

Michael is a 25 year old male who has been prescribed Kaletra and Combivir. Michael is having mild diarrhea. During the conversation Michael tells the peer educator that he has been smoking marijuana about once a week and that he has the habit under control-"it's to help me chill out after I get home from work".

Please answer the following questions in your assigned group. Please refer to the resources you have.

1. What questions would the Peer Educator ask?

2. What strategies would the Peer Educator suggest?

3. What is the outcome?

Prevention for Positives

Curriculum Template

Topic of Training Segment:

Prevention Education for PLWAs

Time Allotted:

20 minutes

Materials Needed:

- Computer/Laptop and Projector
- Screen
- Condoms
- Penis Models
- Optional: dental dams and female condoms for examples

Instructions:

Lead the discussion by following the power point slides and instructor notes.

Talking Points: (On power point slides)

<u>What we know</u>:

- In the US there are approximately 1.185 million as of 2005
- CDC estimates 40,000 new HIV infections annually in the US
- 25% of people HIV infected do not know they are infected
- CDC goal is to decrease rate of new infections annually by 50% (20,000)

<u>Providing prevention to clients living with HIV/AIDS</u>

1. Why are prevention messages important to an HIV positive person?
    a. Supports HIV + persons from becoming infected with a co-infection (STDs) as STDs further break down the immune system
    b. Reduces chance of developing another strain of HIV
    c. Decreases opportunity for drug-resistance mutation
    d. Prevents spread of new HIV infections.

2. What are the barriers to prevention?

    a. Client is HIV+ so there is no need for prevention because they already have the virus
    b. Client has a multitude of issues-depression, substance abuse, domestic violence or sexual compulsivity so prevention is not a priority
    c. Needle exchange programs for Intravenous Drug Users are illegal and unavailable
    d. Client fears that asking their partner to use a condom results in the partner thinking that there is a question of infidelity
    e. Fear of disclosing status
    f. Access to condoms (male and female), dental dams, drug-works (ID Users)
    g. Assumption that if sex partner did not ask to use a condom means that they are also HIV+
    h. Prevention Burnout-people are tired of hearing the same messages
    i. Changing Demographics-prevention messages need to target specific populations.
    j. Providers are not always comfortable talking about risk behaviors, not trained, have time only to focus on medical care and lack resources to refer their patients to services needed.

3. What tools support safer behaviors?

    a. Anal Sex-correctly use a latex condom with water-based lubricant and new condom with each new partner or each act of intercourse

    b. Vaginal Sex- correctly use a latex condom (male or female) with water-based lubricant and new condom with each new partner or each act of intercourse

    c. Oral Sex-Dental dams or non-microwaveable plastic wrap for oral sex on a woman or rimming and a condom for male oral sex.

    d. Other penetrative sex (fisting, handballing or fingering) - use a latex glove and water-based lubricant

    e. Sex Toys-Use condoms or clean with soap and water after using with each person.

    f. Making small steps to support risk reduction.

Goals and Objectives:

1. Participants will understand rational for CDC's Advancing HIV Prevention Strategies
2. Participants will understand the importance of prevention messages
3. Participants will be able discuss options to increase safer sex choices

Condom Demonstration:

Summary and Closing:

- CDC's goal of reducing the number of people becoming infected with HIV is going in the right direction. They have developed strategies such as making HIV testing a routine part of medical care, rapid HIV testing in non-traditional settings, working with HIV + persons to develop risk reduction plans to prevent future infections and decreasing perinatal HIV transmission by encouraging testing of the mother and infant.
- Talking about sexual behaviors is sometimes difficult or uncomfortable but very important. Encouraging providers to talk with their patients about safer sex choices is critical to reducing HIV infection. Not because a person tests HIV positive does it mean they will abstain from sex.
- There are options to choose to continue safer sexual relationships.
- Reducing risk by cleaning drug works and using needle exchange programs is a positive choice.
- Providing information about substance abuse treatment options supports reducing transmission rates.

I have copies of these articles to include in the participant book.

Women Alive Spring Newsletter 2003 –What are HIV-Positive Persons' HIV Prevention Needs?
HRSA Care Action March 2003 Newsletter-Prevention Is Treatment: Prevention With Positives in Clinical Care

Steps to putting on a condom the right way.

1. Talk to your partner.
2. Buy condoms.
3. Check the expiration date of the condom.
4. Check for any holes in the package.
5. Push condom inside the package to one side, and tear open.
6. Blow into the condom to get the sombrero look.
7. Penis is erect.
8. Add water based lubricant to the inside of condom if desired.
9. Massage penis with lubricant if desired.
10. Pinch tip of condom to remove air.
11. Unroll condom down to base of erect penis.
12. Gently smooth out air bubbles.
13. Enjoy having safe sex.
14. Hold the base of the condom when he pulls out to keep the condom from slipping.
15. Remove the condom carefully to keep contents from spilling.
16. Throw the used condom away. (Never use a condom twice).

Sexually Transmitted Disease Chart

STD	Cause (Pathogen)	Symptoms	Treatment	Special Conditions
Chancroid	*Haemophilus ducreyi* (bacterium)	Women: Painful ulcers at entrance to vagina and around anus; may cause pain on urination or defecation, rectal bleeding, pain on intercourse, vaginal discharge; may have no symptoms Men: Painful ulcers on penis or tenderness in groin	Antibiotics	
Chlamydia women, inflam- infer-	*Chlamydia trachomatis* (bacterium-like organism)	Women: Vaginal discharge, pain on urination, spotting after intercourse, dull pelvic pain, bleeding; up to 80 percent have no symptoms Men: Urethral discharge, pain on urination; up to 50 percent have no symptoms	Antibiotics	If left untreated in can lead to pelvic matory disease (PID), tility, ectopic (tubal) pregnancy
Gonorrhea women, inflam- infer-	*Neisseria gonorrhoea* (bacterium)	*Women:* Vaginal discharge, pain on urination, spotting after intercourse, pelvic pain; may have no symptoms Men: Urethral discharge (pus), pain on urination	Antibiotics	If left untreated in can lead to pelvic matory disease (PID), tility, ectopic (tubal) pregnancy
Hepatitis B ongoing	Hepatitis B Virus	Women and Men: Jaundice (yellowing of the skin and eyes), fatigue, abdominal pain, loss of appetite, nausea, vomiting; may have no symptoms	Preventable with a Vaccine	Symptoms may be can result in cirrhosis, cancer of the liver
Herpes skin- more	Herpes Simplex Virus (HSV) types 1 and 2	Women and Men: Painful, blister-like sores (usually in genital area or around mouth), when sores are present pain on urination, headache, backache, fever, malaise	Acyclovir (Zovirax), to lessen the severity of future outbreaks	Can be spread by to-skin contact; is contagious
Syphilis the	*Treponema pallidum* (spirochete)	Women and Men: Primary-chancre (single, firm, painless, bump) on vulva, cervix, penis, nose, mouth, or anus Secondary-skin rash, fever, sore throat, headache, swollen lymph nodes Tertiary-cardiovascular problems, motor disturbances, paralysis, insanity	Antibiotics	Can cause congenital syphilis in newborns if mother is not treated
Trichomoniasis "official" researchers	*Trichomonas vaginalis* (protozoan)	Women: Thin, green or yellow, frothy discharge with foul odor, itching, pain on urination, pain on intercourse Men: Usually without symptoms but may involve urethral discharge, pain on urination, itching	Antibiotics	Not considered an STD by some
Genital Warts skin-	Human Papilloma Virus (HPV)	Women and Men: Small, firm, painless, cauliflower-like bumps that may appear in Clusters; may have HPV with no visible warts	Topical solutions, laser surgery, cryotherapy (freezing)	Can be spread by to-skin contact

Sources: American Social Health Association Internet website: httpJ/sunsite.unc.edu.ASHA/

James K. Jackson, M.D., Wellness: *AIDS, STD, and Other Communicable Diseases*, The Dushkin Publishing Group, Inc., 1992.
Population Reports, *Controlling Sexually Transmitted Diseases*, Series L, Number 9, June 1993.
Public Health Service Healthfacts, *Sex-Transmitted Diseases-Nine More Reasons to Be Careful*!, March 1993.
U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, *Division of STD/HIV Prevention 1994 Annual Report.*
U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Factsheet: *Series on Sexually Transmitted Diseases: Genital Warts.*
U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance,* 1994; 1995.

