The Creation and Evaluation of an Education Manual for Facilitators of the
HIV/AIDS Peer Education Diploma Program

by

Meagan Rogers

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Dedication

For those living and those we’ve lost.

This manual is dedicated to the people who are currently living with HIV/AIDS and to those that we have lost. Additionally, this manual is dedicated to everyone else who experiences stigma, harassment, discrimination, or marginalization due to others lack of association, education, or compassion.

Education is important because what you didn’t want to know yesterday might be what you need to know tomorrow.
Abstract

The *HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program* manual was created as a resource for HIV/AIDS Regional Services staff. The manual was created as a facilitator’s guide and was designed for use with a population of women who are new to Canada. The manual was developed in four parts. Part one opened the manual with the purpose of the program, an outline for recruiting group members, and the intended audiences for the peer education program. Part two outlined each of the eight weekly sessions, organized by session. Each session included a pre-group note, required materials for the group, and content for a two-hour group session. Part three displayed a small list of local services that were available to people living in Kingston, ON. The final section included all of the handouts and take-home information that would be used during the program. The manual was evaluated in its entirety by HARS staff and students who agreed that it was accurate, well put together, and would be an asset to the agency. The manual had its limitations but, more importantly, had its strengths. Among the major strengths were women in the community being provided with an opportunity to free and accessible education, the HIV/AIDS awareness that can be created by peer educators, and HARS’ increased representation in the community. Future recommendations included implementing the peer education diploma program with a group and assessing the results with pre- and post-test measures.
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Chapter I: Introduction

Human immunodeficiency virus (HIV, the virus known to cause AIDS) and acquired immunodeficiency syndrome (AIDS) have been and continue to be two of the world’s most challenging and severe health concerns (U.S. Department of Health & Human Services, 2015a). Since the first diagnosed case of what would later be known as HIV in 1981, the virus has claimed over 34 million lives (World Health Organization, 2015b). HIV is currently affecting more than 37 million people world-wide (World Health Organization, 2015c), 70,000 of whom are Canadian (Government of Canada, 2015). The cases of HIV diagnosed continue to increase each year; an estimated 2 million people will be diagnosed as HIV-positive in 2015 (World Health Organization, 2015c).

Both HIV and AIDS are chronic diseases which can have life-long complications for anyone who has been diagnosed (Deeks, Lewin, & Havlir, 2013). Someone who has been diagnosed as HIV-positive or as having AIDS can experience a number of adversities throughout their lives. Among the most challenging effects can be the cost of ongoing treatment, the irrational and degrading stigma, and increased risk of opportunistic infections (Hellinger, 1993; Ledergerber et al., 1999; Valdiserri, 2002). In many cases, those living with these conditions have been largely marginalized and discriminated against by other people, groups, and communities in society (Parker, 2002; Valdiserri, 2002).

Since the AIDS epidemic in the 1980s, many programs have been developed that offer education, information, support, and treatment options for individuals diagnosed as HIV-positive or as having AIDS (U.S. Department of Health & Human Services, 2015a). Despite the development and increase of programs and services available, there is still negative stigma and discrimination surrounding this community and shame associated with the utilization of services offered (Parker, Aggleton, Attawell, Pulerwitz, & Brown, 2002). The marginalization that is experienced can affect the drive and willingness for an individual to seek testing, assistance, support, or treatment (Busza, 1999).

Cabezas, Fornasini, Dardenne, Borja, and Albert (2013) conducted research in three Ecuadorian states; it was determined that HIV education programs were necessary to improve knowledge and decrease transmission rates among their targeted group, company workers.

Rationale

HIV/AIDS Regional Services, more commonly referred to as HARS, is a not-for profit organization within the community of Kingston, Ontario (HIV/AIDS Regional Services, 2015). The HARS organization strives to educate the community about HIV/AIDS, the risk factors involved, and harm reduction practices; the agency offers extensive support programs for anyone within in the community and surrounding areas. HARS also supports and works towards creating awareness for the LBGTQ+ community, homelessness, safe drug use, and also provides services and education for these priority populations.

Kingston Community Health Centre (KCHC), Immigration Services is another organization that also supports people in Kingston and the area (Kingston Community Health Centres, 2015). Among the many services KCHC offers, the Immigration
Services sector supports people who are new to Canada. KCHC is an organization that, much like HARS, dedicates their resources to help people in the community; the two organizations collaborate on many programs.

Kingston is home to 125,000 residents, which include newcomers to Canada (City of Kingston, 2014b). An average of 250,000 people immigrates to Canada each year (Butler, 2014). Immigrants account for almost 20% of the Canadian population (Scoffield, 2013). Kingston is a neutral location for immigrants to locate to as it is a city with career opportunities with the military, industry, prisons, or post-secondary institutions. Kingston is close to major cities and metropolitan areas, such as Toronto, Ottawa, and Montreal, and is very close to the United States’ border (City of Kingston, 2014a).

Based on the research, it is evident that there is a need for and a benefit to providing HIV/AIDS education as a means of eliminating the hurtful stigma (Parker, Aggleton, Attawell, Pulerwitz, & Brown, 2002). HIV education should benefit the general population as the harmful stigma and marginalization may exist as a result of an information deficit; the knowledge people receive could ultimately alter their behaviour and beliefs by making factual information and perspectives known.

HARS felt that it was important to educate people and sees the value in educating women who are new to Canada about HIV/AIDS, the risk factors, treatment options, supports available, and why it is important to learn about HIV/AIDS in Canada. Providing people in the community with HIV knowledge would be beneficial for the community, HARS, and service users of both HARS and KCHC. Hence, the need for and ultimately the development of HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program was established. The manual developed in this thesis outlined the diploma program, which was designed to be delivered in two-hour sessions, once a week for eight weeks.

This manual provided HARS with the opportunity to run the diploma program in the future with any staff member as the group’s facilitator. HARS staff members ensured the manual was an appropriate tool for facilitators by completing an evaluation of the manual.

Overview of Thesis
The introduction of this thesis outlined the importance of HIV education and how the thesis presented a way to do that. The next chapter, identified important and meaningful research relevant to HIV and AIDS education. The third chapter outlined the development of the manual, which contained each of the eight peer education diploma program sessions. That chapter also described the evaluation of the education manual which was completed by staff and a student once the manual was finished. The fourth chapter presented the completed manual and analyzed the results of the evaluations. The final chapter summarized the results of the current study and discussed the strengths and limitations of the peer education manual that was developed, and the contribution of this study to the behavioural psychology field, as well as recommendations for future research.
Chapter II: Literature Review

HIV/AIDS

HIV/AIDS has affected more than 78 million individuals worldwide (World Health Organization, 2015c). Relevant data shows that the infection rates are increasing with newly infected people every day (Egan, 2013). Almost half of the people who have HIV are unaware of their positive status (World Health Organization, 2015c). People who do not know the risk for certain illnesses or viruses such as HIV will not know to be tested which could result in increased chance of opportunistic infection as a result of the untreated HIV and weakened immune system (World Health Organization, 2015c).

AIDS is the final stage of an HIV infection, when the immune system is no longer able to do its job (World Health Organization, 2015c). Throughout this thesis, the virus will specifically be referred to as HIV as AIDS refers to the final stage of the HIV infection.

Opportunistic infection. An opportunistic infection is something that people who are HIV-positive have to face in their lives. It is called an “opportunistic” infection because it takes the opportunity of a compromised immune system to flourish (Kaplan et al., 2009). Due to this, someone with HIV is more likely to become sick with disease, virus, or infection (Kaplan et al., 2009). When an infection is present in someone who has HIV, it can be challenging to treat and can end up being fatal. Pneumonia, tuberculosis, hepatitis (A, B, and C), and cancer are among the most common opportunistic infections affecting individuals who have an HIV positive diagnosis (Kaplan et al., 2009). The increased risk for opportunistic infection adds to the challenges someone with a positive status faces, and the development of an infection can alter someone’s quality of life.

Stigma. Stigma refers to negative beliefs or assumptions made about a specific person, persons, or groups based on fear of the unknown and a lack of knowledge of the marginalized community (Busza, 1999). People belonging to marginalized groups have experienced negative stigma based on their association; for example, someone with an HIV status of positive might not disclose that information for fear of judgment or harassment. Similarly, someone who uses drugs recreationally or regularly, someone who is homeless, or someone using social assistance may face discrimination or stigma (Logie, James, Tharao, & Loutfy, 2011). People in society judge without considering personality, work ethic, family history, and the other things that make up who a person is, not to mention any trauma that individual has faced. Stigma creates a divide between the affected person(s) and those with no affiliation or knowledge of the stigmatized behaviour, lifestyle, or illness/disease (Busza, 1999).

Jonathan Mann, the late executive director of the World Health Organization, while speaking about the HIV/AIDS pandemic said that the stigma and discrimination associated with the illness is as challenging as living with the actual disease (Parker et al., 2002). It has also been said that decreasing, and ultimately eliminating, the HIV/AIDS stigma is the single most important condition needed for combating the AIDS pandemic (Brown, Macintyre, & Trujillo, 2003).

The stigma that people are faced with each day can dramatically affect their everyday personal and interpersonal lives (Liping, Peng, Haijilang, Lahong, & Fan, 2015). The stigma surrounding HIV/AIDS can directly affect an individuals’ family life, friendships, relationships, income/employment, mental health status, health care options, health care professionals’ attitude or willingness to help, and even travel destinations...
This form of discrimination can undoubtedly lead to self-shame, self-harm, or an overall poor quality of life (Liping et al., 2015).

**HIV Probability and Prevention**

HIV is transmitted when an infected person is in direct contact with the blood or bodily fluid of a person who has not been infected (U.S. Department of Health & Human Services, 2015b). Only certain bodily fluids can carry or transmit HIV (blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk), making the conditions for transmission very specific (U.S. Department of Health & Human Services, 2014). The highest probability for HIV transmission is engaging in sexual contact without protection, sharing injection drug use equipment, and children who are born to HIV positive mothers or are breastfed by positive mothers (U.S. Department of Health & Human Services, 2014).

In Canada and the majority of countries around the world, blood is screened and tested before it is used for transfusion (World Health Organization, 2015a). This is not always the practice that is used though; in some underdeveloped countries, blood is used before being screened, as there is lack of time or accessibility to other blood or screening equipment (World Health Organization, 2015a). Blood that has not been screened may contain HIV, which was the case for over 14,000 Americans who became HIV positive after receiving blood transfusions in the early 1980s (Donegan, 2003).

The current HIV statistics available from AVERT, a not-for-profit organization part of the forefront of eliminating HIV/AIDS, stated that between the years 2000 and 2014 there were 38 million new HIV infections and only 36 million people living with HIV in 2014 (AVERT, 2015). AVERT stated that over 25 million people died within the 14-year span due to AIDS or opportunistic infections. The AVERT site stated that 49% of people living with HIV are unaware of their positive status and 59% of people are not actively accessing treatment. AVERT stated that sub-Saharan Africa is where HIV is most prevalent with more than 70% of all cases of HIV. In addition, they noted that Asia, the Pacific countries, Europe, North America, and Latin America are places where HIV is affecting more than 10 million individuals (AVERT, 2014).

An individual must engage in high-risk behaviour in order to be exposed to HIV. However, there are many variables other than behaviour that are important to account for when considering probability of being exposed HIV (Stuber, Meyer, & Link, 2003). Some groups specifically have been identified and labeled as most likely or most at risk of HIV acquisition, for which the reasons vary.

In the 1980s when the AIDS pandemic began, before the virus had been named, it had been referred to as gay-related immunodeficiency disease (GRID; Halkitis, 2010). Though the resources for HIV/AIDS have developed through the years and it has been established that HIV can affect anyone, the HI virus is still linked and associated by most of society to gay men (Halkitis, 2010).

In Canada, men who identify as gay, bisexual, or as a man who has sex with men (MSM) account for 63% of the population of people who are living with HIV (Public Health Agency of Canada, 2013). The reason MSM account for such a large percentage of HIV positive people, in Canada, is because anal intercourse is an effective means of transmitting the virus, not the sexual orientation of the individual. In other parts of the
world, however, such as sub-Saharan Africa, the primary means of transmissions is through vaginal intercourse (U.S. Department of Health & Human Services, 2014).

Anal sex is a common form of sexual intercourse for both men and women, of heterosexual, homosexual, and bisexual orientation (Wilton, 2014). According to Wilton (2014), condomless anal sex is a likely form of transmission because there is a higher viral load in rectal fluid. Wilton goes on to explain that the person inserting their penis into the anus is most likely to acquire HIV due to the rectal fluid entering the bloodstream from abrasions or open sores on the penis. However, another article stated that it is the person on the receiving end who is most at risk due to the chance of semen entering the blood through tears or abrasions in the anus (Alemango et al., 1998).

In another article, Carballo-Diéguez and Bauermeister (2004) conducted online research regarding MSM and condom use. Men who have sex with men who do not use condoms are engaged in something referred by the gay community as barebacking. The authors explained that individuals who are engaged in barebacking are sometimes naïve about the risks involved and are more focused on the freedom and liberation felt when having condomless anal sex (Carballo-Diéeguez & Bauermeister, 2004). Due to the type of sex that MSM engage in, the probability of HIV transmission is higher, which explained why MSM account for a high percentage of people living with HIV (Alemango et al., 1998).

The data also shows that certain populations are representative of higher rates of infection. Online resources stated that in Canada, the groups or populations that account for the highest levels of HIV acquisition are MSM, injection drug users, individuals from countries where HIV is still an epidemic (who are living in Canada), those from aboriginal decent, incarcerated individuals, and women (Challacome, 2015).

The populations listed as high prevalence groups are not specifically at risk of acquiring HIV because of their association to such groups, but rather due to other variables. Injection drug users account for the second largest group of HIV-positive people for more than one reason (Booth, Watters, & Chitwood, 1993). Injection drug users are specifically at risk of HIV acquisition when the equipment used is shared between users. One user must be HIV-positive in order for the virus to be transmitted (Booth et al., 1993). Booth et al. wrote about HIV-positive (injection and inhalation) drug users being labeled as ‘injection drug users’ because of the HIV stigma around injecting and transmitting HIV. Individuals who inhale their drugs and also have a HIV positive status are often labeled as injection users due to their status, regardless of how the virus was acquired. Booth et al. go on to explain that individuals who inject or inhale their drugs can also acquire HIV from the sexual activity that is engaged in while high, rather than the stigmatized drugs which are being consumed.

People who are from countries where HIV is still endemic and individuals of aboriginal heritage make up a higher population of HIV-positive persons in Canada (Challacome, 2015). The individuals who make up those populations are marginalized by society for being different than the social norm (Stuber, Meyer, & Link, 2008). There is evidence linking the experience of stigma and discrimination with overall poor quality of health and negative perceived ideas of self. Marginalized populations may experience stress, which can be accompanied by negative physical, psychological, and biological effects, and any number of forms of mistreatment (Stuber et al., 2008). These conditions
are often the foundation for engaging in and being exposed to risky behaviours and situations (Stuber et al., 2008).

Brennan et al. (2012) drew attention to the fact that transgender (trans) women have similar prevalence rates of HIV infection as men who have sex with men. Brennan and colleagues explain that trans women are susceptible to negative discrimination and marginalization which can lead to poor overall health with feelings of victimization, psychological distress, substance abuse, and physical, sexual, or emotional abuse (Brennan et al., 2012). The adversities trans women experience increase their exposure and engagement to risky situations including unsafe sexual encounters and drug abuse, which creates a risk for HIV acquisition. Brennan and her colleagues continued to reinforce that trans women are not being accounted for when referring to HIV statistics as there is limited research, leaving individuals from this community in a vulnerable position.

**Immigrant Women as a Priority Population**

It is widely known that men who identify as homosexual or men who have sex with men are the highest risk group for acquiring HIV (AVERT, 2014). The fact that HIV can affect anyone who has engaged in risky behaviour or come into direct contact with another person’s blood or bodily fluid is often ignored or dismissed (AVERT, 2014). Men who have sex with men account for the most prevalent group of those who are positive (except for women in sub-Saharan Africa), but intravenous drug users, incarcerated individuals, immigrants from Africa, sex-workers, individuals who identify as transgender, and individuals who are Latino or Hispanic are particular groups who are also specifically at risk, as a result of the stigma and marginalization experienced due to associated with said groups (AVERT, 2014). AVERT (2014) stated that education is crucial for ending the pandemic and notes that the groups listed above are most in need of education.

An overlooked group in need of education, are women, particularly women of ethnic minority (Csete, 2005; Logie et al., 2011). Some may think that only women of bisexual or homosexual orientation are at risk or are in need of education; however, it is women of heterosexual orientation who are most vulnerable and therefore most in need of education (Csete, 2005). Women as a whole, whether heterosexual, homosexual, or bisexual are a part of a risk group for HIV acquisition for many reasons. It has been established that HIV can affect anyone, but HIV has very much been associated with gay men, making many women unaware of their own risk (Csete, 2005).

Women from Canada, specifically, may not be at the highest risk among women around the world but are by no means excluded from the poverty, health concerns, social exclusion, violence, sexual abuse, gender discrimination, and subordination that can be experienced (Csete, 2005). Marginalized women such as those of aboriginal origin or who have immigrated to Canada, those who identify as lesbian, bisexual, or trans, black women, and those who engage in intravenous drug use are more vulnerable than privileged, white, English-speaking Canadians (Csete, 2005; Logie et al., 2011). The marginalized women of Canada are susceptible to stigma, racism, homophobia and/or discrimination which place them in many risk categories including risk of acquiring HIV (Logie et al., 2011).
People from marginalized communities are at an increased risk of being exposed to HIV based on the circumstances leading to marginalization; someone experiencing stigma and racism may also develop anxiety or depression and use drugs or casual sex as a form of coping. Munoz and Mendelson (2005) state how susceptible immigrants are to diagnosed depression and linked the time of stay to the intensity of depression. Not everyone who experiences marginalization is exposed to HIV, but the cycle that sometimes follows results in risk, which is why education, specifically for certain populations is very important. Women represent over 25% of Canada’s total of HIV infected persons and account for an even higher percentage of new infections annually in Canada (Ceste, 2005; Logie et al., 2011). Hence, women are in need of HIV knowledge in order to make informed and educated decisions or choices in life.