Navigating the System
Resources in the Community

Topic of Training Segment:
Navigating the System

Time Allotted:
30 minutes.
6-20 participants.

Materials Needed:
Newsprint (one copy for each small group, prepared with question that each group will discuss)
Markers
Masking Tape
Work Sheet –What resources are in your community?
Community Resource Books

Instructions:

Introduce the activity by explaining that participants will be assigned to small groups to brainstorm answers to key questions that will define what a peer is and some roles and responsibilities.

- Pass out worksheet- What resources are in your community?
- Assign participants to 4 groups by counting off 1-4 until all participants are assigned to a group.
- Assign a space in the room for each group.
- Ask participants to go to their assigned group in the respective space.
- Give each small group a piece of prepared newsprint that has a question written on it.
- As each group to appoint a reporter and a recorder
- Instruct group to use the newsprint to brainstorm answers to the question.
- Tell the group they will have about 10 minutes to do this activity.
- Bring the entire group back together and ask each reporter to go over his or her group's work
- Ask open-ended questions to draw out their thoughts on how a peer might be able to support a client in navigating the system both at the agency and community levels.
- Discuss any other brainstorming answers to all the questions.

Goals and Objectives:
Participants will-

- Identify services offered at their respective agency
- Identify community resources.

Summary and Closing:

- Ask participants if they now understand the importance of supporting clients in navigating their agency and community resources.
- Explain to participants that agency and community resources will change based on funding opportunities and restrictions and that it is key to keep up to date on these resources.

Bridge:
We will now go onto another activity.

Wrap Up

"Pulling It All Together"

Topic of Training Segment:

Wrap Up

Time Allotted:

15 minutes

.

Materials Needed:

Newsprint
Markers

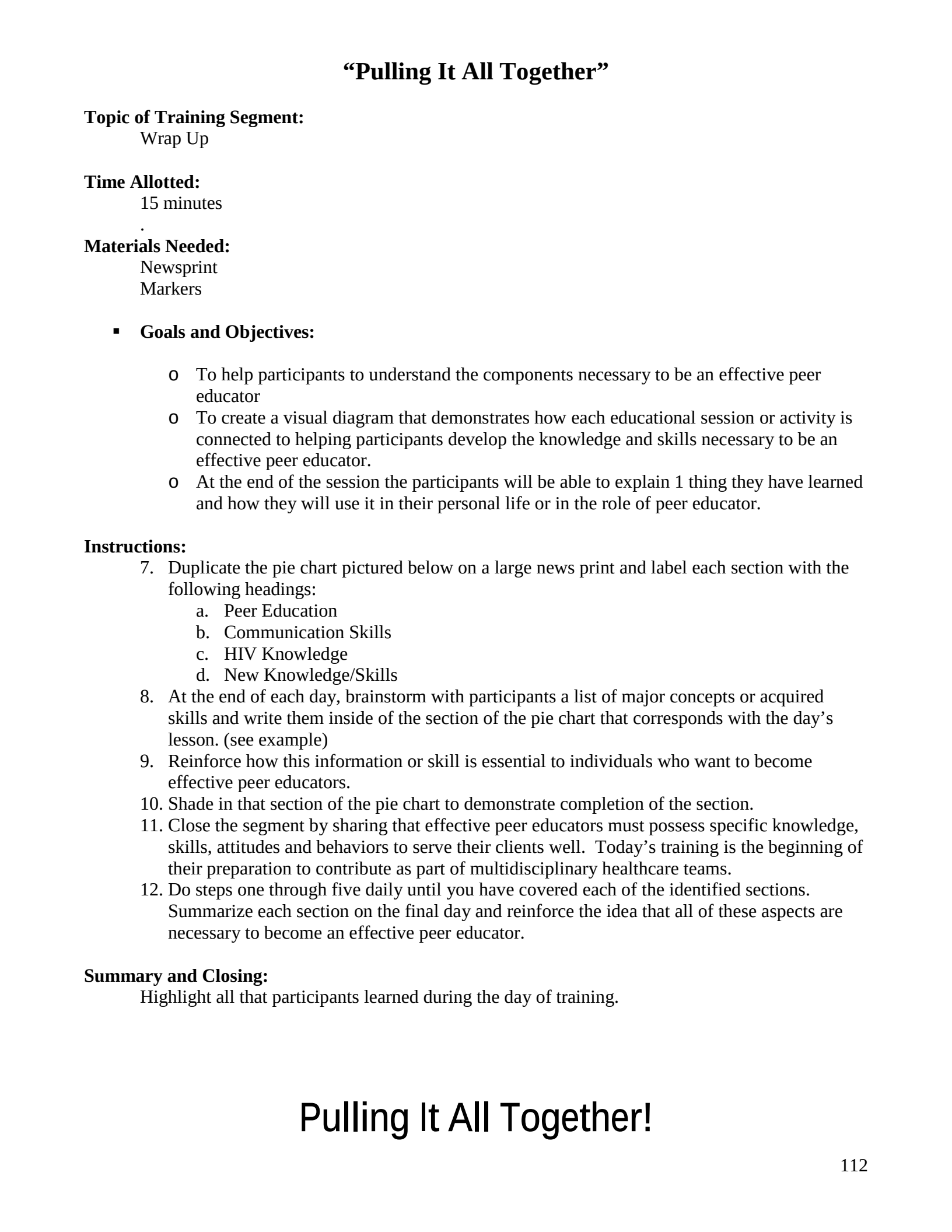
- **Goals and Objectives:**
  - To help participants to understand the components necessary to be an effective peer educator
  - To create a visual diagram that demonstrates how each educational session or activity is connected to helping participants develop the knowledge and skills necessary to be an effective peer educator.
  - At the end of the session the participants will be able to explain 1 thing they have learned and how they will use it in their personal life or in the role of peer educator.

Instructions:

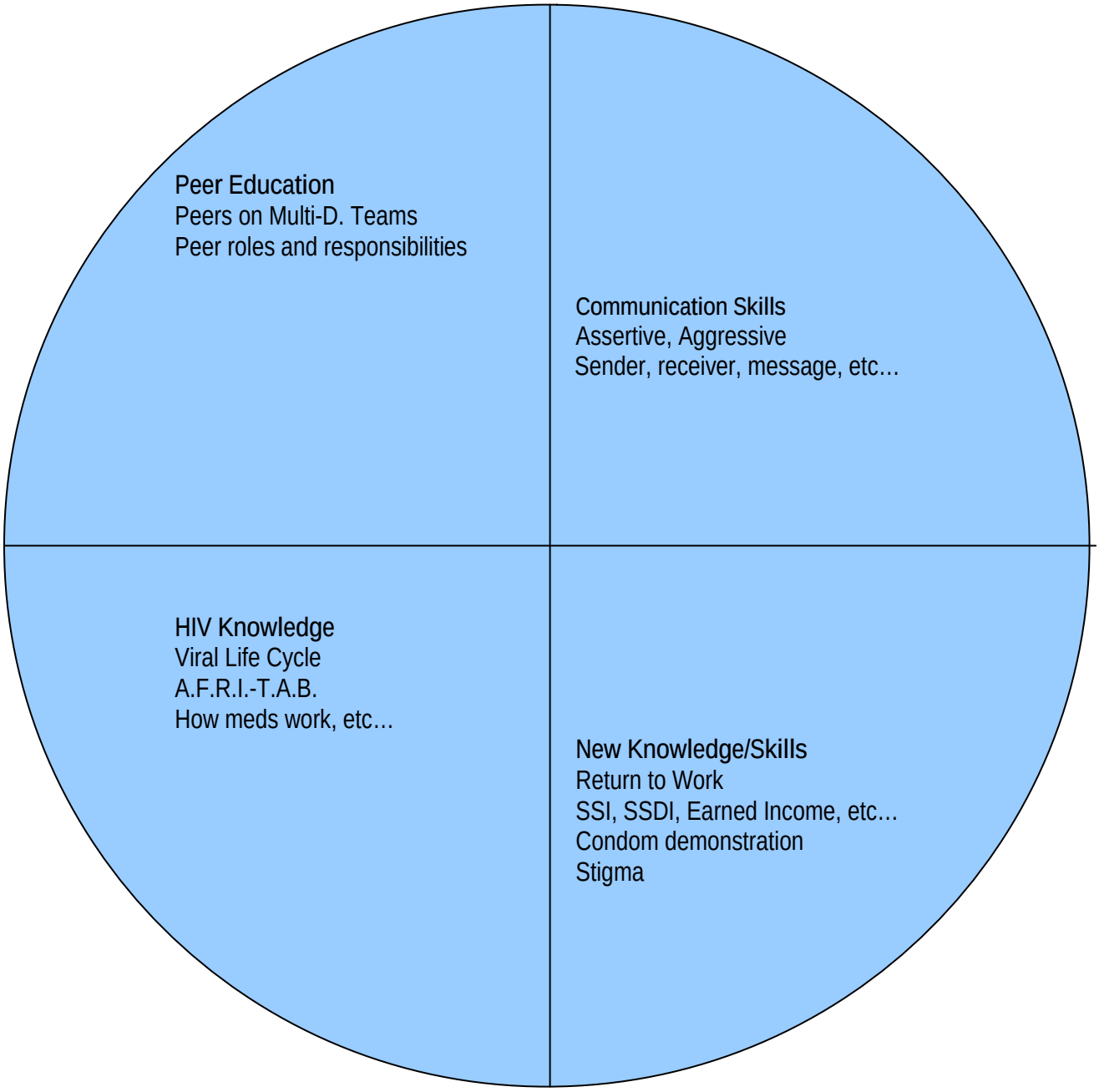
7. Duplicate the pie chart pictured below on a large news print and label each section with the following headings:
   a. Peer Education
   b. Communication Skills
   c. HIV Knowledge
   d. New Knowledge/Skills
8. At the end of each day, brainstorm with participants a list of major concepts or acquired skills and write them inside of the section of the pie chart that corresponds with the day's lesson. (see example)
9. Reinforce how this information or skill is essential to individuals who want to become effective peer educators.
10. Shade in that section of the pie chart to demonstrate completion of the section.
11. Close the segment by sharing that effective peer educators must possess specific knowledge, skills, attitudes and behaviors to serve their clients well. Today's training is the beginning of their preparation to contribute as part of multidisciplinary healthcare teams.
12. Do steps one through five daily until you have covered each of the identified sections. Summarize each section on the final day and reinforce the idea that all of these aspects are necessary to become an effective peer educator.

Summary and Closing:

Highlight all that participants learned during the day of training.



Effective Peer Educator



Day 3 Agenda

Level II Training Agenda
Day 3

Review of Day 2 / Overview of Day 3

Taking Charge – Working in Partnership with Your Provider

What is Stigma?

Break (15 min.)

Special Populations

Return to Work Issues

Balancing Benefits

Lunch – Noon (45min)

Return to Work Issues (cont.)

Workplace Do's and Don'ts

Peer Educator Ethics

Break (15 min.)

Role-Play (3 hours)

Evaluation & Wrap-Up

Review Agenda
&
Day 2

Taking Charge: Working in Partnership with your Provider

Curriculum Template

Topic of Training Segment:

Taking Charge-Working in Partnership with your Doctor

Time Allotted:

30 minutes

Materials Needed:

- Prepared laminated cards with headings for each category (Provider Role, Patient Role)
- Prepared laminated cards with provider and patient roles/responsibilities
- Masking Tape

Objectives:

- Role clarification of provider and patient
- How to become an active participant in your healthcare

Instructions:

- Tape categories/headings to a wall in the room to form 2 columns
- Distribute 2 cards to each participant from the patient and provider roles/responsibilities laminated cards to participants until all are accounted
- Prepare pieces of masking tape that participants will use to attach the laminated provider and patient roles/responsibilities cards to assign to the 2 categories. Let participants know that they should use the masking tape to tape roles/responsibilities to the assigned category.
- Tell participants that they can work individually on this activity or can problem-solve with each other if questions arise in assigning a concept/phrase with a category
- Give participants 5 minutes to tape concepts/phrases with categories

Laminated Cards include:

Provider Role/Responsibility	Patient Role/Responsibility
Support patient interests in healthcare	Learn different provider roles
Be flexible	Be Honest in sharing point of view
Describe both the provider and patient sides of issue	Choose the type relationships-Traditional vs Partnership
Respond Medically	Increase your HIV/AIDS knowledge
Be available	Be prepared emotionally
Know personal issues	Be open
Respect Confidentiality	Prepared list of concerns
	Keep appointments
	Be assertive
	Take notes Bring a support person

Talking Points:

- HIV treatment is complicated, making decisions to begin medications, manage side effects and understand laboratory results requires that both the provider and patient is a good match for each other and have a common goal.

What is the Patient role?

- Learn the different roles of your providers-Doctor, Nurse Practitioner, Nurse, Medical Assistant
- Share your point of view-be honest about your feelings and what is or isn't working for you
- Choose the type of relationship you want with your provider-*Traditional* (the doctor leads the treatment and the patient follows) or the *Partnership* (doctor and patient participate in the decision making process)
- Learn information-increase your knowledge about HIV/AIDS so that you can be an active participant in discussions
- Be prepared emotionally-sometimes the news shared during a medical visit requires that the doctor be more sensitive or maybe a patient wants the approach to be more direct. Utilize supports because there is only so much a doctor can give.
- Be open-tell all that is going on with you-eating, sleeping, medication side effects, exercise, partying, smoking etc
- Take advantage of your time with the doctor by being prepared with a **list** of questions, concerns, alternative therapies you want to try, changes to your listing situation etc. Bring a copy for your doctor.
- Keep your appointments, be on time, call if delayed
- Be assertive-get the answers you are searching for, ask questions if you don't understand until you understand
- Take notes, fact sheets or bring a support person who can take notes and help you understand.

What is the Provider role?

- Support patient's interest in their healthcare-allow the patient to be an active participant by listening to their questions/concerns and the patient will usually do the same. It builds trust.
- Be flexible – Listen openly to what clients have to say about their treatment, questions they have because the disease treatment options are ever evolving and because patients have increase HIV knowledge.
- Describe both sides of the issue- medical reasoning versus the patient point of view. Support clients in making the right decision even if it may not be what you recommend.
- Respond Medically- Provide monitoring to their patients even if the patients sometimes do what is not recommended by the doctor. It is important to not refuse monitoring as it diminishes the relationship.
- Be available to their patients- accept new patients, follow schedules.
- Know their patients personal issues- take an interest in their patients outside of management of the disease
- Confidentiality-ensure that this is respected.

Discussion Questions:

- Review each heading and matching role/responsibility
- Ask group if there are additional role/responsibility that they would associate with the headings

Summary and Closing:

As you can see it is critical that a patient decides the type of relationship they want with their provider, understand the roles and responsibilities that each play in the relationship and be active participants in achieving the ultimate goal- good health and good quality of life.

Handout

What is Stigma?

Stigma Discussion

Activity Template

Topic of Training Segment:
HIV/AIDS Stigma

Time Allotted:
20 minutes

Materials Needed:
Key terms
Laptop and projector with screen or blank wall

Objectives:
- Participant will be able to define key terms associated with stigma development.
- Participants will be able to discuss differences between key terms associated with stigma development.
- Participants will be able to identify the relationship between HIV/AIDS stigma and barriers to HIV/AIDS services.
- Discuss the disparities in access to HIV/AIDS services and care experienced by racial/ethnic minorities

Instructions:
The facilitator will:
1. Read all 5 key term words and the official definitions of the key terms from power point. (Optional - facilitator can give more examples).

Key Terms (power point slides)

Stereotype
Prejudice
Racism
Bias
Stigma

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

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

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

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

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

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

Stereotypes
Prejudice
Racism
+ Biases
= Stigma

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

Stigma Impacts:

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

Countering Stigma

- **Multi-level Interventions**
  - Women of color
  - Gay
  - MSM of color
  - Community at large
- **Interventions**
  - Individual level
  - Community level
- **Reduction Methods**
  - Information dissemination
  - Counseling
  - Coping skills
  - Contact with those affected

Discussion Questions:

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

Summary and Closing:

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

Bridge:

Contact Information
http://www.nmac.org/nmac2/stigma/resource/main.html

Managing HIV/AIDS in Special Populations

Curriculum Template

Topic of Training Segment:
Special Populations

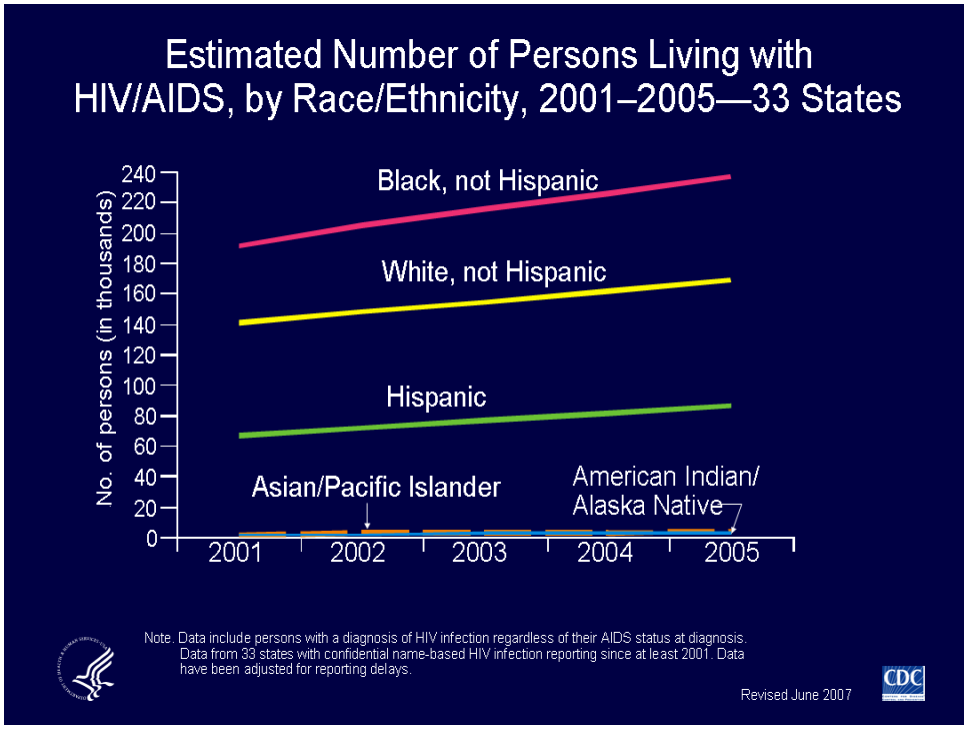
Time Allotted:
30 minutes

Materials Needed:
Laptop
Projector with screen or blank white wall
Participant booklet to follow lesson on power point
Centers for Disease Control Fact sheets – Reference www.cdc.gov/hiv/topics/survelliance/basic

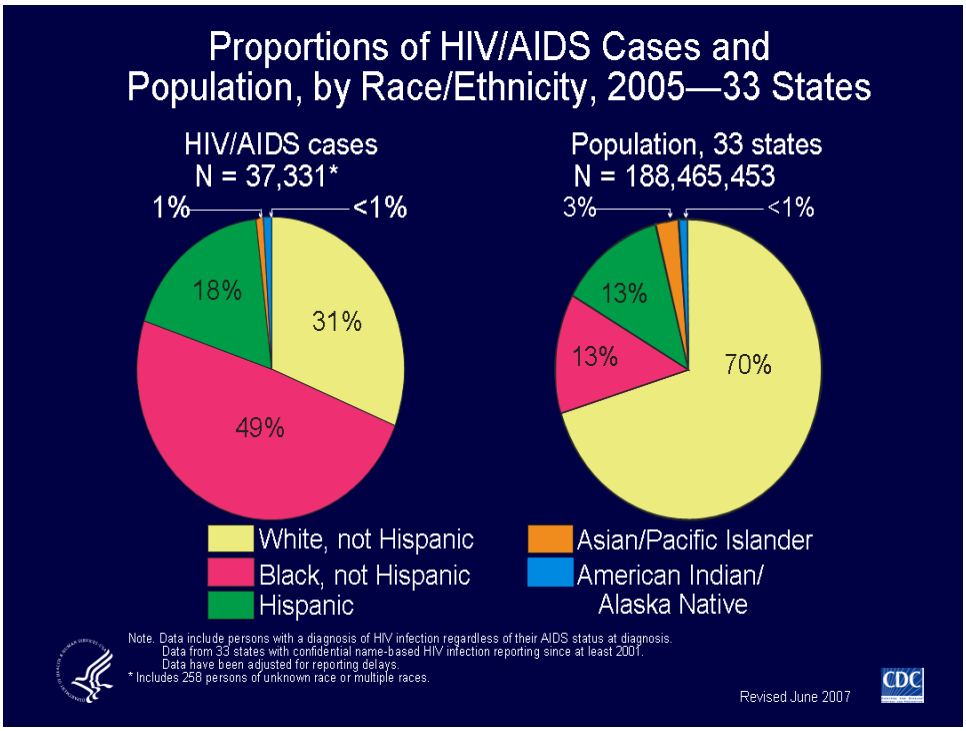
Objectives:
- Understand the risk and challenges that special populations have with regard to living with HIV/AIDS
- Understand what ethnic groups are affected in this pandemic which is increasingly becoming problematic and why they are facing such challenges
- Understand reported health statistics for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

Instructions:
- Participants will follow power point presentation on Special Populations.
- Participants will follow along using presenter slide notes.

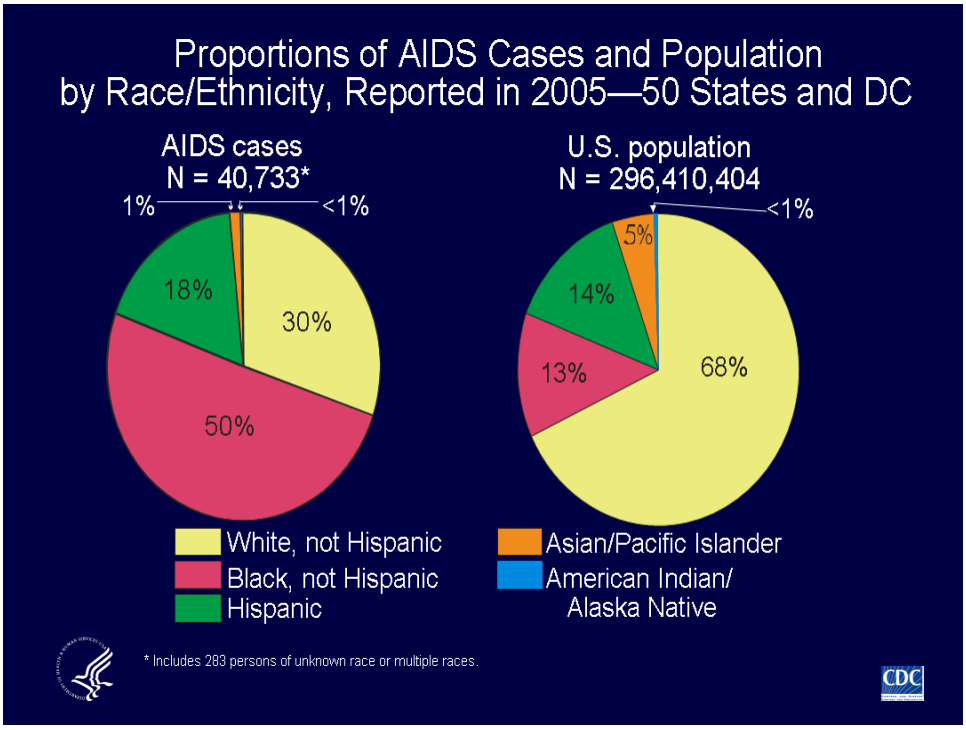
Special Populations
- Rates of HIV/AIDS are highest and growing in the African American population
- Overall survival rates have improved over the last 10 years
- Unique considerations require attention to improve HIV/AIDS management among African Americans and Hispanics