Peer Education

North America is home to more than one million people who are currently living with HIV or AIDS (AVERT, 2015). It is reasonable to assume that, every day, someone who marginalizes the HIV or at-risk community interacts with a person who is HIV-positive. AVERT (2014) determined that education programs to teach people about HIV/AIDS and the rights of individuals with HIV + status are among the most successful ways to create awareness, break the stigma, and prevent as many people as possible from contracting HIV or AIDS.

In Bangladesh, Hossain et al. (2015) reviewed a nation-wide tuberculosis (TB) campaign for increasing knowledge and risk factor information in order to reduce rate of contraction of TB. Hossain et al. hypothesized that raising awareness among the general population and providing information on TB would lead to more cases of early diagnosis and utilization of TB treatments and support services. Hossain et al. used newly diagnosed TB patients as peer educators to spread awareness, information, and knowledge to others in their communities. It was found that individuals in the general population had significantly less knowledge regarding TB than those just recently diagnosed (Hossain et al., 2015). Hossain et al.’s study showed the importance of making TB facts and information general knowledge for the population as a whole. Hossain et al. showed that there is a need for peer educators when they determined that the general community was not aware of important TB information, such as risk factors, transmission routines, and signs and symptoms. People were unable to make educated decisions or avoid taking risks when they had little or no knowledge regarding the issue.

As an example of insufficient education leaving a particular marginalized community vulnerable, Harris’ research (2013) examined the issue of the “black church” being responsible for African American communities’ prevalence of HIV/AIDS in the United States. Harris noted that the “black church” did not provide the African American community with important information regarding HIV/AIDS risks and transmission, not due to the negative stigma associated with the virus but due to the lack of appropriate cultural presentation of the material. Harris goes on to emphasize the importance of teaching HIV/AIDS knowledge to all people with a culturally appropriate approach.

Poor knowledge can leave the community in a vulnerable position. If people do not know the symptoms or risk factors, they do not know their own risk, the need to be tested, or how to be safe when engaged in risky behaviours (Milaszewski, Greto, Klochkov, & Fuller-Thomson, 2012). This statement begs the question, would common
HIV knowledge and understanding among the general population lead to a reduction in the number of HIV/AIDS acquired cases, decrease the stigma surrounding HIV, and increase the services or supports utilized?

Collica-Cox (2015) conducted a study on self-esteem, showing that incarcerated women who became peer educators, providing HIV education to other incarcerated women, had higher self-esteem than women who were not peer educators. Collica-Cox successfully showed that when individuals, specifically women, are empowered with education, the women become proud of themselves and are more likely exert themselves as confident, which would be a beneficial asset when reintegrating into society (Collica-Cox, 2015).

Another example of a successful peer education study was when fraternity and sorority college students took leadership and provided safe alcohol knowledge with other students (Russett & Gressard, 2015). Russet and Gressard (2015) write about teaching responsible drinking choices to students who are involved with a fraternity or sorority, as they are notoriously known as a high-risk group for binge drinking. The education started with facilitators providing the education; within two weeks they had identified student leaders to become peer educators. The peer educators were to design and execute an education program for their peers. Russet and Gressard found that the program was successful, and the participants appreciated the focus on harm reduction in an open, respectful, and non-judgmental environment.

HARS, as well as many national organizations, agree that education and harm reduction are the basis and most important aspect of overcoming the world’s HIV and AIDS pandemic (AVERT, 2015; HARS, 2015; World Health Organization 2015c). Education is important for many reasons. People need to have education in order to make informed and educated choices (Milaszewski et al., 2012). People need to know the risk factors so they are aware if and when they have been exposed to a risky situation and how to make smarter decisions in order to avoid those circumstances. People may not understand the extent of the risk for HIV acquisition, leaving them vulnerable and in need of knowledge (Milaszewski et al., 2012). People who are uneducated about HIV may not know that there is a risk for opportunistic infections when diagnosed as HIV-positive. People who are unaware of their status could be susceptible to another infection, showing the importance for HIV knowledge among the general population (Kaplan et al., 2009).

Manual Development

Butollo (1996) described a study that used psychologists, social workers, and therapists as peer educators for individuals with similar job descriptions but under very different circumstances. The participants of this study were health care professionals working with victims in an ongoing war-like atmosphere in Bosnia from 1993-1995 (Butollo, 1996). Butollo and his team created training manuals, which would be used to train peer educators. The educators followed the training outlined in the manuals while providing support and education to the participants during training seminars (Butollo, 1997). The participants in this study benefited from the “hands on” approach to learning as they were able to ask specific questions during the seminar and learned new techniques from other professionals in the group as well as the groups’ facilitators (Butollo, 1996). Butollo (1996) stated that the need for this type of hands on training is important,
substantial, and relevant. The success from this specific training benefitted the participants, the facilitators, and the victims and people in the area of Bosnia.

Munoz and Mendelson (2005) reviewed and evaluated manuals which were created to provide accurate culturally appropriate information and education to those whose lack of education might have lead to stigmatization. Munoz and Mendelson encouraged the use of manual development and evaluation because it can be an effective way to provide teaching about and to marginalized communities. After conducting their research, they stated that the ultimate test of a program that is culturally effective rests with the outcome. If the hypothesized outcome was achieved with the culturally relevant group, then the program was culturally effective. Munoz and Mendelson suggested that marginalized communities are underrepresented in mainstream research and ran programs already outlined in manuals provided by agencies. They were able to successfully execute programs in a culturally sensitive manner and offer suggestions for further successful programs.

Wantland et al. (2008) wrote about the lack of readily accessible education materials regarding HIV symptoms. They created a symptom management manual in order to provide a simple form of learning about the common symptoms that can be experienced when one is HIV-positive (Wantland et al., 2008). The authors gave their participants an evaluator’s manual to complete after reading material regarding HIV symptoms. Two different groups used the evaluator’s manual to assess two manuals: one an old, outdated, long nutrition guide and the other an updated, revised, and shortened version, the symptom management manual. They found the evaluation manual to be effective for assessing the two documents; the manual created by Wantland et al. was found to be more effective than the nutrition guide it was compared against.

Manuals can be created for a variety of purposes but can be very beneficial to the individuals using them. Wilson (1996) wrote about the use of manuals for clinical treatments. Wilson noted the dismissal the psychological community showed regarding manual-based treatments; nonetheless, Wilson went on to show the importance of using manuals during intervention. Wilson stated that treatment manuals benefit clinicians who are using psychotherapy as they provide a flow that is consistent each time the manual is used. Wilson also stated that there had been success with manual use for non-behavioural issues, such as group facilitation. Wilson highlighted the importance of using manuals by questioning whether or not cognitive behavioural therapy (CBT) would be as advanced without several of Beck’s publications including his Cognitive Therapy Instruction Manual first developed in 1967.

**Relating the Literature to the Current Project**

HARS has recognized the importance of educating people in the community, specifically populations identified as priorities by the companies who fund HARS (HARS, 2011). HARS has identified women new to Canada as a target group of HIV peer educators based on the consistent increase of HIV-positive diagnoses in immigrant women and the same demographics’ inclusion in HARS list of priority population’s (U.S. Department of Health & Human Services, 2014; HARS, 2011). Education was noted as one of the most important ways of combating the HIV virus, and peer education was found to be an effective way to teach individuals about a concept in order to reduce
stigma and increase awareness (AVERT, 2015; Russet & Gressard, 2015; Parker et al., 2002).

The women who choose to participate in the peer education diploma program should fulfill their roles as peer educators successfully as the education taught will be important information for many people in the participants’ lives. Additionally, women were found to be more empathetic than men during a health care study, which showed women scored higher for perspective talking, compassionate care, and empathizing with patients than men in the same roles (Hojat et al., 2002). Based on the research, it was expected that women would make successful peer educators, in addition to women being targeted based on their vulnerability and need for education.

The research also suggested that following an already designed manual can be beneficial when executing or implementing group training or education sessions, as the information is delivered in a “flow” that is consistent throughout each session (Wantland et al., 2008). The literature reviewed showed a need for and the benefit of the utilization of both a manual for group facilitation and peer educators to inform the general public.
Chapter III: Method

Section One: Program and Manual Development

An education manual, entitled *HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program*, was developed for eight sessions for a peer education diploma program. In the future, HARS will run a peer education diploma program for women who are new to Canada; this manual will provide a guideline for how the weekly sessions should run. The manual was made to help facilitators execute this program and included instructions for all possible activities and handouts in the manual’s appendices. The manual’s main purpose was to provide education and a framework for the group sessions; however, it could be utilized as an effective teaching or learning resource for HARS students, volunteers, and individuals or organizations in the community.

The HIV 101 manual also could be a great source for Kingston Community Health Centres as it provided the reader with extensive HIV/AIDS knowledge, which could be used to teach staff and educate service users. The goal was to create a program where women from the community could feel safe and openly talk and learn about HIV/AIDS. It was a goal that the participants of the program would share their new knowledge with others in their communities. This manual provided the reader with knowledge about HIV and AIDS and showcased the HARS organization.

After reviewing the relevant literature and communicating with HARS employees, it was agreed that a manual be made for facilitators. Butollo’s (1997) success with training manuals and peer education sparked interest in combining the two education techniques. A lack of participants ultimately led to the development of *HIV 101: A Facilitator’s Manual for Teaching a Peer Education Diploma Program* for the future rather than using implementing it with a group of potential peer educators. It was hypothesized that the manual would be effective for teaching a peer education program.

The eight-week peer education diploma program was focused on educating women who are new to Canada about HIV and AIDS. The weekly sessions were designed to be education-based and provide the participants with general and specific knowledge relating to the virus, risk factors, supports available, treatment options, stigma, and harm reduction practices. The participants would receive a Peer Educator Diploma that could be added to their resumes or professional portfolios. In conjunction with the educational sessions, the manual was structured so that participants would build an information package. During the sessions, the women would receive a binder that they would use to hold information notices, pamphlets, cards, and contact information for services offered that they receive throughout the duration of the program. All handouts and take home information were included in the manual.

The peer education diploma program was created as eight two-hour sessions, which were as follows:

Session One – Introductions, Ice Breaker Activity, and HARS 101
Session Two – HIV 101, History of HIV, and HIV Statistics
Session Three – HIV in Canada, Globally, and Common Misconceptions
Session Four – Stigma, Discrimination, Marginalization, Confidentiality, Disclosure, and HIV and the Law
Session Five – HIV Prevention and Treatment
Session Six – Living with HIV Discussion and Guest Speaker
Session Seven – HIV in Canadian Prisons
Session Eight – Movie, Cake, and Graduation

Section Two: Manual Evaluation

Participants. To ensure that the HIV 101 manual was going to be useful for HARS, five individuals evaluated it. Four of the evaluators were HARS employees, and the fifth assessor was another student who was completing placement at the agency. The individuals who completed the manual evaluation were contacted in person by the student evaluator and asked if they would evaluate the manual. Those who showed interest in participating were given an evaluation information notice (Appendix A) which described in detail the responsibilities as a manual evaluator. The notice highlighted the benefits of participating but also indicated any possible risks. As well, it outlined that their participation in the survey was voluntary and that they could withdraw at any time without penalty. They were assured of the anonymity of their survey answers and informed of how long the data would be kept.

Five individuals employed at HARS identified their interest in evaluating the manual. These individuals received the information notice in person and were asked the following day if it was of interest to them. All five individuals who indicated that they wanted to participate received electronic copies of the manual, which they were given two weeks to evaluate by reading though and completing the associated surveys.

Setting/apparatus. The manual was sent electronically to the participants on Monday December 7th, 2015 along with two links that sent participants to the surveys on Survey Monkey. The evaluators had a total of two weeks to complete the evaluation. The surveys (described below) were available online at any time during the two-week period, making them readily available for the participants to complete with any internet connection for participant convenience. There was a printed version of the manual available for anyone who preferred the printed version, located within the student office at the HARS office, 844a Princess Street.

Materials/measures. The electronic and printed copies of the manual were the most important material since that was what was being evaluated. There were two surveys to be completed as part of the evaluation, both available any time during the two-week period. The surveys were created using SurveyMonkey.com, forming a readily available survey that was able to be completed anonymously. One of the surveys, entitled HIV 101 Manual Evaluation I (Appendix B), was a 10-question survey in the form of a Likert-scale. For each of the 10 questions there were five possible responses, (strongly agree, agree, neutral/not applicable, disagree, strongly disagree). The Likert-scaled questions indicated the participants’ evaluations of specific components of the developed manual.

The second survey, entitled HIV 101 Manual Evaluation II (Appendix C), contained four open-ended questions asking for general feedback and opinions of the participants regarding the manual.

Procedures. The participants received an information notice (Appendix A), which outlined what the evaluator position would entail. The purpose of the information notice was to ensure that participants were making an informed and educated decision when deciding to evaluate the manual.

Once the evaluators were identified, they were all asked for their e-mail addresses. On Monday December 7th 2015 each of the five participants was sent an e-
mail from the student researcher. Enclosed in the e-mail (Appendix D) was an electronic attachment for the manual and two hyperlinks, directing the participants to each of the two surveys. In the e-mail was a typed greeting thanking the participants for their contributions and providing the location of the printed manual. It was disclosed to the participants that they would need to contact the author when interested in the printed copy in order to arrange a time for it to be made available.

When the participants entered the Survey Monkey site to complete the surveys, they were welcomed with the first question of the survey and were not disrupted with log-ins or sign-ups. There were not any waiting times or time caps for any of the questions. Surveys could be accessed at any time by any of the evaluators. However, once each survey session was started, it needed to be completed as there was no log in or membership associated with the survey; hence evaluators could not stop and return to the survey.

The data collected from the completed evaluations were analyzed and are presented in tabular form in the results section.
CHAPTER IV: Results

Creation of HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program

HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program (Appendix E) was created for HIV/AIDS Regional Services (HARS) for the purpose of providing education for priority populations. This manual was designed for HARS staff, students, or volunteers to use in order to implement a Peer Education Diploma Program. The program was designed for women who are new to Canada, though the information is useful for all people, and it can be modified and used for peer education purposes with other populations.

The manual was organized in four different sections. The first section, entitled Introduction & Pre-Group Considerations, contained important information for the facilitator to consider before running a peer education diploma program such as the purpose of the program and how to recruit participants. Part two, entitled Session Breakdown, outlined each of the eight weekly group sessions. Each session contained a pre-group outline, which listed the agenda and the materials required for that session. The third part of the manual, entitled Services Offered, listed services within the Kingston area that are available or may be helpful for someone who is living with HIV, someone who wants to learn more, or someone who wants to help the cause. The final portion of the manual, Appendices, showed a visual representation of any handout, activity, and additional take home information that would be covered during the group sessions.

Survey Results

Five individuals completed the two surveys rating the above manual. Four of the individuals who completed surveys were employed by HARS, and the final individual was a student of St. Lawrence College who was completing their school placement at HARS. The results of HIV 101: Manual Evaluation I can be seen in Table 1, and the raw data are available in Appendix F.

Table 1
Percentage of Evaluators Endorsing Each Choice on Evaluation I (n=5)

<table>
<thead>
<tr>
<th>Survey Questions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral/ Not Applicable</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I find the HIV 101 Manual to be user friendly and easy to read.</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>2. I believe the information in this manual to be factual.</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>3. I learned something new while reading this manual.</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>
Overall, the responses for the HIV 101: Manual Evaluation I were positive; none of the “negative” answer options were selected. All five individuals completed all 10 of the survey questions. The most positive responses “strongly agree” (or “strongly disagree” for questions 5, 6 and 9) were selected as the answer 58% of the time. In ranking the available answer options (strongly agree, agree, neutral, disagree, and strongly disagree) the second most positive response, “agree” (or “disagree” for questions 5, 6 and 9) was selected 35% of the time. Thus; 94% of the responses were positive. The remaining category that was selected as a response was the neutral/not applicable option, which was selected a total of 6% of the time.

The evaluators rated the manual quite positively as noted by the all of the respondents agreeing or strongly agreeing that the manual was user-friendly and easy to read, was not disorganized, will be used and recommended in the future, will be beneficial to HARS, was factual, would have the outline followed in the future, and did not require more research. Although a minority of evaluators indicated a neutral response to having learned new information, feeling confident to run the group in the future, and whether the manual was missing information, the majority still felt positive about those facets of the manual as well.
The HIV 101: Manual Evaluation II contained four open-ended questions; the written responses were summarized and are shown in Table 2, while the raw data responses from Survey Monkey are available in Appendix G.

Table 2
*Summarized Comments from Evaluation II (n=5)*

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Question’s Response</th>
</tr>
</thead>
</table>
| 1. Please comment on your overall impression of this manual. | - Great job  
- Organized and easy to follow  
- Well written  
- Amazing piece of work  
- Love the session overview and resources required |
| 2. Please comment on the downfalls and/or limitations of this manual. | - The research needed before running program.  
- Hasn’t been used/tested.  
- Stats, treatments, and information changing |
| 3. Please comment on ways to improve the manual. | - This manual is great as it is.  
- More activities or learning tools.  
- There are just a few spelling errors. |
| 4. Please leave any additional comments you have regarding the manual. | - Well done!  
- Great resource!  
- Excellent job! |

Note: Due to some responses being similar, some skipped, and some longer than others, the responses were summarized for the purpose of this table.

The results from the HIV 101: Manual Evaluation II again showed positive qualitative feedback along with some constructive feedback regarding a few detected spelling errors and identified limitations.
Chapter V: Discussion

Summary

The HIV 101 manual was created as an educational resource for HIV/AIDS Regional Services; it was developed as a facilitator’s guide for carrying out a peer education diploma program. The manual itself was developed for HARS staff (or students/volunteers) who would fulfill the role of facilitators. The content of the manual was designed to be relevant for women who are new to Canada since that population is considered a priority for education by HARS funders. The HIV 101 manual was evaluated by five individuals whose feedback was positive and deemed the manual to be beneficial and useful for HARS.

The first survey “HIV 101: Manual Evaluation I” asked 10 questions in Likert scale format; the results of that survey were positive. The majority of the evaluators (at least 80%) agreed that the manual was easy to read/follow and responded positively when asked if they would use the manual. The evaluators also disagreed that the manual was unorganized or required more research. All of the questions were answered with 94% of responses being positive, and the final 6% of the responses from the neutral/not applicable category. None of the responses were negative.

The second survey “HIV 101: Manual Evaluation II” included four open-ended questions. Each participant answered at least three of the four questions. The qualitative feedback given in that evaluation was also positive but included some (solicited) criticism. The positive answers given “well done,” “great job,” and “amazing piece of work” were among other positive comments. The criticism included pointing out some spelling errors and some limitations such as not testing the program with a group and needing to update statistics/information before running the program.

Implications for the Behavioural Psychology Field

The current program contributed to the behavioural psychology field in many ways. The manual was created for two different reasons, as a guide for facilitators and as a peer education diploma program, for women who are new to Canada.

As a facilitators’ guide, the manual provided a local not-for-profit organization, HIV/AIDS Regional Services, with a useful and beneficial manual which outlined an eight-week peer education diploma program. This resource would allow HARS to run this program with minimal staff preparation. Running the program could increase the awareness of HARS and their services used and also provide individuals in the community (particularly women who are new to Canada) with accessible education about HIV/AIDS.

The second purpose of the manual, the peer education diploma program itself, was to increase the awareness and knowledge of HIV/AIDS information among individuals in the community. Though the program was limited since it was created for women who are new to Canada, after graduation these women could become peer educators and could share the knowledge with others in their communities (e.g., families, friends, co-workers, etc.). Peer education was named one of the most successful ways to eliminate HIV stigma, increase awareness, and utilization of services according to AVERT, a HIV/AIDS charity organization (AVERT, 2014). Since HARS was seen as a community leader with similar goals of reducing stigma, creating awareness, and offering
services, the HIV 101 manual would allow HARS to implement a peer education program with women who are new to Canada.

As HIV is something that affects more than 70,000 people in Canada (Government of Canada, 2015) it was important from a psychological perspective to make HIV information general knowledge to help eradicate the HIV/AIDS stigma, discrimination, and marginalization that still exist. The creation of this manual provided a tool to do so.

**Strengths**

The literature that was reviewed made it apparent that ending HIV stigma, discrimination, and marginalization is a key feature for combating the virus. The literature showed that peer educators can be a meaningful and successful way to spread awareness and information to many people in a community (AVERT, 2014; UNICEF, 2015). HARS staff had a similar outlook and decided that a facilitators’ guide for teaching a peer education diploma program would be a great resource. This program offered HARS a chance to run a peer education diploma program at any time in the future since it has now been created.

The manual was evaluated by five individuals, who completed two surveys; the manual was received optimistically as the feedback was considered 94% positively. More positive feedback included statements which made it clear that the manual would be of great use to HARS and deemed the manual to be an asset.

The peer education diploma program would provide women who are new to Canada with a chance to access free education. This was important because when women (or anyone) come to Canada any education that they had will likely no longer be recognized. Providing free education would give these women a chance to complete the program, become a peer educator, and have some education present on a resume. This form of education would empower the participant, which encourages them to fulfill their peer educator roles, and gives women a chance to network and create new friendships and widen their communities.

**Limitations**

Though there are many strengths, the manual is also limited for a variety of reasons. One is in regard to the evaluations. It was agreed that each participant would read the manual in its entirety: however, there was no way to know if any of the participants skimmed or skipped sections. Another limitation regarding evaluations was that one of the original raters did not complete the survey. As the surveys were anonymous, there was no way to identify which staff member did not complete the survey, since all reported completing the survey. At that point, a HARS placement student completed the fifth and final evaluation.

Along with the limitations occurring in relation to evaluations, it should be noted that the participants were all affiliated with HARS, either as a staff member or as placement student. This gave HARS great feedback since the resource is for them; however, there was not any diverse feedback which could have been achieved by including other members of the community into the evaluation process.

A limitation that was clear during the creation of the manual and was also pointed out in the evaluation is the fact that the facilitators will always need to research the
current statistics and relevant information before beginning the program with a group. Though the program is already created, providing a readily available document, the future facilitators will need to research the information of each section before sharing the information with peer educators. This may be a logistical challenge for facilitators but will ensure that the information is always the most relevant.

Another limitation of the current program was that it was created for future facilitators and has not yet been used with a group. The evaluators responded with expectations that the program will be successful; however, that is speculative until it has been used to guide facilitators through the peer education diploma program.

Finally, the content in the manual was created with a target population in mind, women who are new to Canada. This population was an education priority for HARS which is why women who are new to Canada were identified as the group’s participant focus. The information in the manual was reserved for the identified participants; however would be beneficial for any group. It was established earlier that HIV/AIDS is something that can affect anyone (who has been exposed to transmission circumstances); for this reason, HIV education is valuable for all people. Nevertheless, the peer education diploma program developed for HARS is limited to women who are new to Canada.

**Recommendation for the Future**

A recommendation for the future of this program would be to implement the 8-week peer education diploma program with a facilitator(s) and participants. It was the initial plan to run the program with participants. Low recruitment numbers at the time of the study ultimately led to the decision to just create the manual, without running the program. In the future, this program could run as intended with women who are new to Canada or it could be modified to be used with any other population.

Due to the targeted population that was selected, it was decided that there would be no pre- or post-test to determine the level of knowledge that was gained. Women who are new to Canada belong to a group of people who have also likely experienced some form of stigma or discrimination; to not deter them from participating in the group, it was developed without a plan for testing their knowledge. In the future, a pre- and post-test could be beneficial for understanding more about the usefulness of the peer education diploma program in increasing knowledge about HIV.

Another consideration for the future would be to ask for participant feedback after completing the program. Again, this idea was eliminated to ensure that no one felt uncomfortable in the group; however, this information could be very useful when making changes for the next group.

Word Count (Literature Review): 4068
Word Count (Thesis): 8685
References


Appendix A: Information Notice

HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program was developed for the use of HARS. The purpose of this manual is to help the facilitator of the group execute the program. The HIV 101 manual was created by Meagan Rogers to fulfill the requirement of the Bachelor of Applied Arts Degree in Behavioural Psychology program’s applied thesis. If you agree to be an evaluator, your participation will include reading the manual in its entirety and answering a total of 14 questions regarding the practicality and organization of the manual.

Benefits of participating include the ability to contribute to the development and refinement of the manual for HARS. There are few risks associated with participation, although it is a lengthy process to review the entire manual. As well, you must complete the surveys at one time and are not able to stop and return to the surveys once you have started.

The evaluation is available online through a site called Survey Monkey. There are two different surveys to complete. The first survey, HIV 101 Manual Evaluation I, consists of 10 questions where you will have five answer response options (strongly agree, agree, neutral/not applicable, disagree, and strongly disagree). You will be asked to answer each question to the best of your ability. The second survey, HIV 101 Manual Evaluation II, consists of four open-ended questions. There is no time limit or cap for any of the questions. The surveys are available online to ensure that your answers will be anonymous. Your answers will be used to evaluate the manual and will also be used in my thesis and any publications or conference presentations that arise from it. At no time will anyone be able to associate your identity with your answers. The link to the evaluation will be sent electronically along with an e-copy of the manual. Once the surveys are completed, I will delete each survey, and all responses given will be erased from Survey Monkey after 90 days. I will retain all of the data, secured on my password protected laptop, until May 2016, at which point it will be deleted.

If at any point the data will be kept longer then May 2016, for unknown reasons such as publication or presentation, you will be contacted and informed of a new date at which the data will be deleted.

The survey should take approximately 10 minutes to complete and will be available until December 18th, 2015. If all evaluations are complete before the end date, the survey will close early in order to analyze the results.

On Monday December 7th, you will receive an e-mail with an electronic copy of the manual and two hyperlinks to the surveys. You will be given a two-week time period to complete the manual evaluation. Please note that the reviewing of the manual may be extensive as it was created to entail the entirety of eight, two-hour sessions. It is expected that the evaluation process will take more than one sitting. There will be many times when you will need to pause reading to review the handouts in the appendices. If you
choose to withdraw your participation at any time, please let me know as another evaluator will need to be selected. There will be no penalty associated with your decision.

If you have any concerns or are looking for more information, please contact Meagan Rogers by calling the HARS office (613-545-3698) or by sending an e-mail (mrogers24@sl.on.ca). Any additional concerns or questions can be sent to my St. Lawrence College supervisor, Dr. Susan Meyers (meyerss@queensu.ca).
Appendix B: HIV 101 Manual Evaluation I

**1. I find the HIV 101 Manual to be user friendly and easy to read.**

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral/Not Applicable
- [ ] Strongly Disagree
- [ ] Disagree

**2. I believe the information in this manual to be factual.**

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral/Not Applicable
- [ ] Disagree
- [ ] Strongly Disagree
### HIV 101 Manual Evaluation I

#### 3. I learned something new while reading this manual.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral/Not Applicable
- [ ] Disagree
- [ ] Strongly Disagree

### HIV 101 Manual Evaluation I

#### 4. I would feel confident facilitating the peer education diploma program after reading this manual.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral/Not Applicable
- [ ] Disagree
- [ ] Strongly Disagree
5. I find this manual unorganized with little to no flow.

- Strongly Agree
- Agree
- Neutral/Not Applicable
- Disagree
- Strongly Disagree

6. This manual is missing important information.

- Strongly Agree
- Agree
- Neutral/Not Applicable
- Disagree
- Strongly Disagree
HIV/AIDS PEER EDUCATION

HIV 101 Manual Evaluation I

7. I would follow the manual's outline closely if I were to facilitate this program.
   - Strongly Agree
   - Agree
   - Neutral/Not Applicable
   - Disagree
   - Strongly Disagree

HIV 101 Manual Evaluation I

8. I will use this manual in the future or recommend it to others.
   - Strongly Agree
   - Agree
   - Neutral/Not Applicable
   - Disagree
   - Strongly Disagree
9. I think this manual could benefit from more research and information.

- Strongly Agree
- Agree
- Neutral/Not Applicable
- Disagree
- Strongly Disagree

10. I think this manual will be beneficial for HARS.

- Strongly Agree
- Agree
- Neutral/Not Applicable
- Disagree
- Strongly Disagree
Appendix C: HIV 101 Manual Evaluation II

1. Please comment on your overall impression of this manual.

2. Please comment on the limitations of this manual.
3. Please comment on ways to improve the manual.

4. Please leave any additional comments you have regarding the manual.
Appendix D: E-Mail to Evaluators

Evaluation Package

Hi ____________,

Thank you for your interest in evaluating HIV 101: A Facilitator’s Guide for Teaching a Peer Education Diploma Program. You are providing a great service and get the opportunity to give suggestions and review the manual that will be used to educate women in the community.

I have attached an electronic copy of the manual to this e-mail. Please feel free to make changes as you see fit (using track changes), leave suggestions using word or e-mail, or just complete the surveys.

There are two different surveys that require completion. Please answer the questions to the best of your ability. Please click on each of the two links below to open the surveys.

HIV 101 Manual Evaluation I (10-Question Likert Scale)
http://www.surveymonkey.com/r/8HSTBYS
HIV 101 Manual Evaluation II
http://www.surveymonkey.com/r/RSNDG8B

Please note that there is a printed version of the manual available for anyone who prefers a hard copy. The printed version will be kept in the student office at HARS from Monday December 7th until Friday December 18th.

Thank you very much for your role in my thesis, your time, effort, and feedback is greatly appreciated.
Appendix E: HIV 101: A Facilitator's Guide for Teaching a Peer Education Diploma Program

HIV 101
A Facilitator’s Guide for Teaching a Peer Education Diploma Program
Designed for Women who are New to Canada

Created by: Meagan Rogers
St. Lawrence College
HIV/AIDS Regional Services
2015

The procedures in this facilitators manual are meant to be used by HARS staff, as a part of the broader services they provide, or under supervision of agency staff.

Images were obtained from and used with permission from freeimages.com
HIV 101: A Facilitator’s Guide to Teaching a Peer Education Diploma Program

By: Meagan Rogers

Permission for the images used in this manual were obtained from multiple sources. All images were approved for the purpose of education.

The above image was obtained and used with permission from freeimages.com
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PART ONE: HIV 101
INTRODUCTION AND PRE-GROUP CONSIDERATIONS

Image used with permission from freeimages.com
**INTRODUCTION**

---

**Welcome**


This manual was created to provide facilitators with a tangible prepared guide for a Peer Education Diploma Program. This manual outlines eight weekly education sessions and is broken down session by session. This manual is designed for facilitator use and should be delivered in a group setting.

Peer education is an effective way to educate people around specific topics, in this case HIV. The attendees of the group will receive a Peer Education Diploma, and can be considered Peer Educators of HIV. The objective is for the peer educators to share and spread the education with others in their communities.

---

**Intended Audience**

This manual was created with women who are new to Canada as the intended audience. Women who are new to Canada are a part of HARS priority population, and HARS receives funding to provide services such as education to this population.

The information provided in this manual may be altered in order to deliver similar peer education sessions to other groups, particularly those outlined as a HARS priority populations. Alterations will need to be done by the current facilitator(s) to ensure the content is appropriate for the newly-targeted audience.
**Prerequisite Skills**

This manual was designed for facilitators who have some existing HIV knowledge. As HIV/AIDS statistics are always changing this manual will be used as a guideline for providing education and will require some research on current statistics before being executed with a group. Facilitators can decide how to execute the sessions; it is up to the current facilitator to prepare slide shows or additional activities/handouts.

---

**Purpose**

This manual was developed with many purposes in mind, among them are the following three;

- **First**, this manual will provide HARS with the opportunity to run a peer education diploma program at any time. With this manual HARS staff and students will be able to easily execute the group sessions and provide education.

- **Second**, this manual was developed in order to provide women who are new to Canada with learning options that provide certificates for their resumes or portfolios. When people come to Canada much of their schooling, certificates, and/or experiences, are deemed inactive or not transferable. This diploma program will give these women an opportunity to gain free education that is current, relevant, and accepted in Canada.

- **Finally**, this manual was developed as a way to spread HIV awareness around the community. HIV is a virus that most people avoid talking about, but is a reality for over 70,000 people living in Canada. HARS feels it’s important to work towards building an inclusive community where all people are accepted and can openly and informally speak about HIV/AIDS without fear or resentment. The group members will receive a Peer Education Diploma and will spread information with others in their communities.
**Required Materials**

Prepare Before Program
- This manual and access to the printer, for scanning or printing.
- Have handouts and take home information ready to deliver to group members before each group session starts.
  
  **TIP** There are many resources available in the Education Office, preparing these in advance will ensure a smooth start to the sessions.
- Enough folders for the group to make Peer Education Folders.
- Glue, old magazines, beads, tissue, markers, and paint for the group members to decorate their Peer Education Folders.

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**Session Overview**

It is up to the facilitator’s discretion to change session topic or focus. It is also up to the facilitator to research the data provided in manual as it is only current as of 2015. New research is constantly being developed, and the statistics may have changed. Please make sure that statistics and information are accurate before teaching it to the group.

**Session One**
- Introduction
- Confidentiality
- Ice Breaker Activity
- Peer Education File Folder (Deliver and Decorate)
- HIV/AIDS Regional Services 101

**Session Two**
- HIV 101
- HIV/AIDS History
- HIV Statistics and Prevalence
| Session Three                              | - HIV/AIDS in Canada                      |
|                                          | - HIV/AIDS Global Perspectives            |
|                                          | - Common HIV Misconceptions Facts VS Myths|

| Session Four                              | - Stigma, Discrimination, and Marginalization |
|                                          | - Criminal Law and Confidentiality         |

| Session Five                              | - HIV Prevention                           |
|                                          | - HIV Treatment                            |

| Session Six                               | - Living with HIV                          |
|                                          | - Guest Speaker                            |

| Session Seven                             | - HIV Inside Prisons                       |

| Session Eight                             | - Graduation                               |
PRE-GROUP CONSIDERATIONS

Participant Recruitment

This manual is targeted for women who are new to Canada; to ensure as many people receive education as possible, it is important to advertise, promote and encourage the Peer Education Diploma Program.

To create awareness of the group session, create an original flyer or use the template (Appendix A). The program can be advertised visually around the HARS office and in the window. Contact Kingston Community Health Centre, Immigration Services and inform them when the program is planned to run and ask for permission to promote within their services. The flyer should be posted on the HARS website and the HARS Facebook page.

When looking for big group turnouts, try contacting:
- Frontenac Cultural Centre (www.centreculturelfrontenac.com)
- Afro-Caribe Community Foundation of Kingston (afrocaribekingston@gmail.com)
- Kingston Immigration Partnership (kipcouncil.ca)

Developer Information

This manual was created by Meagan Rogers, a fourth-year Behavioural Psychology Student of St. Lawrence College.

As a part of my thesis, I created this manual to provide HARS with the opportunity to easily educate women in our community about HIV/AIDS. This manual is intended for HARS staff, students, or community partners as a means of facilitating the Peer Education Diploma Program.
Note to Facilitators

These sessions are designed with a two-hour time frame; however, the activities and breaks can be altered in order to accommodate one-hour sessions.

Only sessions which require notes to the facilitator will have this section provided in the overview. Any other reference to the facilitator will be identified with an asterisk (*).

Role of Facilitators

Your role as a facilitator is to:
- Facilitate weekly sessions
- Coach and guide the women
- Encourage education
- Be open to each person’s experiences, values, and beliefs
PART TWO: HIV 101
SESSION BREAKDOWN

Image used with permission from freeimages.com
Session One
PRE-GROUP

Session Overview

- Introductions
- Confidentiality
- Ground Rules
- Ice Breaker Activity
- Break
- Peer Education
- Peer Education Folder
- HARS 101
- Debrief

Required Materials

- Chosen Activity Printed and Prepared (paper cut)
- Folders (enough for group)
- Art Supplies (glue, scissors, paper, tissue, markers, paint, beads, etc.)
- HARS Information Pamphlet (handout)
- HARS Bookmark (handout)
- Community Pet Food Sharing (handout)
- Sex Workers Action Group (handout)
Session Refreshments

- **Check Community Kitchen** (are there extra food donations that can be used for the group refreshments)
- **Purchase Any Extra Items**
- **Prepare Snacks** (cut fruit, vegetables, or cheese)

It is required that each session provides refreshments. The refreshment process will be the same each week, and the “Session Refreshments” section will only reappear for Session Eight’s Overview.

*Note to Facilitator(s)*

The session outline is a guideline; certain circumstances will require the timing or organization of the session to be altered. Uncertainties do not have to derail the sessions. The goal is to provide education, move on and focus on the importance of educating the participants in a safe environment.