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



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



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

Facilitator Notes

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

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

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

*Includes 33 states with long-term confidential name-based HIV reporting.
**Includes 50 states and the District of Columbia.

Hispanics & HIV/AIDS

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

**Includes 50 states and the District of Columbia.
Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 2005

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

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

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

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

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

MSM & HIV/AIDS

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

Includes 33 states with long-term confidential name-based
HIV reporting
Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 2005

Women

- Women with AIDS made up an increasing part of the epidemic. In 1992, women accounted for an estimated 14% of adults and adolescents living with AIDS in the 50 states and the District of Columbia. By the end of 2005, this proportion had grown to 23%.
- Of 40,608 AIDS diagnoses in the 50 states and the District of Columbia, 10,774 (26%) were for women
- Of the 126,964 women living with HIV/AIDS, 64% were black, 19% were white, 15% were Hispanic, 1% were Asian or Pacific Islander, and less than 1% were American Indian or Alaska Native
- Social and medical aspects of HIV tied together (care of children and household – tend to put yourself last)
- 1 in 4 women eligible for HAART - are on the regimen

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

Women-Pregnancy

- Transmission rate (with treatment) from mother to infant is as low as 2% with some studies showing a zero transmission rate
- Transmission rate (without treatment) is a one in four chance of passing the virus on to babies
- Still 90% of pregnancies in HIV-infected women are unplanned
- Risk increase with vaginal versus cesarean delivery, mothers with high viral

loads, and mothers who breastfeed increases – 28%
- All babies receive treatment from 3 to 6 months

Youth
- An estimated one-fourth of HIV infections occur among ages 21 and younger
- In 2005, 2,283 estimated AIDS cases among people ages 15 to 24
- Given the average time from HIV infection to progression to AIDS, poor access to HIV testing, and lack of HIV reporting systems surveillance data do not reveal the scope of the epidemic among adolescents
- Barriers are:
  - limited understanding of HIV disease;
  - links between the disease and behaviors;
  - feelings of invincibility;
  - lack of youth friendly counseling and testing facilities;
  - fear of being tested and of receiving the test result;
  - and consent and confidentiality concerns

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

Children
- New infections of children are rare where antiretroviral medications and good medical care for pregnant women are available
- According to U.S. health statistics, age 13 or younger is counted as a child
- The cumulative estimated number of AIDS cases through 2005 is 9,112
- Children's immune systems are still developing; CD4 cell counts and viral load counts are higher and infant's viral load usually declines until age 4 or 5 then stabilizes
- Children respond differently to ARVs and have larger increases in CD4 cell counts and they recover more of their immune response than adults
- There are approximately 12 ARVs approved for use by children

U.S. Census Bureau, 2004, CDC and Prevention (CDC). HIV/AIDS Surveillance Report 2004
Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report 2005

Aging
- Nearly 27% of people living with AIDS in the U.S. are 50 or older
- Numbers of cases, will increase as people of all ages survive longer due to triple-combination drug therapy and other treatment advances
- Despite myths and stereotypes, many seniors are sexually active, and some are drug users
- Health care and service providers – and older adults do not realize they are at risk as other age populations; often are reluctant to discuss or question matters of sexuality with aging patients/clients
- Older adults are not routinely tested
- Seniors are unlikely to consistently use condoms during sex due to generational mindset and unfamiliarity with HIV/STD prevention methods

Substance Abuse
- The spread of HIV disease in the U.S. is fueled by use of illicit drugs, direct transmission – sharing needles, indirect transmission - sexual contact with HIV-positive injection drug users

- Non-injected drugs increases risk for HIV because of its effect on decision making and sexual risk taking
- Without treatment for drug problems, substance abusers have difficulty adhering to therapies and accessing care
- In 2004, estimates of new AIDS cases through IDU exposure were:
  - 21.5 percent - adolescents and adults
  - 19.2 percent – men
  - 27.8 percent - women

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

Mental Health with HIV/AIDS

- Common psychological disorders - Men and Women:
  - Depression
    - Low self esteem, anxiety, forgetfulness, sleep disturbances, changes in appetite, weight loss or gain, decreased libido, sense of hopelessness
  - Anxiety
    - Sense of numbness, emotional detachment, or a dazed state
    - Types of anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and phobias
  - Dementia (AIDS Dementia Complex or ADV) common among people with advanced HIV
    - Problems thinking clearly, lack of concentration, loss of memory, social withdrawal, sluggish thinking, short attention span, poor coordination, impaired judgment, vision problems and altered personality

Critical Issues & Risk Factors for HIV/AIDS in Special Populations (Power point slides)

Risk Factors often overlap for Special Populations (such groups included in this list are women, children, youth, persons with sexuality and gender differences, substance use and mental health challenges).

- Psychosocial Issues
  - Poverty
    - Poorer than the general population
    - Live below the poverty line
    - Homelessness
  - High risk heterosexual contact
    - Relationship inequality (age, power)
    - Fear of abuse or partner leaving
  - MSM (unprotected sex and STD's increase risk)
  - Denial or unaware of risk (monogamy, marriage, bi-sexuality)
    - Underestimate their risk
    - Overestimate how safe their partners are
  - Sexually Transmitted Diseases
  - Substance abuse
  - Social discrimination and cultural issues (stigma may inhibit accessing health care and testing)
  - Mental Health (Depression, Anxiety, Dementia (AIDS Dementia Complex or ADV)
- Health Disparities
  - Limited healthcare
  - No health care (minorities less likely to receive care)
  - Poor access (i.e. rural area, transportation, resources)

- Provider insensitivity
- Provider lack of cultural competency
- Provider lack of knowledge

- Racial and Ethnic Minorities Healthcare
  - Less likely to receive combination therapy
  - Less likely to receive drugs to address opportunistic infections
  - Less likely to be admitted to the hospital when presented to the emergency department
  - Less frequently monitored by a health care provider on a regular basis
  - Test late in the disease process
  - Minorities experience poorer health outcomes
  - Receive lower quality health care than whites do, even when insurance status, income, age, and severity of conditions are compared

Shapiro, et al. 1999. Variations in the care of HIV-infected adults in the US. JAMA, 281:24(June):2305-2315
**MMWR. Late versus early testing of HIV-16 sites, United States, 2000-2003. June 27, 2003/Vol.52/No.25.

Special Populations

- ***Of all the forms of inequality, injustice in health is the most shocking and the most inhuman***

  - Dr. Rev. Martin Luther King Jr.

Discussion Questions:

- Do you see the need for the HIV/AIDS community and our government to promote programs that focus on Special Populations due to the higher incidence of infection?
- What do you feel will happen if these programs are not funded and/or promoted?
- Is there validity in promoting HIV/AIDS programs in the specific communities to target special populations?