All notes to facilitators within session breakdowns will be identified with an asterisk (*).
Session ONE

**Group Introduction – 5 Minutes**

- Introduce Facilitator(s)
- Facilitators Role*
- Introduce Group (Peer Education Diploma Program)
- Benefits of Peer Education
- Purpose of Group
- Explain Break Time and Refreshments

*As the group’s facilitator, you should try to actively engage the attendees in educational conversation and discussion. Your role will be to lead the group towards mutual understanding of the HIV Virus and create awareness and passion amongst the group that will lead to a spread of the knowledge learned.

**Confidentiality - 5 Minutes**

It will need to be addressed that all information shared during the sessions needs to remain within the group. The women in the group should feel confident that their attendance, performance, and any information revealed will be kept safe, and the facilitators will honor their confidentiality by not revealing any information. The women will need to agree to keep all information they learn about the other women to themselves and not bring up their attendance, questions asked during group, or information revealed.

This group can also serve as networking opportunities for these women. Any women who become friends outside of the group shouldn’t speak about the attendees of the group outside of the group even if no other attendees are present. This ensures everyone’s confidentiality is kept safe.
**Ground Rules - 5 Minutes**

- **Safe Space** (no discrimination or harassment)
- **Share the Air** (respecting others questions, reveals, experiences, and abilities)
- **Thumbs Up Rule** (if anyone leaves the room to use the washroom to give a thumbs up. If no thumbs up is given, the facilitator(s) will assume there was a triggering incident or issue and check in with that person during break)
- **Core Thoughts/Misconceptions** (will only be challenged if they impede education and will be communicated positively and professionally in an educational manner)

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**Ice Breaker Activity - 15 Minutes**

This activity will give the participants a chance to get to know and become more comfortable with each other. When the facilitator engages in the icebreaker, the individuals have a chance to feel equal to the facilitators and can begin to build a trusting but professional rapport. Facilitators can use their discretion when doing the icebreaker activity and alter when needed.

*There are three Ice Breaker Activity options. Chose one in advance or prepare all three and have the group decide on which on they would rather participate in.*

**Facilitators can change the activities and introduce a new one if preferred.**
### Activity Options

<table>
<thead>
<tr>
<th>Truth, Truth, Lie</th>
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</thead>
<tbody>
<tr>
<td>Ask group members to think of three things to say to the group during their introduction. The participants will say their name followed by two facts and one piece of fiction. The group members will decide as a group which of the topics said is the untrue one.</td>
</tr>
<tr>
<td>Example: I’m Inga. I have three siblings, I'm scared of heights, and my favourite lunch is an egg salad sandwich.</td>
</tr>
<tr>
<td>The group would then guess which ones were the truths and which one was a lie, and then Inga would reveal if the group was right or which one was the fib.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conversation Starters</th>
</tr>
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<tbody>
<tr>
<td>Print and cut out conversation starter cards (Appendix B). Have each group member select a card and begin a conversation regarding that topic. The participants can tell a fictional or non-fictional story or a fact regarding the topic. Any topics that are unknown can be put back or discussed as a group.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Human Bingo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print and hand out Human Bingo cards (Appendix C). Give the participants time to interact with one another to check off items on their bingo cards. Participants can find the information they need by asking each other questions. This activity gives the group an opportunity to really get to know each other as many different conversations will happen.</td>
</tr>
</tbody>
</table>
**BREAK TIME – 15 Minutes**

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time, the facilitators can address any “thumbs up” or any other concerns.

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**Peer Education – 15 Minutes**

Peer education is a form of learning that is done through the word of peers.

UNICEF states that “peer education is based on the reality that many people make changes not only based on what they know, but on the opinions and actions of their close, trusted peers. Peer educators can communicate and understand in a way that the best-intentioned adults can’t, and serve as role models for change”.

The participants need to have a clear understanding of the roles of a Peer Educator, because the goal of the Peer Education Diploma Program is for the group members to take the information learned and share it with other individuals within their communities.

HIV is a virus that holds a lot of stigma because of its history, because of the negative stigma associated, and because people feel it is something that doesn’t and won’t affect them. HIV is a virus that is preventable, yet millions of people are affected by it.

They say that ‘knowledge is power.’ If people have knowledge, they have the power to spread their knowledge. HIV education can one day become common knowledge and will aid in HIV prevention.

Ask the participants to comment on something they have learned through someone else, how that knowledge was more powerful coming from someone they trust or respect.

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Peer education quote used from UNICEF website http://www.unicef.org/lifeskills/index_12078.html
### HARS 101 – 30 Minutes

Hand out HARS pamphlet (Appendix D) and go over with the group members. There will be no way to tell group members’ level of understanding; ensure important information from pamphlet is read aloud for auditory learners.

HIV/AIDS Regional Services is a not-for profit organization in Kingston, Ontario. This agency has existed for over 25 years (est. 1988) and runs year-long support programs, services, and events with a staff of only eight people.

Also hand out: HARS Bookmark (Appendix E), Community Pet Food Sharing Program Pamphlet (Appendix F), and Sex Workers Action Group (Appendix G). Go over each hand out with the women to make sure all-important information is covered. Leave time for questions and motivate people to ask more by saying things like “does anyone have any questions” or “did everyone understand that.”

HARS’ priority is to serve people who have been diagnosed as HIV+. Anyone with a positive status can obtain a free membership, which offers that individual free counseling, transportation, clothing, monthly gift cards, and many other services.

HARS also provides services for priority populations in Kingston. There is a drop in space, which is heated in the winter and cooled in the summer. This space offers comfortable couches, free coffee, water, and tea, Wi-Fi access, and free clothes and items from the donation cupboard.

HARS service users can also use the community kitchen on Thursdays for free cooking demonstrations or come in and get free pet food from their Community Pet Food Sharing Program. HARS is also one of only two places in Kingston that offers free harm reduction supplies for intravenous drug, steroid, hormone, or insulin users. As well as the many services offered, HARS dedicates Wednesday evenings to FUSE, an LGBTQ+ youth group.
### Services that HARS offers

- The Drop In (Food, Drink, Comfort)
- Pet Food Sharing Program (aka Lucy’s Fund)
- Harm Reduction Room (Free Needle Exchange, Sterile Equipment and Supplies)
- Clothing Cupboard (Free Donated Clothes and Items)
- Community Kitchen (For Food Demos and Refreshment Preparation)
- FUSE (LGBTQ+ Youth Group)
- Good Food Box Program (Ordering and Pick-Up)

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### Peer Education Folder – 15 Minutes

Hand each future peer educator a folder. These can be the brown paper folders which are readily available at HARS office or purchased plastic folders from the Dollar Store (if there is enough in the budget for the folders).

Explain that the folders are for all of the information the women receive. This way, they can build a Peer Education Folder to use when fulfilling their roles as Peer Educators.

Bring out art supplies and let the women decorate their folders if they would like. During this time, the women can work on their folders and have an open discussion with each other and get to know each other. This could also be a time for facilitators to interact on a more personal level with the women.

Before moving on to the last 15 minutes of the session, have the women put all the handouts they’ve received in their folders.
**Peer Education Folder Cont.**

The women can keep their folders with them and bring them every week or they keep them together in a box at the office.

*There is a risk of the women losing their folders if they are taking them home so there are benefits to keeping them at the office. Use your own discretion; however, it is suggested that the women hand in their folders at the end of each session.*

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**Debrief – 15 Minutes**

Always end the sessions with a 15-minute debrief. The information in these sessions can be heavy or may contradict what some of the participants believe to be true. The information might resonate with someone who has feelings they want to address. Whatever people are feeling, this gives everyone an opportunity to bring up any confusion and the facilitators a chance to listen to and participate in debate and open dialogue.
Session Two
PRE-GROUP

Session Overview

- HIV Activity
- HIV 101
  - HIV in the Body
  - Stages of HIV
  - HIV Origin
- Break
- HIV/AIDS History
- HIV Statistics and Prevalence
- Debrief

Required Materials

- Blank Sheets of Paper
- Pens
- Ballot Box x 2
- HIV/AIDS Basic Facts Pamphlet
- If You Are HIV Positive Pamphlet
- Caring Safely for People with HIV or AIDS Booklet
- HIV Viral Load Testing Pamphlet
Session Two

**HIV Activity – 15 Minutes**

Assign one of the facilitators or volunteers to assist in any way (writing it out, spelling, translating it to English, any other assistance needed). Make sure to clearly state before beginning that their participation and responses in this activity will be anonymous.

Everyone gets paper and pens; instruct the group to write out as many facts they know about HIV or AIDS and then ask them to separately write any questions they have about HIV/AIDS. Pass around two empty small ballot boxes. Designate one box for facts and one for questions. Make sure everyone has the same coloured paper and pens so no one feels uncomfortable or worried about their fact or question being identified.

Collect the boxes and go over the facts, identifying which ones are facts and which ones are common misconceptions. Remind the women this isn’t to put down anyone’s personal beliefs, it is to identify those things that are commonly associated with HIV and contribute to the stigma.

This activity can be done out loud as well without the paper, pens, and a ballot box. If this activity will be done out loud, the women’s responses will not be anonymous as the group will be present to hear.

**TIP** If you provide an example, the women might be more likely or willing to participate.
Example – “Before I had all of the HIV education I have now, my friends told me that HIV could be transmitted through sweat.”
**HIV 101 - 30 Minutes**

Hand out CATIEs HIV & AIDS Basic Facts pamphlets (Appendix H). Go over the pamphlets as a group. Read out load, take breaks, and ask if anyone has questions or if it makes sense. Also hand out:

- HARS If You Are HIV Positive Pamphlet (Appendix I)
- Caring Safely for People with HIV or AIDS (Appendix J)
- CATIEs HIV Viral Load Testing (Appendix K)

**HIV**

Human Immunodeficiency Virus

HIV is the virus that causes AIDS.

**AIDS**

Acquired ImmunoDeficiency Syndrome

AIDS is the final stage of HIV.

**HIV 101 Cont. What Does HIV do to the Body**

Hand out Organs of the Immune System (Appendix L)

HIV affects your body's immune system. The immune system is comprised of many vital cells, tissues, and organs, which work to fight off infections, viruses, and bacteria that enter our bodies. Our immune system is made up of tonsils and adenoids, lymph nodes, lymphatic vessels, thymus, spleen, appendix, peyer's patch, and bone marrow.

HIV weakens the immune system and makes a person sick because they aren't able to fight off natural things like the cold and flu like a healthy person can.

Go over the information on the handout with the women, leave breaks and time for questions.

*The image on the handout is on the next page.*
**Stage 1 – Acute Infection**

This is the first stage of HIV. This is the stage someone begins once acquiring HIV. During this stage, the virus is replicating itself in CD4 cells in the body. This will continue to happen until interrupted with treatment. Most people feel side effects in the form of flu-like symptoms.

During this stage, a person’s viral load is high, and they are at the highest likelihood for transmission.
### HIV 101 Cont. Stages of HIV

#### Stage 2 – Clinical Latency
This is the second stage of HIV. This is the stage when the individual is adhering to treatment. Due to the treatment, most people’s HIV viral load will be low or undetectable during this stage. While in the clinical latency stage, a person does have an active HIV positive status, but the virus is replicating itself at very low levels and not harming very many CD4 cells.

During this stage, the virus is alive in the body, but it is not producing any symptoms.

#### Stage 3 – Acquired ImmunoDeficiency Syndrome
This is the final stage of HIV. Once a person’s CD4 cell count is lower than 200 cells/mm3, they are considered to have AIDS. A person can begin treatment in this stage, and progress to the clinical latency stage. Without treatment, someone with AIDS may live three years.

Someone may also be considered to have AIDS when they've been diagnosed with an opportunistic infection, regardless of their current HIV stage or CD4 count.
**HIV 101 Cont. Origin**

There is a lot of debate and controversy over the origin of HIV/AIDS. There is no one specific answer as there is a lot of research which speculates opposing ideas. AVERT (AIDS and HIV Education and Research Trust) states that there are two strains of HIV (HIV-1 and HIV-2). They say HIV-1 was found in chimpanzees in the form of simian immunodeficiency virus (SIV) and that HIV-2 was found in sooty mangabeys (type of monkey) in the form of SIV. AVERTs researchers state that the virus was transmitted to humans originally in the 1920s in the Democratic Republic of Congo. It is thought that hunters ate the meat of infected monkeys with SIV, and that is how HIV-1 started affecting humans.

AVERTs website states that HIV-2 was found first in Haiti in the 1960s. It was assumed that the Haitians that were helping in the Congo acquired the virus and were responsible for the spread of the virus; however, it is believed to have been from the consumption of sooty mangabey monkeys.

**BREAK TIME – 15 Minutes**

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time, the facilitators can address any “thumbs up” or any other concerns.
**HIV History – 30 Minutes**

Hand out HIV History flyer (Appendix M) and follow outloud with the group.

A full history breakdown is available in the Appendices (Appendix N). The History Breakdown is designed for reference; it will not need to be taught to the women. It is broken down by year and displays relevant HIV information since the epidemic began.

- In the United States in 1981, a condition known as pneumocystis carinii pneumonia was affecting gay men in San Francisco and another condition called Kaposi’s Sarcoma were causing similar side effects for gay men in New York and California.
- The condition is referred to as GRID (Gay Related Immuno Deficiency).
- In 1982, the virus was named acquired immunodeficiency syndrome (AIDS).
- Doctors and scientists discovered that a virus affecting T-cells is causing AIDS, later named human immunodeficiency virus (HIV).
- In 1985, the FDA approved the first HIV test. The same year, actor Rock Hudson died of AIDS related illnesses and his good friend, fellow actor Elizabeth Taylor, established American Foundation for AIDS Research (amfAR).
- In 1986, brothers Ricky, Robbie, and Randy Ray, all HIV-positive as a result of blood transfusions from an illness called hemophilia, were bullied and banned from their public school.
- The next year, the Ray family’s house was burned down.
- In 1987, the first panel of the AIDS Memorial Quilt was made. The quilt had more than 40,000 panels.
- The same year (1987), the FDA approved the first HIV medicine, an antiretroviral drug, AZT.
### HIV History Cont.

- The AIDS Coalition to Unleash Power (ACT UP) was established by an activist, Larry Kramer.
- A nationwide education campaign focusing on AIDS was created with the help of The Ad Council, amfAR, and the National AIDS Network.
- Ryan White died, and shortly after, the U.S. Government enacts the Ryan White Care Act.
- In 1991 the red ribbon became the symbol for HIV/AIDS awareness after being passed out by singer Paul Jabara (founder of the Red Ribbon Foundation) and the Visual AIDS Artists Caucus at the 1991 Tony Awards.
- At the end of 1991, Magic Johnson, NBA all-star, announced his HIV-positive status and retired from basketball.
- In 1993, the movie Philadelphia came out featuring Tom Hanks and Denzel Washington, based on a true story about an attorney who was fired after it was identified that he had HIV.
- In 1994, the musical Rent opened off Broadway, showing the lives of young artists and the struggles they faced, including poverty, stigma, and HIV.
- Elizabeth Glaser died in 1994 after transmitting HIV to her daughter through her breast milk and to her son while in utero.
- In 1996, the Joint United Nations Programme on AIDS (UNAIDS) was founded.
- Combination antiretroviral drugs were established and deemed effective as HIV treatment.
- 1997 was the first year that the United States saw a decline in new HIV infection rates.
- In 2000, AIDS was announced to be a threat to U.S. national security.
**HIV History Cont.**

- In 2002, the FDA approved a HIV test, which shows results in 20 minutes.
- In 2005 the FDA approved HIV medications made in foreign countries, making this drug more accessible as it would be cheaper.
- Bono created Product Red and donated profits of goods to AIDS organizations.
- Bill Gates donated money and time (after retiring) to the Gates Foundation, a private sector company which funded ending the HIV/AIDS epidemic.
- Obama removed the U.S. travel and immigration ban, allowing people living with HIV to enter the United States.
- PrEP, an antiretroviral drug used for HIV prevention was effective, reducing HIV-negative individuals HIV transmission risk by 44%. PrEP is still awaiting approval for use in Canada.
<table>
<thead>
<tr>
<th>HIV Statistics and Prevalence - 15 Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- HIV is one of the world’s biggest health concerns</td>
</tr>
<tr>
<td>- 37 million people living with the virus</td>
</tr>
<tr>
<td>- 2.6 million are children (under 15)</td>
</tr>
<tr>
<td>- 230 people contract HIV every hour</td>
</tr>
<tr>
<td>- There are more than 5,000 new infections each day</td>
</tr>
<tr>
<td>- In 2014 more than 1 million people died from AIDS or AIDS related infections</td>
</tr>
<tr>
<td>- Almost 80 million people have contracted the virus since the beginning of the pandemic</td>
</tr>
<tr>
<td>- Almost 40 million have died from AIDS or AIDS related infections since the beginning of the pandemic</td>
</tr>
<tr>
<td>- In 2015, only 15 million people were receiving HIV treatment (41% of all people living with HIV)</td>
</tr>
<tr>
<td>- 88% of children who are living with HIV live in sub-Saharan Africa</td>
</tr>
<tr>
<td>- 66% of the world's AIDS related deaths in 2014 happened in sub-Saharan Africa</td>
</tr>
<tr>
<td>- 70% of all people living with HIV live in sub-Saharan Africa</td>
</tr>
<tr>
<td>- 5 million people who are living with HIV live in Asia and the Pacific</td>
</tr>
<tr>
<td>- 280,000 people are living with HIV in the Caribbean</td>
</tr>
<tr>
<td>- Almost 2 million people in Latin America are living with HIV.</td>
</tr>
<tr>
<td>- 240,000 people are living with HIV in North Africa and the Middle East</td>
</tr>
<tr>
<td>- 1.5 million people are living with HIV in Eastern Europe and Central Asia</td>
</tr>
<tr>
<td>- 2.4 million people who are living with HIV live in Western and Central Europe and North America</td>
</tr>
</tbody>
</table>
Always end the sessions with a 15-minute debrief. The information in these sessions can be heavy and may contradict what some of the participants believe to be true. Or it might resonate with someone who has feelings they want to address. Whatever people are feeling, this gives everyone an opportunity to bring up any confusion and the facilitators a chance to listen to and participate in debate and open dialogue.
Session Three
PRE-GROUP

Session Overview

- HIV in Canada
- HIV Global Perspective
- Break
- Common Misconceptions
- Facts VS Myths
- Debrief

Required Materials

- HIV Misconception Quiz (enough for each group member)
- Two Different Coloured Pens (two pens, one of each colour for each group members)
- HIV/AIDS in Canada Handout
- People Living with HIV in Canada Handout
- New HIV Infections in Canada Handout

Note to Facilitators

This section relies heavily on statistics. The data is as current as possible as of 2015; however, the present facilitator(s) will need to complete research to ensure the most current data available is given to the participants.
### HIV in Canada – 30 Minutes

Hand Out CATIEs HIV/AIDS in Canada handout (Appendix O), People Living With HIV in Canada handout (Appendix P), and New HIV Infections in Canada handout (Appendix Q)

First reported case in 1982, right after the epidemic began. There were an estimated 3,170 new HIV infections in Canada in 2011, with an estimated total of 71,300 people living with HIV in Canada (2011).