Summary and Closing:

In summary, there are many critical issues and risk factors that we've discussed that contribute to the increase of HIV/AIDS despite the numerous Prevention and Intervention programs offered, it is the burden of society as a whole to continue to define strategies and methods to meet this pandemic.

Bridge:

We are our brother's keeper and as Dr. King's quote says – "*Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."* We must continue to demand equality and justice in our healthcare system.

Return to Work Issues:
Balancing Benefits

Curriculum Template

Topic of Training Segment:

Return to Work Issues-Balancing Benefits.

Time Allotted:

45 minutes

Materials Needed:

Computer
Projector
Screen/White Wall

Goals and Objectives:

- Participants will gain knowledge about the different state and federal benefits available to persons with disability or needing assistance
- Participants will understand the impact of employment to their benefits
- Participants will become knowledgeable about the return to work plans offered by Social Security Administration
- Participants will have a list of resources to further gather information related to back to work issues

Key Points:

- Thinking about returning to the work force after being diagnosed with a disability and receiving benefits requires thorough research as you explore how a salary or a stipend may impact your benefits.
- This segment will give you an overview of how benefits maybe affected by employment income
- We will review the different State and Federal Funds guidelines to ensure that you make the best decision for yourself.
- We will provide you with resources so that you can personally meet with a benefits expert who will give you that one-on-one guidance you seek.

Talking Points (On Slides)

Basics!!!!

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

Glossary

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

What is SSI & SSDI?

- Both programs are administered by the SSA and offer benefits to individuals who are unable to work due to physical or mental disabilities which at least 12 months
- SSDI provides benefits to disabled or blind individuals who are "insured" by workers' contributions to the Social Security trust Fund. These contributions are required by the Federal Insurance Contributions Act (FICA) which created Social Security taxes which are paid based on your earnings or those of your spouse or your parents.
- SSI makes cash assistance payments to aged, blind and disabled individuals (including children under age 19) who have limited income and resources or do not qualify for SSDI or whose SSDI is less than the SSI standard amount. Federal Government funds SSI from general tax revenues.
- A person is said to be "concurrent" if they receive benefits from both SSI and SSDI.
- Apply for benefits at SSA and eligibility is determined

How Employment Earnings Affect SSI?

- Must report your earnings monthly to SSA
- When other income goes up your SSI goes down
- When you earn more than your SSI limit (max $637 in 2008), your payments will stop for those months
- SSA disregards the first $85 you earn
- Disregards Impaired Related Work Expenses (prescription drugs, transportation, personal attendant, job coach, cane, a wheelchair or any specialized work equipment)
- Disregards ½ of your earned income
- Example: You work and earn $1,000 in December. You receive no other income besides your earnings and your SSI. SSA would deduct $457.50 from your SSI payment for December.
  $1,000
  -$85
  $915 divided by 2= $457.50
  December SSI check would be $601-$457.50=$143.50
  December income would be $1000 (earned income) + $143.50 (SSI) = $1143.50
- If you lose your SSI b/c your income exceeds your SSI payments and you become unable to work again because of your medical condition, you may ask SSA to start your payments again. You will not have to file a new disability application if you make this request **within 5 years** after the month your benefits stopped.

How Employment Earning Affect SSDI?

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

SSA Ticket to Work Program

- Available to SSDI or SSI recipients
- Voluntary program

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

PASS Program

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

Public Assistance Programs managed by Missouri Family Support Division

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

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

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

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

Medicare Impact

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

Contact Information:

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

Create a Plan of Action

What is your goal?

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

Determine Your Goal

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

Plan Your Future

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

Summary and Closing:

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

Return to Work Issues:
Workplace Do’s & Don’ts

Curriculum Template

Topic of Training Segment:

Return to Work Issues - Workplace Do's & Don'ts

Time Allotted:

30 minutes

Materials Needed:

- Projector
- Laptop
- Screen/Wall

Instructions:

- Follow the power point presentation
- Use slide notes as a reference during presentation

Goals and Objectives:

- To orient participants about basic questions they may about returning to work.

Answers to questions you want to know, but don't want to ask?

- ✓ <u>What are my hours?</u>
  - o It is important to know what hours you report to work and end your day
  - o Depending on the number of hours your work/volunteer agencies will encourage you to take a 15 minute break or/and a lunch break
- ✓ <u>How should I dress when going to work?</u>
  - o Present in a professional manner-dress code, grooming, personal hygiene
  - o Business casual-slacks and shirts, skirts/slacks and blouse, sweaters, vests, sport-coats, blazers and shoes. Examples of what not to wear-caps/hats, exercise gear, shorts/tank-tops, slippers/flip-flops, clothing with inappropriate words/pictures, clothing that is wrinkled, ripped, frayed
- ✓ <u>What is confidentiality in the workplace?</u>
  - o Working with patients who have a chronic disease is sensitive and requires a high degree of confidentiality. It is critical that patients know that their records are stored confidentially and that staff working with them will not reveal information about the services they provide. Patients have to complete written consent forms to have their records shared with another provider.
- ✓ <u>What are my job responsibilities?</u>
  - o A job description is provided to staff or volunteers
  - o Understand daily job tasks that need to be completed
- ✓ <u>Will I have an agency orientation?</u>
  - o Human Resources or your Department Supervisor will schedule for new hires to meet with managers of all agency departments to become familiar with agency services.
  - o Usually occurs within the first 30 days of employment.
  - o There maybe orientation to agencies in the community to increase knowledge of services
- ✓ <u>Do I have to fill out timesheets?</u>
  - o Timecards or timesheets are used to track the number of hours a person works or volunteers. Human Resources will provide education on task.
- ✓ <u>Can I use the agency phone for personal business?</u>
  - o If you are unsure ask your supervisor

- Use discretion when using the phone
- Use when on a break

✓ Should I have my cell phone on when working?
- If you are unsure ask your supervisor
- Use of vibrate or ringer off option

✓ How and who to report a problem in the workplace?
- Report concerns to your supervisor
- Report concerns to Human Resources if it relates to your supervisor, sexual harassment or discrimination

✓ Will there be parking?
- Agency may have parking lots available to staff who drive.

✓ Are there transportation assistance benefits?
- Discounted monthly bus passes programs.

Summary and Closing:

This topic raises lots of questions that you may have about working or volunteering at an agency. I hope it's been a lively discussion and helped relieve some anxieties that you had. Most agencies will provide your will an orientation and employee manual which will be your guide in being successful at your placement.

Peer Educator Ethics

Topic of Training Segment:
Ethics and Peer Educators

Time Allotted:
30 minutes.
6-20 participants.

Materials Needed:
Newsprint (one copy for each small group, prepared with question that each group will discuss)
Markers
Masking Tape
Write the following questions on 3 pieces of newsprint:

1. What are Ethics?
2. Why are they important?
3. What are some ethical standards peers should follow in working with clients?

Instructions:
Introduce the activity by explaining that participants will be assigned to small groups to brainstorm a list of Ethics and standards for Peer Educators should follow.

- Assign participants to 3 groups by counting off 1-3 until all participants are assigned to a group.
- Assign a space in the room for each group.
- Ask participants to go to their assigned group in the respective space.
- Give each small group a piece of prepared newsprint that has the 3 questions written on it.
- Ask each group to appoint a reporter and a recorder
- Instruct group to use the newsprint to brainstorm answers to the question.
- Tell the group they will have about 10 minutes to do this activity.
- Bring the entire group back together and ask each reporter to go over his or her group's work
- Ask open-ended questions to draw out their thoughts on the Ethical Standards that Peer Educators should follow.
- Discuss any other brainstorming answers to all the questions.
- Review resource-Ethical Standards for Peer Educators.

Goals and Objectives:
Participants will-

- be able to describe what is Ethics
- be able to identify ethical standards that peer educators should follow.

Potential answers to brainstorming Ethical Standards for Peer Educators:

Ethics are principles that govern right and wrong practices and moral conduct.

Ethical Standards for Peer Educators.

These principles may include but are not limited to:

Propriety	The Peer Educator shall maintain high standards of personal conduct in the capacity as a Peer Educator.
Competence and Professional Development	The Peer Educator shall strive to become and remain proficient in the performance of his/her professional function.
Integrity	The Peer Educator shall act in accordance with the standards of professional integrity.
Privacy of Client's Interests	The Peer Educator's primary responsibility is to client's rights and prerogatives as well as their general health and well being. The Peer Educator shall make every effort to foster maximum self-determination/empowerment on the part of clients.
Confidentiality and Privacy	The Peer Educator shall respect the privacy of clients and hold in confidence all information obtained in the course of professional service.
Respect, Fairness and Courtesy	The Peer Educator should treat clients and colleagues with respect, courtesy, fairness and good faith.
Community Service	The Peer Educator should assist in making Treatment Advocacy/Education services available to the general public.
Employment Commitments	The Peer Educator should adhere to commitments made to the employing organization
Maintain Integrity	The Peer Educator shall uphold and advance the values, ethics, knowledge, and mission of the Peer Program.
Knowledge Development	The Peer Educator shall take responsibility in continuing his/her education/training to provide peer services.

Edited and adapted from the Standards of Care Committee, HIV/AIDS Treatment Advocacy/Education, Los Angeles County Commission on HIV Health Services.

Summary and Closing:

- Ask participants if they now understand how important ethical standards are in the work that peer educators do with clients
- Explain to participants that ethical standards help new peer educators in the management of peer/client relationship
- Explain that ethical standards provides the general public information that they can to hold peer educators accountable

Bridge:

We will now go another activity that will clarify the knowledge, skills and qualities need to be a Peer Educator. This activity will mirror some of the answers that you developed in the previous activity and further intrigue you to become a Peer Educator.

Role-Play

Topic of training segment
Role-Play
Time allotted
3 hours
Materials needed
Dry erase / chalk board or newsprint, markers and tape, Role-Play scenarios
Objectives
To give participants an opportunity to put into practice the skills they have learned during the course of the training and to receive feedback from the group and facilitators.

Introduction

Write on the board or prepare a piece of newsprint with the following skills learned over the last three days of the training. This can be done as a brainstorm, allowing participants to briefly review the skills. The list should look like this:

Viral Life Cycle
Stigma
Disclosure
Special Populations
Medications
- Side Effects (long & short term)
- Lab Values
- Adherence Issues (tools)
- Cultural Issues

Motivation
Association
Repetition
Use of Senses

Styles of Communication
Passive
Passive Aggressive
Aggressive
Assertive
Non-Verbal
- Facial expression
- Body language

Message
Sender ↔ Receiver
Understanding

Attentive Listening
- Nodding
- Yes, uh huh
- Asking questions

Rephrasing

Divide group into pairs. Cut role-play scenarios into individual strips of paper, and let participants blindly choose which role-play they will perform. Allow them to work with their partners for 10-15 minutes to prepare for their role-play. If a participant is uneasy with a role-play scenario, allow him or her to choose a different one.

Directions for Role Play
Remind role-play participants not to lose the focus of the situation they are acting out (i.e. getting caught up in a values-based debate. If Participants slip out of their roles, they lose the protection role-playing affords, and the situation may become sensitive. It is up to the facilitator to make the environment safe for those participating in the role-play.

o Set ground rules

All need to feel that they will not be attacked or teased about their role-playing.

Call time-out if needed.
Stay in role during the role-play
Don't get personal.

o Performing the role-play

Always begin the role-play with a clear signal, such as announcing, "You are now in role." Some instructors put up a sign with "In Role" written on it.

An important skill for instructors is "letting go," which simply means that, once participants are put "in role," the instructor allows them to perform the role-play without interruption. If a role-play seems to struggle, the instructor can steady it by giving minimal feedback or directions.

Watch for any signs that participants may be troubled about personal issues connected to the role-plays. *This is important if any participant too closely identifies with their role.* If emotions get out of hand, step in and remind them of the time-out option or refocus the role-play to be less emotional. If needed, end the role-play.

Role-play instructions taken from the American Red Cross' African American HIV/AIDS Instructor Trainer Manual.

Role-play Scenarios for P2P Level 2

1.
Henry, a 70 year old widow, recently moved into a retirement community where he leads a very active life. He is an avid tennis player and loves to travel to exotic countries. Lately, Henry complains of feeling uncharacteristically tired, so he scheduled an appointment with his doctor for an evaluation. That is when he was diagnosed with HIV. Shocked and nervous, Henry expressed his fears about dying and of his friends finding out to his doctor. His doctor suggested that he meet with the peer educator before leaving the office so that could learn about support groups and how a peer could help him manage his diagnosis.
(Please address HIV 101, disclosure, support group information, educational groups)

2.
Jenny, a HIV positive single mother of 3 just found out that she will lose her housing assistance in 30 days. She doesn't know what to do because she cannot afford the rent with out assistance. Moving in with her family is not an option either since all of her family lives out of state. To add to her dilemma, Jenny has been experiencing night sweats and painful tingling sensations in her feet when walking. Jenny's peer educator has been a tremendous support to her lately, so she scheduled an appointment to meet to develop a plan of action.
(Please address community resources, medication side effects, talking with healthcare provider)

3.
Bryson is HIV positive, a successful attorney and lives a lavish life with his partner of 5 years. Six months ago Bryson and his partner purchased a new home in an exclusive neighborhood in their city. In the beginning things were great. They entertained their neighbors for dinner as often as once a week. It wasn't long when Bryson noticed that his neighbors were less and less available to visit. Then a light bulb went off in his head! Bryson remembered the day that his HIV medications were accidentally delivered next door. They were packaged in a plain wrapper, but he can't seem to shake the feeling that his neighbor knows his status. Bryson shares his concerns with his peer educator as he considers how to handle this situation.
(Please address Stigma and disclosure issues)

4.
Fred is a charismatic, high energy, newly diagnosed HIV positive man who has enrolled in the peer program at his local clinic. Every time Fred meets with his peer educator he seems to be so hyper that it causes alarm with his peer educator. The source of Fred's excited mood is methamphetamines. During the session, the peer educator learns that Fred forgets to take his medications. The peer would like to discuss the effects of mixing street drugs with his ARV's and how forgetting to take his medications could lead to drug resistance.
(Please talk about the importance of adherence, explain drug resistance and community resources for drug treatment)

5.
Pedro and Maria have been together for a year and have decided to take their relationship to the next level to include sex. Maria was diagnosed with HIV before her relationship started with Pedro who is HIV negative. Their relationship has been very open and built on trust. Maria and Pedro decide to meet with a peer educator to discuss prevention methods. When Maria and Pedro arrive to the meeting it becomes very clear to the peer educator that language is a barrier because Maria and Pedro do not speak English well. The peer educator also notices that when he asks Maria questions about her sexual history, Pedro responds. The peer educator is not sure how to help them as he doesn't speak Spanish.
(Please problem solve language and cultural barriers, HIV 101, condom usage skills)

6.
Jodi is HIV positive and very adherent to her health routines. She takes her ARV's as prescribed by her doctor the right way every time except for one medicine. To her surprise her doctor recommends that she begin a new drug regimen. It seems that she has developed resistance to her current treatment. Jodi visits her peer educator to understand more about resistance.
(Discuss resistance and how to talk with her physician)

7.
Murphy is an HIV positive health and fitness coach who has been medication free for 7 years because his viral load was low and his CD4 count has remained above 350, until recently. Due to changes in his lab results, Murphy's doctor suggests starting ARV's to manage his HIV disease progression. Murphy believes in herbal treatment methods and does not want to use traditional HIV medications. He schedules a meeting with his peer educator to discuss his concerns.
(Discuss treatment options and how to talk with his physician)

8.
Leon is an African American community activist in one of this country's largest city. His role has made him very visible and the public watches his every move. When Leon was diagnosed with HIV three months ago he became overwhelmed with thoughts of people in the community finding out and discriminating against him publicly, so he moved to a small rural farming community where his mother lives. Leon felt very depressed and isolated from his life in the big city, so his mother suggested that he visit a peer educator at their local hospital. Reluctantly, Leon agreed and scheduled an appointment. When Leon arrived to his session he was greeted by his peer educator, a short, bald, overweight, older white male. Leon gasped as he followed the peer educator to the private meeting room.
(Discuss mental health referrals and address cultural barriers and changes to life in a rural community.)