- Over 11% of the new infections, totaling 380 occurred in British Columbia.
- Almost 8%, totaling 250 occurred in Alberta.
- Over 7%, totaling 230 occurred in Saskatchewan.
- Over 3%, totaling 115 occurred in Manitoba.
- Just over 44%, totaling 1,400 occurred in Ontario.
- Almost 34%, totaling 760 occurred in Quebec.
- Just 1%, totaling 35 occurred in Atlantic Canada.

Aboriginal Canadians account for a substantial amount of the people who are living with AIDS in Canada. CAITE approximates that 30 in every 100,000 Aboriginal Canadians account for new HIV-positive statuses. That number is four times smaller for Canadians who are not aboriginal (8 in every 100,000).

9% or 6,380 people who are living with HIV in Canada are Aboriginal. 23% or 16,600 people who are living with HIV in Canada are female.

Men who have sex with men account for the highest percentage of people in Canada who are living with AIDS and for new infections. Men who have sex with men account for an estimated 443 new HIV infections out of 100,000 people.
**HIV in Canada Cont.**

Injection drugs users are 46 times more likely to acquire HIV then non-users. It has been estimated that out of 100,000 people who inject drugs, more than 430 account for new HIV infections.

One fourth of the people living with HIV are unaware of their positive status, which represents over 17,900 people. It is estimated that heterosexual sex accounts for the highest group of undiagnosed new infections, claiming 34% of the 17,980+ people who are unaware that they are living with HIV. CATIE estimates that the other groups of people who are unaware of their HIV positive status are people who inject drugs with 24% and men who have sex with men who make up 20%.

There were an estimated 71,000 people living with HIV in Canada in 2011, of that 33% identified as heterosexual (23,170 people). Of the heterosexual people living with HIV, 15% were from sub-Saharan Africa, the Caribbean, or other countries where HIV is still endemic (10,640). Less than 1%, a total of 600 people, of all people who are living with HIV in Canada acquired the virus through blood transfusions, mother to child transmission, or of a result of needle-stick injuries.

**HIV Global Perspective – 15 Minutes**

In 2014, there were an estimated 36.9 million people from around the world who were living with HIV, 2.6 million were children. More than half of the population of people who are living with HIV are living in low- or middle- income countries with a total of 2/3 of people living in sub-Saharan Africa, more than 25 million people.
### HIV Global Perspective Cont.

- Sub-Saharan Africa 25,800,000
- Asia & the Pacific 5,000,000
- Western & Central Europe and North America 2,400,000
- Latin America 1,700,000
- Eastern Europe & Central Asia 1,500,000
- Middle East & North Africa 280,000
- The Caribbean 240,000

In March 2015, there were 15,000,000 people who were receiving antiretroviral treatment for their HIV+ status; that’s 41% of those living with HIV. AVERT estimates that 59% of people who are living with HIV are not receiving the much-needed treatment.

It’s important to briefly cover why people aren't accessing treatment. Ask the women for their ideas first, but make sure these are addressed, as they are important.
- Unaware of Status
- Fear of Testing
- Fear of Positive Status or Disclosing Status
- Fear of Stigma, Discrimination, Harassment
- Cost of Treatment
- Feelings of Worthlessness

### BREAK TIME – 15 Minutes

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time the facilitators can address any “thumbs up” or any other concerns.
Common Misconceptions Activity - 15 Minutes

A Misconception Quiz (Appendix R) was created for the purpose of this activity. The quiz is meant to identify common misconceptions about HIV/AIDS. Although the women will have already accumulated HIV knowledge, this quiz will still work to show the misconceptions.

Hand out the quiz and two pens (of two different colours) to each group member. Explain to the women that this quiz is for the purpose of identifying the misconceptions that they believed before this program. Let them know that this quiz is for them only; they will not need to hand it in or reveal their answers.

Instruct the women to pick one coloured pen for their current understanding or assumptions and one colour for their previous understanding or assumptions.

Once the women have completed the test go over the quiz as a group and have an open discussion about the correct answers. Some may be confused or have questions.

Facts VS Myths - 30 Minutes

Myth 1
I'm not gay I don’t need to protect myself from HIV.

Fact 1
Everyone should have HIV knowledge in order to protect themselves from HIV. You don't have to be gay in order to have HIV. Many people believe this to be true because of the way HIV started. For the first year, HIV was known as GRID (Gay-Related Immune Deficiency) because at the time only gay men had been identified as having the virus.
### Facts VS Myths Cont.

| Myth 2 | Only people who are gay or use injection drugs are at risk of HIV. |
| Fact 2 | Men who have sex with men and injection drug users have dealt with decades of negative stigma. These individuals are not the only people at risk. Men who have sex with men and injection drug users account for a higher percentage of people who are living with HIV because of the HIV risk involved with anal sex and sharing injection drug equipment. The recent research actually states that individuals engaging in heterosexual sexual intercourse account for the highest prevalence of new HIV infections. |
| Myth 3 | I should be worried about interacting with people with HIV in case they sneeze, spit, or begin to bleed. |
| Fact 3 | HIV cannot be transmitted though nasal secretions (sneezing) or saliva. That should not be a concern for anyone. HIV is transmitted through blood, and if someone is HIV positive and they begin to bleed, regular universal precautions should be practiced. The infected blood would need to enter your bloodstream in order for the virus to transmit. This means that someone would need to be touching the blood with a part of their body that had an open cut, lesion, or sore in order for the blood to enter their bodies. There has never been a recorded instance of someone acquiring HIV from handling spilt blood or semen. The risk, however, of transmission does still exist as the virus can enter the blood stream through cuts or lesions on hands/arms (or anywhere on body) when handling any of the virus carrying substances: blood, semen, vaginal secretions, anal secretions, or breast milk. |
### Facts VS Myths Cont.

**Myth 4**  
I can get HIV from kissing.

**Fact 4**  
There is almost no risk in kissing. It has already been discussed that you cannot acquire HIV from saliva. HIV is transmitted through blood; under certain conditions if there were open sores in and around the mouths of both the HIV positive person and the HIV negative person, then blood could have a chance of entering into the bloodstream. This is very rare but has happened before 1990, where both partners had bloody sores. There has been no link since that time to any HIV transmission as a result of kissing.

**Myth 5**  
I had sex with a sex worker, I probably have AIDS.

**Fact 5**  
This is a very stigmatizing thought. HIV does not affect people based on their job description. Anyone who is having condomless vaginal or anal intercourse is putting themselves in a high exposure situation for HIV or any sexually transmitted infection (STI). Anyone who engages in sexual activity with partners whose past sexual and drug experience is unknown is in a high exposing situation and should receive testing for HIV and STIs. Even anyone who does not feel at risk, if you’ve engaged in sexual activity or sharing drug equipment, a HIV test is the only true way to know your status.
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Session Four
PRE-GROUP

Session Overview

- Stigma
- Discrimination
- Marginalization
- Harassment
- Privilege
- Confidentiality
- Break
- HIV and the Law (In Canada)
- Disclosure
- Debrief

Required Materials

- Laptop, Projector, and Speakers (for YouTube videos)
- Criminal Law & HIV Non-Disclosure in Canada Information Package (Prepared in Advance)
Note to Facilitators

This section should be a group discussion. Ask lots of questions after each topic and encourage the women to open up and interact.

You will need to prepare the Criminal Law and HIV Non-Disclosure in Canada document in advance. It is 18 pages long (can be printed double sided) and each group member will need one. The document can be found online at http://www.aidslaw.ca/site/wp-content/uploads/2014/09/CriminalInfo2014_ENG.pdf and the first page can be seen in the appendices (Appendix S)
### What is Stigma?  - 10 Minutes

Stigma is defined by the Oxford Dictionary as

> “A mark of disgrace associated with a particular circumstance, quality, or person: the stigma of mental disorder, to be a nonreader carries a social stigma”

Someone who is HIV+ may disclose their status to their family and notice that they are no longer invited to birthday parties, holidays, or weddings. This is a form a stigma that many people who are living with HIV have experienced.

Social and Self Stigma (search “social and self stigma”)  
https://www.youtube.com/watch?v=_jz7yo7L3Z0

Ask the women if they have ever experienced stigma or if they can think of a time someone else experienced stigma that wasn't necessary or deserved.

### What is Discrimination?  - 5 Minutes

Discrimination is defined by the Oxford Dictionary as

> “The unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex: victims of racial discrimination, discrimination against homosexuals”

Someone who is living with HIV may disclose their status to a group of “friends” at work. One of the friends might tell other people at work and make fun of, avoid, or even abuse that person.
### What is Marginalization? – 5 Minutes

Marginalization is defined by the Oxford Dictionary as

> “Treatment of a person, group, or concept as insignificant or peripheral: he worked hard to eliminate social and economic marginalization, women experienced marginalization in many localities”

Marginalization happens all of the time in our society, people who identify as gay are often times marginalized and seen as and treated like outsiders.

### What is Harassment? – 5 Minutes

Harassment is defined by the Oxford Dictionary as

> “Aggressive pressure or intimidation: they face daily harassment by the police”

Many people experience harassment on a daily basis. People who are living with HIV often keep their status undisclosed in fear of the harassment that could follow. It wasn’t until 2010 that people who are living with HIV were able to travel to the United States due to the HIV Travel and Immigration Ban.

*Everyone may have different experiences with stigma, discrimination, marginalization, and privilege. Make sure the participants feel comfortable and safe. This conversation is not meant to hurt or diminish anyone or their personal experiences; it is meant to show perspective and provide new information and show how people who are living with HIV may experience things differently because of the related stigma with the virus.*
### What is Privilege? - 10 Minutes

Privilege is defined by the Oxford Dictionary as

“A special right, advantage, or immunity granted or available only to a particular person or group: he has been accustomed all his life to wealth and privilege”

Privilege Video (search “sometimes you’re a caterpillar”)
https://www.youtube.com/watch?v=hRiWgx4sHg

Watch the video and have a conversation about how privilege fits in and contributes to the stigma, discrimination, harassment, and marginalization that someone who has a positive HIV status may experience.

### What is Confidentiality? - 10 Minutes

Confidentiality is defined by the Oxford Dictionary as

“The state of keeping or being kept secret or private: the lead bank’s duty of confidentiality to the borrower, visitors have to sign confidentiality agreements”

Confidentiality Case Scenario

Pete and Jamie have been best friends since they were children. Recently, Pete told Jamie that he was gay and was going to pursue a relationship with a man. Pete asked Jamie not to tell anyone yet as he hadn’t told his parents. Jamie is shocked by the news and decides to tell his girlfriend about Pete’s sexual orientation. Jamie makes Kate promise not to tell, and then tells her that Pete has come out as gay and is dating a guy. Kate, not knowing the implication of her gossip, tells three friends that Pete is gay. One of those friends tells a coworker who happens to be Pete’s aunt.
**What is Confidentiality? Cont.**

Discuss the scenario with the women; ask them what they would do if they were Pete’s aunt or how they would feel if they were Pete.

Now ask the women to imagine the ramifications of crossing the confidentiality line when it involves someone who is disclosing their HIV status.

Have an open discussion about scenarios or times where confidentiality was broken and information was revealed.

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**BREAK TIME – 15 Minutes**

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time, the facilitators can address any “thumbs up” or any other concerns.

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**Disclosure – 10 Minutes**

Disclosure is defined by the Oxford Dictionary as

"The action of making new or secret information known: a judge ordered the disclosure of the government documents"

When it comes to HIV, disclosure is up to the person with the virus; they can tell their friend and family or keep their positive status unknown to others. This means that a person with HIV should be the only one sharing their HIV+ status. It is actually a breach of confidentiality for someone to share anyone’s positive status.
Example.

Peggy has tested positive for HIV; she had disclosed her status to her mother, sister, and, best-friend Joy. Joy tells Mark that Peggy is HIV positive.

This is not Joy’s place to share this information as it is up to Peggy to decide who she wants to share her status with.

Disclosure and the Law – 10 Minutes

There is a law in Canada that states anyone who is HIV positive has the duty to inform their sexual partners prior to sexual activities. This means that if Peggy decides to be intimate with Mark, she must first tell him that she has HIV.

Because HIV is a chronic condition, meaning there is no cure and it is a life long illness, it is the law for all people aware of their HIV positive status to share that information with any and every sexual partner before having oral, anal, or vaginal sex. If Peggy doesn’t tell Mark about her status even though she knows and then Mark finds out from Joy after, Mark could criminally charge Peggy with aggravated sexual assault.

The same law that outlines the duty to disclose also states that anyone who has a low or undetectable viral load and is using a condom for vaginal sex does not need to disclose their HIV positive status.

If Mark finds out that Peggy has HIV from Joy, but Peggy has an undetectable viral load and they were using a condom... then Joy just broke confidentiality and disclosed Peggy’s status without her knowing or her permission.
### HIV and the Law (in Canada) - 30 Minutes

Hand out Criminal Law & HIV Non-Disclosure in Canada information package (Appendix S).


This package can be added to the participant’s peer education folders. They can later use this information to educate people or to answer specific questions about disclosure and the law regarding HIV in Canada.

Go over some of the content with the women. Stop often and ask if anyone has questions.

*You are not expected to cover all 18 pages, and the women are not expected to read the whole document during the session. Go over it together and cover important information. Make sure all questions are answered.*
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Session Five
PRE-GROUP

Session Overview

- HIV Prevention
- Best Practices for HIV Prevention
- Upcoming Prevention
- Treatment
- Break
- Prevention and Treatment
- Condom Art Activity

Required Materials

- Condoms, Female Condoms, and Dental Dams (handful for each participant and one of each for demonstration)
- Laptop, Projector, and Speakers (for YouTube videos)
- Condoms (any size, colour, texture) for Condom Art Activity
  - look for expired condoms for this activity
- Canvas, Paint, Paint Brushes, Glue, Beads, Ribbon, Scissors (for Condom Art Activity)
There are many ways to prevent HIV. The most successful way to avoid acquiring HIV is to abstain from sexual intercourse and intravenous drugs, although this is not realistic for many people.

Another successful way to prevent HIV transmission is to be fully educated in the ways HIV is transmitted and knowing the safest ways to engage in high exposing behaviours.

The research suggests that prevention is most effective when delivered in an educational and harm reduction focused manor. It is important for people to know and be aware of the risks that are involved with certain behaviours and how to make safer choices.

The most effective way of reducing sexually transmission is by using condoms, female condoms, and dental dams.

The most effective way of reducing intravenous transmission is by using all clean needles and equipment every time (no sharing, anything).

*The next section refers to best practices including condoms, female condoms, and dental dams. At this time, you should begin a demonstration on each of the three preventative measures.*
Best Practices for HIV Prevention - 10 Minutes

The traditional condom acts as a barrier between the penis and the vagina, front hole, or anus. Condoms are best practice for everyone when being sexually active, but are especially important when one of the partners is HIV+ (or has any STI).

A female condom can be used by anyone and can be used for vaginal or anal intercourse. This type of condom is inserted into the vagina, front hole, or anus before sexual intercourse (not like the condom, which is applied just before oral or sexual intercourse).

A dental dam is designed for use for oral sex and should not be used for sexual or anal intercourse.

For people who are injecting drugs (or smoking them) the best practice is all new, every time. Though intravenous drug transmission holds significantly less risk than sexual transmission, it is still very important to acknowledge the risk, as it is a reality for millions of people who have acquired HIV this way.

ADVERT states that lack of education about injection drug use and HIV and safer drug use practices are to blame for the amount of individuals who inject drugs who are also living with HIV.

It is best practice to complete an HIV test with a doctor or nurse practitioner upon the discovery of pregnancy. This is offered to pregnant women in Canada as a part of regular health care, but it is not required and can be and is often declined. If a woman is pregnant and testing positive for HIV, there is treatment that can be taken; in many cases, the child is born HIV negative. Once the child is born, mothers are advised not to breastfeed as breast milk does hold and can transmit the virus.
Upcoming Prevention – 5 Minutes

PrEP is a prevention medication called pre-exposure prophylaxis. This is a medication that is NOT available in CANADA (yet), as it is not approved by Health Canada. PrEP is available in America, however, and is used to prevent the transmission of HIV. Someone who is HIV negative but is engaging in risky behaviours could take PrEP as a preventative measure against transmission of HIV. If Peggy disclosed her status to Mark but he didn’t feel comfortable with the protection from condoms, Mark could talk to his doctor about PrEP. Once Mark is on the medication, he will be partially protected against HIV only not any other possible infections or STIs. Mark should still use condoms as PrEP does not intend to replace condom use, and Mark will further reduce his risk by using both preventative measures. It is unknown when this medication will be available in Canada.

Treatment – 25 Minutes

There are seven different possible treatments for HIV.
1. Fusion Inhibitor
2. Co-receptor Inhibitor
3. Nukes (nucleoside and nucleotide analogues, or NRTIs)
4. Non-nukes (NNRTIs)
5. Integrase Inhibitor
6. Protease Inhibitors
7. Co-Formulations

1. Fusion Inhibitors

Fusion inhibitors are a form of antiretroviral drug that prevent HIV from merging with other CD4 cells other than the host cell. When the host cell that holds the virus is not able to fuse with other cells, the HIV is not able to mimic itself and affect other cells.
<table>
<thead>
<tr>
<th><strong>2. Co-Receptor Inhibitors</strong></th>
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<tbody>
<tr>
<td>Co-receptor inhibitors are a type of drug used to treat HIV that prevent the virus from entering the CCR5 co-receptors which decreases the likelihood of mutation and spread to other co-receptors.</td>
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<tr>
<th><strong>3. Nukes (nucleoside and nucleotide analogues, or NRTIs)</strong></th>
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<td>Nukes or NNRIIs block one of the proteins that HIV uses for mutation; the protein reverse transcriptase is directed affected.</td>
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<th><strong>4. Non-nukes (NNRTIs)</strong></th>
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<tr>
<td>Non-nukes or NNRTIs is a medication for HIV that binds with the reverse transcriptase protein, disabling the ability to multiply.</td>
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<th><strong>5. Integrase Inhibitor</strong></th>
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<tr>
<td>Integrase inhibitors work by blocking the enzyme needed for HIV to enter CD4 cells in order to replicate.</td>
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<th><strong>6. Protease Inhibitors</strong></th>
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<tr>
<td>Protease inhibitors stop one of the enzymes needed for HIV to mutate itself.</td>
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</table>
7. Co-Formulations

Co-formulations take as little as two different HIV medications and combine them all together into one dose of medication, drastically reducing the amount of pills that are needed to be taken.

Treatment Cont.

HIV medicines are called antiretroviral drugs; they can stop HIV from replicating cells. Often times, antiretroviral drugs when taken as directed can lead to an undetectable viral load. When HIV is not treated, the virus mutates itself, infecting other cells.

Treatment is only effective when it is taken with complete adherence to the prescribed dose and route. Treatment will be a lifelong commitment, as the HI virus will not ever leave the body. Treatment reduces the chance for HIV to replicate itself or spread and weaken the immune system.

BREAK TIME – 15 Minutes

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time, the facilitators can address any “thumbs up” or any other concerns.

Prevention and Treatment – 15 Minutes

Prevention of HIV is most important. This is a life-long illness, and though there are medications that help people live long and fulfilling lives, there are many complications, mentally and physically, that accompany HIV.
Once an individual has been diagnosed as HIV positive, beginning treatment right away becomes most the most important thing.

Watch the below YouTube video, which educationally ties in both prevention and treatment. (Video is 7:05min)
https://www.youtube.com/watch?v=Eqxu3jjh3LE

**Prevention and Treatment Cont.**

Discuss the video and the information learned about prevention and treatment of HIV. Ask the women if all of the information from today was new or if some of it was. Ask if the video summarizing the information was helpful or not. See if anyone has any questions before moving on to the condom art activity.

**HIV Prevention Activity – 25 Minutes**

The most effect way of reducing sexually transmitted risk is by using condoms, female condoms, and dental dams.

People like to have sex and be sexual in different ways; there is no shame in anyone’s preference. This activity, Condom Art, will give the participants a chance to become familiar and comfortable with condoms while producing creative work, which they can keep or display at HARS.

Condom Art
Hand out at least 15 condoms and a canvas to each participant.
Provide paint, paint brushes, glue, beads, ribbon, and scissors that each participant can use.
Let the women know that there is no objective; they are supposed to have fun with this task and be as creative as possible while getting comfortable with touching and playing with condoms.
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# Session Six

## PRE-GROUP

### Session Overview

- Living with HIV (Group Discussion)
- Break
- Guest Speaker
- Debrief

### Required Materials

- Thank You Card (for Guest Speaker)

### Note to Facilitators

As there is a guest speaker, there is not much content listed here in this section. If for some reason a guest speaker will not be attending, use your discretion and decide on an activity or material to be covered.

Make sure to thank the guest speaker for their participation.
Living with HIV – 30 Minutes


As a group, formulate the things everyone is hoping to learn from the guest speaker.

Talk about personal or hypothetical situations a person living with HIV experiences that we are privileged to not experience.

*Use your own discretion. If the group would like to write a thank you card to be presented to the guest speaker after their presentation, then that can be completed at this time. If the group members decide to not participate in the creation of the card or in writing greetings, then the facilitators can prepare a thank you card on behalf of the peer education diploma program group. This time could also be used to hand out items for each of the group member’s education folders.

*Plan to have a guest speaker arrive 30 minutes into the session.

**This is a great topic to bring a guest speaker in for. This gives the participants the opportunity to ask questions and learn about the life and some of the hardships that co-exist when living with HIV.

***In order to be a client of HARS one must have a positive HIV status. Many client’s would be willing to speak about their life and experiences with HIV. Organize this well in advance to ensure there will be a speaker for this session.

BREAK TIME – 15 Minutes

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time the facilitators can address any “thumb up” or any other concerns.
**Guest Speaker – 60 Minutes**

Ask the speaker to do whatever is comfortable for them; they can do a time line of their life, a story, or question and answer with the participants.

*Make sure to let the speaker know that they are in control of the session; they can call a break at any time or alter the subject of the conversation.

**Make sure there are refreshments available for the speaker and provide a bottle of water.

***If this person has not spoken to a group like this before, meet with them before the coming to the group and discuss the plan for the session. At this time, it can also be discussed how the speaker would like to present.

Give the speaker an hour for their presentation.

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**Debrief – 15 Minutes**

Always end the sessions with a 15-minute debrief. The information in these sessions can be heavy and may contradict what some of the participants believe to be true. Or it might resonate with someone who has feelings they want to address. Whatever people are feeling, this gives everyone an opportunity to bring up any confusion and the facilitators a chance to listen to and participate in debate and open dialogue.
Session Seven
PRE-GROUP

Session Overview

- HIV in Prisons in Canada
- Break
- HIV in Prisons Cont.
- Debrief

Required Materials

- HIV in Prison Presentation (derived from HIV and Hepatitis C in Prisons)

Note to Facilitators

There is a 48 page document, HIV and Hepatitis C in Prisons which is very informative about HIV and Hep C in Canadian prisons. This document is long so it is up to the facilitator to review and prepare education about HIV in prisons.
Session Seven

HIV in Prisons – 60 Minutes

There is a very in depth 48 page document available from the Canadian HIV/AIDS Legal Network at http://librarypdf.catie.ca/PDF/P48/HIVandhepatitisCinprisons.pdf

This is a big document and is not expected to be printed and supplied for each of the group members. This document, entitled, HIV and Hepatitis C in Prisons, from 2009, provides important information about HIV within the Canadian prisons.

*It is recommended that you prepare by looking through the document and making slides or handouts for the participants.

You have the freedom to tailor this session to what you feel would be most beneficial for the group members to know. Some of the important facts to share with the group are highlighted below:
HIV in Prisons Con’t

- Canadian federal, provincial, and territorial prisons have seen an increase in positive HIV diagnosis since 1989.
- Prevalence of HIV in prisons (reported from BC, Ontario, and Quebec) is 10 x that of the general population
- Studies found that the population of inmates in prison who have HIV is between 1-9%
- Prisons and jails worldwide have higher populations of people who have HIV than the general population
- Prisons in areas where there is already a high prevalence of people who are living with the virus have higher rates inside (some may already have a positive diagnosis before doing time)
- In 1995 a study by CSC concluded at least 40% of federal inmates have used drugs since beginning their time
- More than 70% of male inmates in Quebec reported to using
- In 1998 a study conducted at Joyceville Petitionary (Kingston, On), 23% of the inmates agreed to using injection drugs since their arrival at that institution
- A BC study from 2004 showed that 76% of the of people registered with Vancouver Injection Drug Users Study (VIDUS) had been in prison since first using injection drugs
- Rates of HIV are likely higher in prisons due the lack of harm-reduction practice available while risky behaviours are occurring (condomless sex and other sexual activity, injection drug use, and tattooing)
- Prisoners who received treatment for HIV reported to receiving less quality care than had been given in the community
- Aboriginal prisoners are reportedly 9x more prevalent than non-Aboriginal prisoners, increasing the rate of HIV among that population
- HIV rates are higher among female inmates than they are for their male counterparts
- In 2005 federal prisons announced 3.6% of women inmates had a positive status and only 2.4% of male prisoners had a positive HIV status
- There are no educational or harm-reduction programs in place in Canadian institutions that offer support for transgender or youth inmates, but there are programs initiated for inmates from ethno-cultural minority communities

**BREAK TIME – 15 Minutes**

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time the facilitators can address any “thumb up” or any other concerns.

**HIV in Prison Statistics – 30 Minutes**

*The following statistics are from the United States. The data from the U.S. is not representative of the situation in Canada, but gives a generalized idea of how HIV looks within the prison systems.*

- In 2004, approximately 2.2 million people were incarcerated
- The HIV rate is at least 3 times higher among incarcerated individuals than it is among non-incarcerated
- Approximately 20-25% of Americas who are living with HIV have served time
- A study conducted with 50 state prisons determined that there were almost 6,000 people living with HIV who were incarcerated
- 1.9% of men doing time are living with HIV
- 2.8% of females doing time are living with HIV
- 61% of incarcerated individuals have used intravenous drugs (vs 27% of the general population)
- More than two thirds of incarcerated people living with HIV are African American
- In Brazil, 15% of incarcerated people are living with HIV (0.6% of the whole population living with HIV)
- In a 1982 report, it was established that approximately 30% of incarcerated men, have sex with men while incarcerated

**Debrief – 15 Minutes**

Always end the sessions with a 15-minute debrief. The information in these sessions can be heavy and may contradict what some of the participants believe to be true. Or it might resonate with someone who has feelings they want to address. Whatever people are feeling this gives everyone an opportunity to bring up any confusion and the facilitators a chance to listen to and participate in debate and open dialogue.
Session Eight
PRE-GROUP

Session Overview

- Movie
- Break
- Graduation

Required Materials

- Peer Educator Diplomas (prepared and printed with each graduate’s name on it)
- Cake (or other special treat)
- TV and DVD Player or Lap Top and Projector (for movie)
- DVD
- Popcorn and Pop

Note to Facilitators

This is the final session. Make sure to give graduates your business cards or e-mail addresses in case they have any questions or need more resources in the future.
Session Refreshments

As this is the final session and the women graduate and become peer educators, make sure to provide some type of treat:
- Cake
- Cupcakes
- Muffins
- Donuts

As there will be a movie playing at the beginning of the session, provide popcorn and pop during the movie. During the break, prepare the special treat to have after the graduation ceremony.
Session Eight

**HIV Movie**

For the last session play a realistic HIV movie, that is entertaining and informative. Ask the women which movie they would like to watch, below are some available choices.

- Philadelphia
- Dallas Buyers Club
- The Normal Heart
- Gia
- Angels in the Dust
- Angels in America
- We Were Here
- Milk

*During the movie make popcorn and pop available.

**BREAK TIME – 15 Minutes**

Break for 15 minutes. Give the women a chance to use the washroom, smoke, stretch, and have a light snack. During this time the facilitators can address any “thumbs up” or any other concerns.
Graduation

After break, begin the ceremony.
*Make sure the diplomas are prepared in advance. Each one should have that individual's name printed on it.

Call the women up one by one to receive their diplomas. This gives the group a chance to applaud their fellow graduate.

*If this would make any of the women uncomfortable, the diplomas can be handed out.

After all of the women receive their diplomas, bring out the cake (or whichever treat is being provided).

*Make sure the women have facilitators’ contact information in case anyone has questions or is in need of resources in the future.

Congratulate the women and let them know they can leave at any time.
PART THREE: HIV 101

SERVICES OFFERED
Community Services Available

HIV/AIDS Regional Services (HARS)  
844a Princess St.  
613-545-3698 or  
1-800-565-2209  
hars.ca

Addiction & Mental Health Services – KFL&A  
385 Princess St.  
613-544-1356  
www.amhs-kfla.ca

K3C Credit Counselling  
417 Bagot St.  
613-549-7850  
www.k3c.org

Queens University Student Wellness Services  
146/140 Stuart St.  
613-533-6740  
http://www.queensu.ca/studentwellness/

Kingston Community Health Centres (KCHC) - Immigration Services  
263 Weller Ave.  
613-544-4661  
http://www.kchc.ca/index.cfm/immigration-services/

Kingston Community Health Centres (KCHC) – Street Health Centre  
235 Wellington St.  
613-549-1440  
http://www.kchc.ca/index.cfm/street-health-centre/

Ontario Works  
216 Ontario St.  
613-546-4291  
https://www.cityofkingston.ca/residents/community-services/ontario-works

Sexual Assault Centre Kingston (SACK)  
400 Elliot Ave Unit 1  
24/7 Crisis Line  
613-544-6424 or  
1-877-544-6424
References


http://www.avert.org/professionals/history-hiv-aids/originpeople

http://www.amfar.org/worldwide-aids-stats/


http://www.oxforddictionaries.com/us/definition/105nglish105_english/stigma


http://www.oxforddictionaries.com/us/definition/105nglish105_english/marginalization

http://www.oxforddictionaries.com/us/definition/105nglish105_english/harassment

http://www.oxforddictionaries.com/us/definition/105nglish105_english/confidentiality

https://www.youtube.com/watch?v=_jz7yo7L3Z0

https://www.youtube.com/watch?v=hRiWgx4sHGg


http://www.catie.ca/sites/default/files/prep.pdf


http://www.aidsmap.com/CCR5-antagonists/page/1729454/

http://www.intelence.com/understanding-hiv-aids/hiv-treatments

https://www.youtube.com/watch?v=Eqxu3jjh3LE


http://hivinsite.ucsf.edu/InSite?page=kb-07-04-13

http://www.cnn.com/2013/03/04/health/timeline-hiv-aids-moments/
PART FOUR: HIV 101

APPENDICES
Manual Appendix A: Peer Education Diploma Program Flyer

VOLUNTERS NEEDED
HIV/AIDS Regional Services (HARS) & Immigrant Services Kingston and Area (ISKA) are looking for WOMEN who are new to Canada to become PEER EDUCATORS to educate others about HIV and AIDS.

Volunteers will receive:
- 8 Weekly Training Sessions
- A Safe Space
- An Opportunity to Connect with Others
- Refreshments
- Certificate Upon Completion

Sessions run

Please Contact
(613) 545-3698

WOMEN OF ALL AGES AND LANGUAGES WELCOME NO EXPERIENCE NECESSARY NO FEE
### Manual Appendix B: Conversation Starter Cards

<table>
<thead>
<tr>
<th>Favourite Meal</th>
<th>Travel Memories</th>
<th>Any Siblings?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Animals?</td>
<td>The Year 1992</td>
<td>Music Preference</td>
</tr>
<tr>
<td>Coffee or Tea?</td>
<td>Funny Story or Joke</td>
<td>Salty or Sweet</td>
</tr>
<tr>
<td>If you could have any job?</td>
<td>Favourite Memory</td>
<td>Best Season of the Year</td>
</tr>
<tr>
<td>Rather have someone choose your meals or clothes</td>
<td>What sport do you play or wish you could play?</td>
<td>Favourite thing about Canada</td>
</tr>
</tbody>
</table>
### Manual Appendix C: Human Bingo

<table>
<thead>
<tr>
<th>Blue Eyes</th>
<th>Two Cats</th>
<th>Wears Contacts or Glasses</th>
<th>Likes Candy More Than Chocolate</th>
<th>Likes Action Movies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name Starts With an S</td>
<td>Doesn’t Smoke</td>
<td>Likes to Sing</td>
<td>Has Allergies</td>
<td>Is Artistic</td>
</tr>
<tr>
<td>Vegetarian</td>
<td>No Kids</td>
<td>FREE Space</td>
<td>Can Name More Than Three Flowers</td>
<td>Last Name Has I in it</td>
</tr>
<tr>
<td>Does Not Drive</td>
<td>Plays Music</td>
<td>Afraid of an Animal?</td>
<td>Wearing Black Shoes</td>
<td>Likes Birds</td>
</tr>
<tr>
<td>Has a Tattoo</td>
<td>Has Played Baseball</td>
<td>More than two Siblings</td>
<td>Someone with Children</td>
<td>Pet Dog</td>
</tr>
</tbody>
</table>
Manual Appendix D: HIV/AIDS Regional Services Pamphlet

This photo was reproduced and used with permission from HARS
(All pamphlets in appendices were photocopied to show the cover, all pamphlets are available in their entirety in the education office at HARS)
This photo was reproduced from a pamphlet and used with permission from HARS
COMMUNITY PET FOOD SHARING (CPFS)

A community based program of...

HIV/AIDS REGIONAL SERVICES (HARS)

CPFS is a proud supporter of Lucy’s Fund, a HARS program which provides help to people living with HIV/AIDS to cover some of their pet costs.

This photo was reproduced from a pamphlet and used with permission from HARS
This photo was reproduced from a pamphlet and used with permission from HARS and Sex Workers Action Group
Manual Appendix H: CATIE HIV/AIDS Basic Facts Pamphlet

This information was provided by CATIE (Canadian AIDS Treatment Information Exchange). For more information, contact CATIE 1 (800) 263-1638 or info@catie.ca
http://librarypdf.catie.ca/PDF/ATI-40000s/40223E.pdf
This photo was reproduced from a pamphlet and used with permission from HARS
Manual Appendix J: Caring for People With HIV or AIDS

This photo was reproduced from a pamphlet and used with permission from HARS
This information was provided by CATIE (Canadian AIDS Treatment Information Exchange). For more information, contact CATIE 1 (800) 263-1638 or info@catie.ca http://www.catie.ca/fact-sheets/testing/hiv-viral-load-testing
How Does the Immune System Work?

Your immune system works because your body is able to recognize "self" and "non-self." This means that your body is able to tell if an invader (virus, bacteria, parasite, or other another person's tissues) has entered it—even if you aren't consciously aware that anything has happened. Your body recognizes this invader and uses a number of different tactics to destroy it.

Your immune system has many different ways of fighting off foreign invaders. When confronted with a virus, your body responds by activating specific processes of the immune system. First your body recognizes a foreign antigen and delivers it to the lymph system, where it is ingested by a macrophage.

The final stage of your immune response involves the suppressor T-cell. Once the number of invaders has dropped significantly and the infection has resolved, the suppressor T-cell will signal the other cells of the immune system to rest. This is important as prolonged activation of your immune response could eventually lead to damage to your healthy cells.