9.
Michael is a newly diagnosed HIV positive man who agreed to participate in the peer program at his doctor's suggestion. During his first two visits with his peer educator, Michael was very talkative but his tone of voice seemed hostile. The peer educator noticed the tension in their relationship, so during their third visit he asked Michael to rate his level of comfort during their visits on a scale from one to ten, one being very comfortable and ten, most uncomfortable. Michael quickly took offence and rose to his feet assuming a defensive posture. Then he blurted, "Don't you go trying to get in my head! I hate it when people try to get in my head! If you ever do that again… well… I'm not sure what I'll do." The peer educator is stunned by the Michael's behavior, but he remains seated and considers what to do next.
(Address boundaries and effective communication)

10.
Darlene is an HIV positive transgender woman who learned of her HIV diagnosis while preparing for the last phase of her transition - sexual reassignment surgery. Darlene is sure of her decision to transition, so she agreed to take part in the peer program to receive support in incorporating HIV treatment into her current health routines. When Darlene's peer reviews her file prior to their appointment, she notices that Darlene has had 2 STD's within the last 6 months. The peer educator decides that this should be addressed. During the session, Darlene shares that she exchanges sex for money to save money to pay for her surgery. She knows the risk of re-infection, but she doesn't see any other way of earning that amount of undocumented money. Darlene doesn't want to risk losing her benefits by making too much money legally.
(Discuss prevention options, disclosure/legal issues)

11.
Sylvia is HIV positive and diagnosed with mild retardation. Sylvia lives in a residential care facility with other people who have similar mental challenges. The facility staff has requested assistance from the peer program to help educate Sylvia about HIV. Sylvia responds well to a one on one learning environment. A peer from the peer program meets with Sylvia.
(Discuss HIV:101)

Evaluation
&
Wrap Up

"Pulling It All Together"

Topic of Training Segment:

Wrap Up

Time Allotted:

15 minutes

.

Materials Needed:

Newsprint
Markers

- **Goals and Objectives:**

  - To help participants to understand the components necessary to be an effective peer educator
  - To create a visual diagram that demonstrates how each educational session or activity is connected to helping participants develop the knowledge and skills necessary to be an effective peer educator.
  - At the end of the session the participants will be able to explain 1 thing they have learned and how they will use it in their personal life or in the role of peer educator.

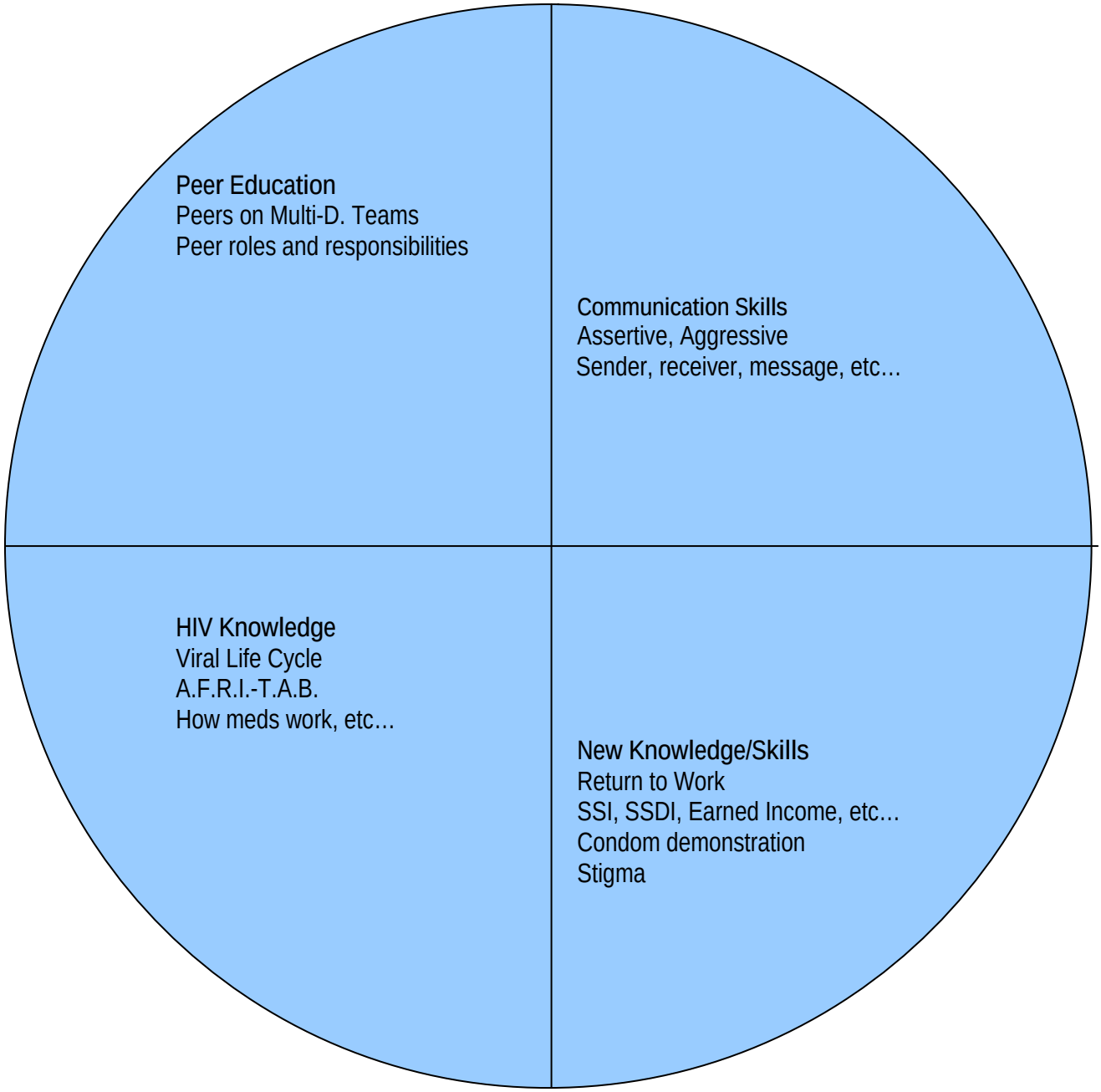
Instructions:

13. Duplicate the pie chart pictured below on a large news print and label each section with the following headings:
    a. Peer Education
    b. Communication Skills
    c. HIV Knowledge
    d. New Knowledge/Skills
14. At the end of each day, brainstorm with participants a list of major concepts or acquired skills and write them inside of the section of the pie chart that corresponds with the day's lesson. (see example)
15. Reinforce how this information or skill is essential to individuals who want to become effective peer educators.
16. Shade in that section of the pie chart to demonstrate completion of the section.
17. Close the segment by sharing that effective peer educators must possess specific knowledge, skills, attitudes and behaviors to serve their clients well. Today's training is the beginning of their preparation to contribute as part of multidisciplinary healthcare teams.
18. Do steps one through five daily until you have covered each of the identified sections. Summarize each section on the final day and reinforce the idea that all of these aspects are necessary to become an effective peer educator.

Summary and Closing:

Highlight all that participants learned during the day of training.

Pulling It All Together!
Effective Peer Educator



Administer Evaluation