Image and information was used with permission from the U.S. Department of Health & Human Services: https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/hiv-in-your-body/immune-system-101/
### Overview of HIV History

- In the United States in 1981, a condition known as pneumocystis carinii pneumonia was affecting gay men in San Francisco, and another condition called Kaposi’s Sarcoma was causing similar side effects for gay men in New York and California.
- The condition was referred to as GRID (Gay Related Immuno Deficiency).
- In 1982, the virus was named acquired immunodeficiency syndrome (AIDS).
- Doctors and scientists discovered a virus affecting T-cells was causing AIDS; it was later named the human immunodeficiency virus (HIV).
- In 1985, the FDA approved the first HIV test. The same year actor Rock Hudson died of an AIDS related illness, and his friend and fellow actor, Elizabeth Taylor, established the American Foundation for AIDS Research (amfAR).
- In 1986, brothers Ricky, Robbie, and Randy Ray, all HIV-positive as a result of blood transfusions from an illness called hemophilia, were bullied and banned from their public school.
- The next year, the Ray family’s house was burned down.
- In 1987, the first panel of the AIDS Memorial Quilt was made. The quilt had more than 40,000 panels.
- The same year (1987), the FDA approved the first HIV medicine, an antiretroviral drug, AZT.
- The AIDS Coalition to Unleash Power (ACT UP) was established by an activist, Larry Kramer.
- A nationwide education campaign focusing on AIDS was created with the help of The Ad Council, amfAR, and the National AIDS Network.
- Ryan White died, and shortly after, the U.S. Government enacted the Ryan White Care Act.
- In 1991, the red ribbon became the symbol for HIV/AIDS awareness after being passed out by sing Paul Jabara (founder of the Red Ribbon Foundation) and the Visual AIDS Artists Caucus at the 1991 Tony Awards.
- At the end of 1991, Magic Johnson, NBA all-star, announces his HIV-positive status and retired from basketball.
- In 1993, the movie Philadelphia came out featuring Tom Hanks and Denzel Washington, based on a true story about an attorney who was fired after its identified that he had HIV.
- In 1994, the musical Rent opened off Broadway, showing the lives of young artists and the struggles they faced including poverty, stigma, and HIV.
- Elizabeth Glaser died in 1994 after transmitting HIV to daughter after breastfeeding and to her son while pregnant.
- In 1996, the Joint United Nations Programme on AIDS (UNAIDS) was founded.
- Combination antiretroviral drugs were established and deemed effective as HIV treatment.
- 1997 was the first year that the United States saw a decline in new HIV infection rates.
- In 2000, AIDS was announced as the threat to national security.
- In 2002, the FDA approved a HIV test, which shows results in 20 minutes.
- In 2005, the FDA approved HIV medications made in foreign countries, making this drug more accessible and cheaper.
- Bono created Product Red and donates profits of goods to AIDS organizations.
- Bill Gates donated money and more time (after retiring) to the Gates Foundation, a private sector company which funded ending the HIV/AIDS epidemic.
- Obama removed the U.S. travel and immigration ban, allowing people living with HIV to enter the United States.
- PrEP, an antiretroviral drug used for HIV prevention was effective reducing HIV-negative individuals’ HIV transmission risk by 44%. PrEP is still awaiting approval for use in Canada.
Manual Appendix N: HIV/AIDS History Breakdown

All of the information provided for the history section was derived from three different sources:
http://www.catie.ca/en/world-aids-day/history
http://www.avert.org/professionals/history-hiv-aids/overview

For more detail on the history and progression of HIV, visit those sites and search history.

Remember to always check the sources for the most current data.

Not all of the information in the facilitator’s manual will be present on the participant handout. Use your own discretion when facilitating, not all of the information printed in the history section needs to be said. Plan ahead and pick out the important information to go over with the larger group.

In June of 1981 five men from Los Angeles (LA) began getting sick; the Centre for Disease Control and Prevention (CDC) diagnosed the case as Pneumocystis carinii pneumonia (PCP). The five men who were affected identified as gay, and within days The Los Angeles Times had reported this issue. Some of those men had already died and more gay men from LA and New York experiencing similar symptoms. Soon after, the CDC then released information about gay men also from New York and California dying from a cancer called Kaposi’s Sarcoma. By the end of 1981, there were 270 people, particularly gay men, affected by Kaposi Sarcoma, and of them, 121 died.

In 1982, the condition was known as GRID, which stood for gay-related immune deficiency. Due to that fact that it was almost all gay men who were becoming ill and dying, people assumed that the condition would only affect gay men.

It wasn’t until September 1982 that the CDC released a statement naming acquired immune deficiency syndrome (AIDS) for killing and affecting numerous gay men. The AIDS virus was found in Haiti and in patients with hemophilia, which is when it was realized that the virus could be transmitted through blood transfusion.

Africa and Canada both reported cases of AIDS that year, and it was believed that the virus began in Haiti. That year, there were cases of AIDS in infants, which was when it was realized that mothers could transmit the virus while pregnant.
In 1983, the CDC stated that AIDS was found mostly among homosexual men (with multiple partners), intravenous drug users, people from Haiti, and people with the condition hemophilia, as they were in need of blood transfusions.

By the end of 1983, there were more than 3000 people in America who were living with AIDS, and more than 1200 people had lost their lives.

In 1984, the U.S. Department of Health and Human Services announced that the cause of the virus was identified.

The CDC stated that avoiding sharing needles and other injection drug equipment should help prevent the virus. By the end of that year, there were 7,699 cases of the virus and 3,665 deaths (in America) and 762 cases in Europe.

Africa announced an AIDS epidemic among all people.

1985 was the year that America began to screen blood before using it for transfusions. It was also the year that all of the world’s regions had announced at least one case of the virus with a total of 20,303 people living with AIDS around the world.

The Canadian Red Cross began testing blood.

In 1986 it was announced that the virus that causes AIDS was called human immunodeficiency virus [HIV]. At that point, 85 countries had announced people living with HIV/AIDS, and the total had increased to 38,401. It was established that AIDS could be transmitted through a mother’s breast milk.

1987 was the year when the first anti-retroviral drug was approved for treatment of HIV. This was also the year that the World Health Organization created a global strategy for HIV. The U.S.A considered HIV to be dangerous enough to demand mandatory testing for visa applicants. Princess Diana touched an individual who was living with AIDS. She is photographed, and the picture was sent to the media. A famous American singer and pianist, Liberace, died of AIDS. That was the year that the president spoke about AIDS for the first time publicly.

By the end of 1987 more than 70,000 cases of AIDS had been identified world-wide with more than 45,000 of those happening in the United States. It was estimated that 5-10 million people around the world were living with AIDS, more than half unaware of their status.
December 1st 1988 was determined to be world AIDS day by the World Health Organization. The first needle-exchange program was put into place in San Francisco. It was announced that there were more women in sub-Saharan Africa than there were men who were living with HIV. Many charity organizations were developed; the government released money for AIDS related programs. AIDS ACTION NOW was established in Toronto.

1989 - Compensation was offered by the Canadian government to those who acquired HIV from blood transfusions. There were least 100,000 cases of AIDS in America. 145 Countries had reported AIDS with over 140,000 cases world-wide.

1990 - Ryan White and Keith Haring died from AIDS related illness. The International AIDS Conference protested against USA’s immigration policy. This policy banned people living with AIDS from entering America; this conference was boycotted by domestic and international (non-government) groups. That year, the USA began the Americans with Disabilities Act (ADA), which banned discrimination against people with disabilities, including people living with HIV/AIDS. The FDA approved zidovudine, a medication used to treat children with HIV/AIDS. The Centre of Disease and Control introduced a “client centered” method, focusing on the person, not the virus. The AIDS ACTION NOW group became the Treatment Information Exchange (TIE) and then later the same year became an independent organization called Community AIDS Treatment Information Exchange (CATIE) which was a resource for information. Most of HARS educational pamphlets are from CATIE. Two new organizations were founded, the Canadian HIV Trials Network and the Canadian Association of HIV Research.

1991 – the red ribbon became the international symbol for AIDS awareness when the Visual AIDS Artists Caucus launched their Red Ribbon Project. The U.S. Department of Housing and Urban Development developed the Housing Opportunities of People with AIDS (HOPWA) to offer housing assistance to people who were living with HIV/AIDS. The U.S Congress approved the Terry Beirn Community-Based Clinical Trials Program Act, to begin trialing HIV treatment/medication. The first-ever National Skills Building Conference, which later became the United States Conference on AIDS was formed. Famous basketball player Earvin “Magic” Johnson announced his HIV-positive status, and legendary Queen signer, Freddie Mercury, died of bronchial pneumonia, an AIDS-related illness the day after announcing his HIV-positive status. AIDS Awareness Week was held in Canada for the first time, and the British Columbia Centre for Excellence in HIV/AIDS was founded.

1992 – 8th International AIDS Conference is moved to Amsterdam instead of Boston because of the U.S. immigration restrictions, which made it impossible for someone living with AIDS to enter the U.S. AIDS is responsible for the majority of deaths in America in men aged 25-44. The FDA released a HIV diagnostic kit, which could be used by health care professionals (test took 10 minutes). A 15-year-old teen dies of AIDS-related illness; Ricky Ray and his hemophiliac brothers created controversy
after they battled in court to be given the right to attend school, which was boycotted by local residents. Tennis professional Arthur Ashe announced he was HIV-positive, transmitted through blood transfusion in 1983. The FDA approved a cocktail of drugs which was successful in treating AIDS. The CDC revised the list of AIDS-related illnesses to include those that affect women and injection drug users. The Canadian HIV/AIDS Legal Network was established. In Canada, the Ontario Ministry of Health created anonymous testing across the province.

1993 – The U.S voted to keep the immigration ban, banning any person who was living with AIDS. Pulmonary tuberculosis, reoccurring pneumonia, and cervical cancer were added to the CDCs list of AIDS indicators. More than 2.5 billion were living with the virus. Rudolf Nureyev and Arthur Ashe died due to AIDS related illnesses. The female condom was approved by the FDA. The White House Office of National AIDS Policy (ONAP) was established by Clinton. U.S. Congress gave the Office of AIDS Research oversight over NH AIDS research, and required agencies to include women and minorities in research. CDC announced new research; AIDS would only be considered when CD4 counts drop below 200. The National Association of People with AIDS (NAPWA) ran the first “AIDS Watch” where hundreds of people went to Washington to protest for more funding. Philadelphia, the movie with Tom Hanks, was in theaters, the first ever, Hollywood film regarding AIDS, based on a true story. Angels in America is a play about AIDS; it won a Tony for Best Play. HIV was rapidly spreading throughout Asia and the Pacific. CATIE created the first edition of “Managing your Health” with the Toronto People with AIDS Foundation.

1994 – AIDS was now the number one cause for most deaths of people in America aged 25-44 (not just men). U.S journalist, Randy Shilts, died of AIDS related illness; he wrote about the AIDS epidemic. CDC released a document called Guidelines for Preventing Transmission of HIV Through Transplantation of Human Tissue and Organs. Pedro Zamora was a young gay man who was cast on the TV show The Real World; he died later in the year. The FDA approved first oral HIV test; this was a non-blood-based test. Public Health Services recommend antiretroviral medication for pregnant women who were HIV positive, as it reduced risk of transmission by over 66%. The Greater Involvement of People Living with HIV (GIPA) Principle was formed, 42 countries agreed to “support a greater involvement of people living with HIV at all...levels...and to...stimulate the creation of supportive political, legal, and social environments.”

1995 – Greg Louganis, U.S Olympic gold medal diver, announced his HIV-positive status. The FDA approved protease inhibitor, highly active antiretroviral therapy (HAART). Eric Lynn Wright, AKA Eazy-E (from the hip-hop group NWA), died from AIDS related illness a month after being diagnosed as HIV-positive. The CDC reviewed needle exchange programs, and The National Academy of Sciences agreed that harm reduction (needle exchange programs) were an effective strategy for preventing disease. President Clinton established a Presidential Advisory Council on HIV/AIDS (PACHA) and also hosted the first ever White House Conference on
HIV/AIDS. More than 500,000 cases of HIV were reported by the end of the year, in just the U.S. Estimated 4.7 Million new HIV infections that year. The World Health Organization estimated that more than 19.5 million people (adults and children) had been infected with the virus since the beginning of the pandemic. CATIE was named a partner in the Canadian AIDS Strategy on HIV/AIDS, which was funded by Health Canada. CATIE took over a national role and continued the national treatment registry project.

1996 – For the first time since the beginning of the pandemic, the rates of new HIV infections in the U.S. were declining. AIDS was no longer the leading cause of death in America. UNAIDS (the Joint United Nations Programme on HIV/AIDS) started their operation. That operation advocated for global action and coordinated HIV/AIDS efforts within the UNs systems. The FDA approved an HIV at-home testing kit, a viral load testing kit, the first non-nucleoside reverse transcriptase inhibitor (NNRTI) and the first ever HIV urine test. U.S. Congress reauthorized the Ryan White CARE Act, which began in 1990, when the young man died. The AIDS memorial quilt was displayed for the last time in full, it covers the National Mall in Washington. Dr. David Ho was named Man of the Year by TIME Magazine, for creating a new “hit early, hit hard” strategy for treating HIV as early as possible. The International AIDS Vaccine Initiative (IAVI) was established in hopes for speeding up the process for finding an effective HIV vaccine. THE 11TH annual AIDS Conference was held in Vancouver; the effectiveness of HAART was highlighted creating optimism. New outbreaks were identified in Eastern Europe, the former Soviet Union, India, Vietnam, Cambodia, and China; it was estimated that 23 million people were living with AIDS. CATIE launched its website and opened a full-time treatment information phone service.

1997 – The “hit early, hit hard” strategy was effective making highly active antiretroviral therapy (HAART) the new standard for HIV treatment. Infection rates in the U.S. had declined 47%; HAART was largely responsible for the decline. Clinton made finding a vaccine within 10 years a national priority. Clinton also asked for the creation of a vaccine research center at the National Institute of Health (NIH), named the Dale and Betty Bumpers Vaccine Research Center. The FDA approved Combivir, which combined two antiretroviral medications into one tablet. UNAIDS estimated that more than 30 million people were living with HIV and that each day 16,000 people became infected. More people begin taking protease inhibitors for treatment, and more and more people were resistant to the drug, causing concern.

1998 – The CDC announces that African Americans made up 49% of AIDS-related deaths in America. African Americans were 3 times more likely to die due to AIDS related illness than those from Hispanic origin and 10 times more likely than white Americans. African American leaders developed a “call to action” and request (to the president and surgeon general) that HIV/AIDS be considered a “State of Emergency” within the African American communities. Clinton declared HIV/AIDS is a “severe and ongoing health crisis” and introduced initiatives focused on reducing the impact of HIV/AIDS within racial and ethnic communities. Congress funded the Minority
AIDS Initiatives; $156 million was donated to improve effective means of decreasing transmission rates among minorities.

1999 – The World Health Organization (WHO) announced that AIDS was the fourth leading cause of death worldwide and was responsible for the highest death rates in Africa. It was estimated that 33 million people were living with HIV and that 14 million people had lost their lives due AIDS and the related illnesses. VaxGen, a biotech company began developing human vaccine trials in Thailand. Leadership and Investment in Fighting an Epidemic (LIFE) was formed and would provide funding towards HIV prevention. 

2000 – The United Nations addressed the impact HIV had on peace and security in Africa; for the first time ever, the threat was a virus. President Clinton announced the formation of the Millennium vaccines, which was an initiative for developing HIV, HEP B, and malaria vaccinations. HIV/AIDS was declared a threat to national security in the United States. Clinton announced his plan to assist developing countries with effective HIV medicines. UNAIDS and WHO (among other groups) began an initiative with pharmaceuticals to reduce the price of HIV medication in developing countries. The G8 Summit announced the need for more resources for HIV/AIDS prevention and for the people who were living with HIV. The Global AIDS and Tuberculosis Relief Act of 2000 was established. The United Nations announced Millennium Development Goals to revert the spread of chronic illnesses like HIV/AIDS, malaria, and TB. The Ryan White CARE ACT was reauthorized for the second time. CATIEs name is changed to Canadian AIDS Treatment Information Exchange (formally known as Community AIDS Treatment Information Exchange).

2001 – February 7th became the National Black HIV/AIDS Awareness Day in the United States. May 18th was the date of the first of observances of HIV Vaccine Awareness. The United Nations introduced a Global Fund to help with prevention and treatment of HIV in other countries. Drug manufactures agreed to drop their prices after generic manufactures announced that they would develop a cheap version of HIV medication for developing countries. The World Trade Organization announced the Doha Declaration, an initiative for developing countries to produce generic versions of the medication. The United Nations announced the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria at the UN Special Session for HIV/AIDS. The Greater Involvement of People Living with HIV (GIPA Principle) was certified by 189 UN member countries during the Declaration of Commitment on HIV/AIDS. It was reported by UNAIDS that more than 40 million people were living with HIV and almost 25 million people had died from AIDS and AIDS related illnesses. In 2001, half of the people who were living with AIDS were women. The Aboriginal Council on HIV/AIDS was formed.
2002 – The Global Fund to Fight AIDS, Tuberculosis, and Malaria was officially established. The Global Fund released its first round of grants, which totaled over $600 million, which was estimated to take two years. The life expectancies in sub-Saharan Africa fell from 62 to 47 years of age. The AIDS Conference was held for the 14th year; many countries (more then 24) reported HIV epidemics, and many other countries reported being on the brink of an epidemic. The U.S. National Intelligence Council announced HIV epidemics in the continent of Asia, in Russia, and in parts of Africa. The FDA announced and released the first rapid HIV test; it was 99.6% accurate, and the results could be seen in 20 minutes. In 2002, approximately 3.4 million new infections happened in sub-Saharan Africa. Drug resistance and drug side effects were being experienced, making people question the “hit early, hit hard” approach.

2003 – The CDC announced that more than half of the 40,000 new infections in the United States were of people who were unaware that they were HIV positive. President Bush formed the President’s Emergency Plan for AIDS Relief (PEPFAR); the plan included $15 million and 5 years to combat HIV/AIDS in countries where there was a high prevalence of HIV. The Bill and Melinda Gates Foundation granted $60 million to the International Partnership for Microbicides to research and develop ways to prevent HIV transmission. The CDC announced Advancing HIV Prevention: New Strategies for a Changing Epidemic, an HIV prevention initiative. The Group of Eight (G8) Summit announced new commitments to the HIV/AIDS focus called Global Fund. October 15th became the first annual National Latino AIDS Awareness Day in the U.S. The WHO created a “3 by 5” initiative that was planning on providing HIV treatment for 3 million people by 2005. The first North American supervised injection site was established in Vancouver, British Columbia.

2004 – $350 million was given to United States President’s Emergency Program for AIDS Relief (PEPFAR). The Global Coalition on Women and AIDS was funded by UNAIDS to raise awareness for women and girls around the world who were affected by HIV/AIDS. The FDA approved a 20-minute rapid HIV test that used oral fluids. The FDA also released a HIV therapies document for developing countries to use to make HIV drugs available there. The G8 Summit created the Global HIV Vaccine Enterprise, made to accommodate more research for HIV vaccine. WHO supported harm reduction practices like needle exchange program for HIV prevention.

2005 – The World Economic Forum announced Africa and other countries where AIDS was endemic would be a focus for them in 2005. It was announced that 700,000 people had been reached and were receiving treatment because of the joint efforts of WHO, UNAIDS, U.S. Government, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The FDA announced that the United States President’s Emergency Plan for AIDS Relief had been given approval to use a generic antiretroviral drug. May 19th became the first ever National Asian and Pacific Islander HIV/AIDS Awareness Day in the United States. The G8 Summit announced
that it would focus on HIV/AIDS development in Africa. Health Canada announced its approval of a rapid HIV test which provided results within two minutes.

2006 – In 2006 it had been 25 years since AIDS was first reported in San Francisco. The United Stated made March 10th National Women and Girls HIV/AIDS Awareness Day and March 20th National Native HIV/AIDS Awareness Day. The CDC announced revisions to their HIV testing recommendations, suggesting all adults aged 13-64 get tested for HIV and those at high risk get tested yearly. The University of Illinois released results from a study stating that men who were circumcised reduced their risk of female-to-male transmission by more than 50%. Men from Kenya were involved in a clinical trial study which supported the statistics. The Ryan White CARE ACT was reauthorized for the third time. The International AIDS Conference was held for the 16th time and was hosted in Toronto.

2007 – Trying to promote people to get tested for HIV, WHO and UNIAIDS released recommendations for “provider-initiated” HIV testing. The International HIV/AIDS Implementers Meeting was held by the Rwandan Government where cosponsors provided information on HIV prevention and treatment. The CDC released Prevention is Care (PIC), a social marketing initiative made for people who care for people who were living with HIV. The CDC announced that 565,000 people had died in the United States because of AIDS since the pandemic started in 1981. WHO and UNIAIDS said that male circumcision could be a means of preventative HIV measures. The Canadian HIV Vaccine Initiative (CHVI) was created as a part of Canada’s involvement with global HIV/AIDS efforts.

2008 – The International HIV/AIDS Implementers Meeting was held by the Ugandan Government. President Bush reauthorized PEPFAR, the bill which stated the HIV positive people can enter the United States but would be assessed for admittance on a case by case basis; in the past HIV positive people were completely banned from entering the United States. The CDC announced due to inaccurate research previously it was estimated that there were 56,300 new HIV infections each year rather than previously estimates stating 40,000. September 18th became the first National HIV/AIDS and Aging Awareness Day, and September 27th became National Gay Men’s HIV/AIDS Awareness Day. World AIDS Day occurred annually for the 20th time. The 17th International AIDS Conference was hosted in Mexico City. CATIE received funding from the Public Health Agency of Canada (PHAC) to become established as a national Knowledge Exchange Broker.

2009 – As Obama took presidency, he announced the need for the United States’ first National HIV/AIDS Strategy. It was announced by the District of Columbia Health Department’s HIV/AIDS, Hepatitis, STD, and TB Administration that the area of Washington, DC had higher rates than West Africa of HIV. The U.S. Government and the CDC established the Act Against AIDS campaign to reduce the rate of new HIV infections. The CDC also released the Act Against AIDS Leadership Initiative (AAALI) to increase HIV awareness among the black communities in the United States. Obama announced the Global Health Initiative (GHI) to address the global health
concern HIV was causing in low-income countries. June 8th became the first annual Caribbean American HIV/AIDS Awareness Day. The Department of Veterans Affairs dropped the need for written consent while testing to increase the amount of people getting testing for HIV (verbal consent was needed). The FDA approved the 100th antiretroviral drug. Obama announced he was going to remove the HIV travel and immigration ban, making it legal for people with HIV to travel to the United States. UNAIDS announces that the HIV rates in the United States had been declining over the past decade while increasing in East Asia. Obama modified the ban on use of Federal funds for harm reduction in the form of needle exchange programs, making funds available for certain aspects of harm reduction (disposal, education, marketing, and evaluations). UNAIDS announced the importance of programs for eliminating mother-to-child HIV transmission.

2010 – The HIV travel and immigration ban was officially removed. The President signed the Patient Protection and Affordable Care Act, giving all Americans greater access to care and prevention with a special focus for people living with HIV and other chronic illnesses. Obama released the National HIV/AIDS Strategy for the United States. The 18th International AIDS Conference was held in Vienna, Austria. The Centre for the AIDS Programme of Research in South Africa (CAPRISA) released the results of a study testing vaginal microbicides as a form of antiretroviral-based preventative medicine. This medicine, a gel, was found to be affective and showed a risk reduction of 39%-54%. The National Institute of Health (NIH) conducted a study, iPrEx trial, that showed taking HIV medicine everyday was effective in reducing the risk of HIV-negative men acquiring HIV from HIV-positive partners; this study supported pre-exposure prophylaxis (PrEP). WHO, UNAIDS, and UNICEF published a report, Universal Access, that stated in 2009 5.2 million people were receiving treatment and the same year about 1 million people newly began treatment, which was the biggest increase of treatment use ever recorded. AIDS Action and National AIDS Fund merged and become AIDS United. The government of Canada and the Bill & Melinda Gates Foundation awarded $139 million for implementation of the Canadian HIV Vaccine Initiative (CHVI).

2011 – The U.S. Department of Health and Human Services (HHS) established the 12 cities Project, where HIV planning and response would be addressed in the 12 U.S. cities most affected by HIV/AIDS. Elizabeth Taylor, a long time AIDS activist, died. She was a chairman of amfAR, American Foundation for AIDS Research. The U.S. Secretary’s speech included “Commemorating 30 Years of Leadership in the Fight Against HIV/AIDS”. A global plan was established to prevent mother-to-child transmission. It had been a year since Obama announced the National HIV/AIDS Strategy. The CDC’s study called TDF2 and another study called Partners PrEP stated that regular adherence to HIV medication can be effective for treating HIV and for preventing HIV when used by HIV-negative partners of HIV-positive people (study tested heterosexual sex). The Road to AIDS 2012 was a series of 15 conferences that were held around the United States as a lead up to the 20th Annual AIDS Conference in 2012. Hilary Clinton announced the United States’ goal for creating an AIDS-free generation and spoke about the progress that had been made
over the past 30 years. On December 1st, which is World AIDS Day, President Obama announced at the ONE campaign and RED event that he was going to increase availability of prevention and treatment and care for those living with the virus. The Journal of Science releases a statement naming HPTN 052 (PrEP study) as Breakthrough Study of 2011. The FDA approved and released Complera an HIV drug which had all the medicines in one tablet. The Supreme Court of Canada ruled in favour of InSite, which allowed the Vancouver based safe supervised needle injection site to continue to run. WHO included, for the first time ever, people who are transgender as a part of their Prevention and Treatment of HIV.

2012 – It was established that people who are on antiretroviral therapy (ART) are at an increased risk of being affected by cardiovascular disease. The U.S. Department of Health and Human Services announced updated Treatment Guidelines stating that anyone with a positive HIV status should receive treatment. Research conducted and released showed that 25% of Americans thought that HIV could be transmitted from sharing the same drinking glass, which was roughly the same amount of people who thought that in 1987. The FDA approved an at-home HIV test that gave the user a chance to see their status right away. The FDA approved a drug called Truvada, for pre-exposure prophylaxis (PrEP); people who were HIV-negative could take this medication to reduce the risk of acquiring HIV. The XIX International AIDS Conference, AIDS 2012, was hosted in the United States in Washington for the first time in 22 years. The AIDS Memorial Quilt was displayed, in full, for the first time since 1996. The Supreme Court of Canada ruled that a person living with HIV has a duty to disclose this information to sexual partners before being sexually intimate unless having vaginal sex, with a condom, and a low or undetectable viral load.

2013 – The Mississippi Baby was the first case of well-documented HIV cure. This baby did not receive any treatment for its HIV yet seemed cured of all signs of the virus. Middle-aged people were the focus for two New York Times articles called The Faces of H.I.V. in New York in 2013 and ‘People Think It’s Over’: Spared Death, Aging People with H.I.V. Struggle to Live. RISE Proud: Combating HIV Among Black Gay and Bisexual Men was released by the National Minority AIDS Council (NMAC). Two people living with HIV in Boston, received bone-marrow transplants for their blood cancer conditions and had been rid of the virus for weeks, despite the ending of antiretroviral drugs. Obama announced the priority of HIV Care Continuum Initiative which aimed to increase the treatment used for people who are living with HIV. The National Latino/Hispanic HIV/AIDS Action Agenda was published to raise awareness for the impact of HIV on Hispanic and Latino communities. Obama initiated the HIV Organ Policy Equity (HOPE) Act, which gave people living with HIV a chance to both donate and receive life-saving organs. Nelson Mandela died at age 95 after years of addressing the AIDS pandemic in South Africa. UNAIDS stated that there were approximately 2.3 million new HIV infections in 2013 and more than 1.5 million people died. Globally, more than 35 million people were living with HIV in 2013. UNAIDS announced new HIV infections had declined by more than 50% in low and middle income countries. UNAIDS also stated that the number of people
receiving treatment had increased over 60% since 2011. The CDC included people who inject drugs as a group who could benefit from PrEP after the Bangkok Tenofovir study showed that antiretroviral drugs worked for reducing rates of transmissions between shared drug equipment. Canada’s first interim guidance on PrEP was released by the Quebec Ministry of Health. CIHR announced the release of funding for two Canadian research projects, which are given five years for cure related research.

2014 – The U.S. Affordable Care Act (ACA) stated that insurers were not allowed to discriminate against people who already have diagnosed conditions, and they were not allowed to put limits on coverage which were benefits for insured people who were living with HIV. The two individuals who received bone marrow transplants for blood cancer relapsed and had detectable signs of HIV. amfAR launched Countdown to a Cure for AIDS, a research initiative given $100 million to find a cure by 2020. A European study, the PARTNER study, released results showing that HIV-positive people who were adhering to antiretroviral drugs and had undetectable viral loads were not transmitting the virus to HIV-negative people. The United Nations Commission on the Status of Women released a report outlining the need to focus on HIV prevention and treatment for women and girls as HIV continued to increase among women and girls. That report identified the increased risk for stigma, discrimination, gender inequality, and violence among females with positive HIV statuses. Douglas Brooks, an African American man living with HIV was appointed the Director of the White House Office of National AIDS Policy (ONAP); he was the first black man or person living with HIV to hold that position. After two years of no identifiable HIV, the Mississippi Baby had detectable levels of HIV. Flight MH17 was shot down in Ukraine, killing the 298 passengers, including six individuals (scientists and AIDS activists) headed to the 20th International AIDS Conference in Australia. At AIDS 2014 it was announced that a one-size-fits-all approach isn’t best suited when approaching HIV; a more targeted-based approach would be more effective. The CDC announced that there were gaps in the designated care and treatment for people who are Latino. The CDC later announced that only 30% of HIV+ Americans were receiving HIV treatment, and of the remainder, more than half were aware of their status but not receiving treatment. The FDA also announced that they were recommending changes be made to the blood donor deferral guidelines, making men who have sex with men candidates for blood donation after refraining from sex for one year. UNAIDS announced the “Fast Track” initiative to avoid 28 million new infections and bring an end to the HIV pandemic by 2030. UNAIDS also announced 90-90-90 targets, aiming for 90% diagnosis rate among people who have the virus, 90% of those people to be receiving treatment, and 90% to have undetectable viral loads by 2020. The European AIDS Treatment Group and NAM issued a consensus report about using HIV treatment for preventative measures. HIV, Stigma and Society was released by the B.C. Ministry of Health, announcing some of the underlying factors contributing to the HIV epidemic. The Melbourne Declaration: Nobody Left Behind was announced at the International AIDS Conference addressing and calling for an end to the stigma and discrimination towards people who are living with HIV.
2015 – START, a large clinical trial, announced that beginning treatment as early as possible gives the person living with HIV a good chance of living without serious illness or death as a result of HIV. The International AIDS Conference was held in Vancouver where it was announced that the world’s leaders needed to make more effort and put greater focus on access to HIV treatment. An English study announced the effectiveness of PrEP for prevention of HIV in men who have sex with men. Gilead Sciences applied for approval of Truvada for HIV prevention in Canada. They are currently awaiting approval from Health Canada. The Canadian Positive People Network was formed supporting people living with HIV and co-infections.
This information was provided by CATIE (Canadian AIDS Treatment Information Exchange). For more information, contact CATIE 1 (800) 263-1638 or info@catie.ca: http://librarypdf.catie.ca/pdf/ATI-40000s/40237.pdf
Manual Appendix P: CATIE People Living with HIV in Canada Handout

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This information was provided by CATIE (Canadian AIDS Treatment Information Exchange). For more information, contact CATIE 1 (800) 263-1638 or info@catie.ca. http://librarypdf.catie.ca/pdf/ATI-40000s/40239.pdf
This quiz is for your education only. Please answer honestly to see the best effect of misconceptions. You have two different coloured pens so that you are able to provide two answers when applicable. One colour should represent your current understanding or assumption and the other colour should represent your previous understanding or assumptions (previous should be the answer you would have given before beginning the Peer Education Diploma Program).

1. HIV and AIDS are the same thing.
   True
   False

2. HIV began
   a) in gay men in San Francisco
   b) from humans having sexual intercourse with monkeys
   c) the Government created the virus
   d) spread of multiple sexual related diseases
   e) none of the above

3. You could acquire HIV by being in the same room as someone who has a positive HIV status.
   True
   False
4. HIV is transmitted by
   a) air
   b) sexual activity
   c) blood
   d) Saliva
   e) none of the above

5. When working with someone with HIV you need to be cautious of your surroundings and make sure not to share cups or cutlery.
   True
   False

6. Who could get HIV?
   a) people who use drugs
   b) gay men
   c) promiscuous people
   d) anyone
   e) none of the above

7. HIV is a death sentence
   True
   False
8. Who needs HIV/AIDS education?
   a) gay men
   b) everyone
   c) teenagers
   d) people who are sexually active
   e) none of the above

9. You should be worried about HIV transmission when learning of someone’s HIV positive status.
   True
   False

10. You could get HIV from
   a) mosquitos
   b) toilet seats
   c) hugging
   d) sneezing
   e) none of the above

*HIV Misconception Quiz was created by Meagan Rogers with feedback from HARS staff members regarding common HIV misconceptions.
Manual Appendix S: Criminal Law & HIV Non-Disclosure in Canada Information Package

This is just an image of the first page. The entirety of the document can be seen and printed from http://www.aidslaw.ca/site/wp-content/uploads/2014/09/CriminalInfo2014_ENG.pdf
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LAST UPDATED: July 2015

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HIV/AIDS PEER EDUCATION

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Appendix F: Results of HIV 101: Manual Evaluation I

Question One

I find the HIV 101 Manual to be user friendly and easy to read.

Answered: 5  Skipped: 0

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Total 5
Question Two

I believe the information in this manual to be factual.

Answered: 5  Skipped: 0

Answer Choices

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Question Three

I learned something new while reading this manual.

Answered: 5  Skipped: 0

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Question Four

I would feel confident facilitating the peer education diploma program after reading this manual.

Answered: 5  Skipped: 0

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Question Five

I find this manual unorganized with little to no flow.

Answered: 5  Skipped: 0

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Question Six

This manual is missing important information.

Answered: 5  Skipped: 0

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Question Seven

I would follow the manual's outline closely if I were to facilitate this program.

Answered: 5  Skipped: 0

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**Question Eight**

**I will use this manual in the future or recommend it to others.**

- **Answered:** 5  **Skipped:** 0

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Question Nine

I think this manual could benefit from more research and information.

Answered: 5  Skipped: 0

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Question Ten

I think this manual will be beneficial for HARS.

Answered: 5  Skipped: 0

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Appendix G: Results of HIV 101: Manual Evaluation II

Evaluator One

PAGE 1

Q1: Please comment on your overall impression of this manual.

You did a great job on this manual! It is very organized and is easy to read and follow. The overview pages will be a big help for facilitators.

PAGE 2

Q2: Please comment on the limitations of this manual.

Facilitators needing to do research before implementing with clients can be both a positive and a negative. Time consuming however it guarantees that users are given the most up to date and accurate information.

PAGE 3

Q3: Please comment on ways to improve the manual.

This manual is great as it is.

PAGE 4

Q4: Please leave any additional comments you have regarding the manual.

Respondent skipped this question
Evaluator Two

PAGE 1

Q1: Please comment on your overall impression of this manual.

- great set up
- easy to follow
- beneficial for HARS

PAGE 2

Q2: Please comment on the limitations of this manual.

Respondent skipped this question

PAGE 3

Q3: Please comment on ways to improve the manual.

Respondent skipped this question

PAGE 4

Q4: Please leave any additional comments you have regarding the manual.

Well done!
Evaluator Three

Q1: Please comment on your overall impression of this manual.

This manual was well written and contains plenty of valuable HIV education.

Q2: Please comment on the limitations of this manual.

This manual has yet to be used.

Q3: Please comment on ways to improve the manual.

More activities or learning tools could be beneficial.

Q4: Please leave any additional comments you have regarding the manual.

*Respondent skipped this question*
Evaluator Four

PAGE 1

Q1: Please comment on your overall impression of this manual.

Meagan, this manual is wonderful! What an amazing piece of work. It is very clear, well laid out, organized efficiently and it looks great! I love the boxed pieces like “session overview” and “resources required” as they are consistent throughout the manual which will allow the facilitator to know at a glance, what is needed.

PAGE 2

Q2: Please comment on the limitations of this manual.

As you mentioned yourself, stats, treatments and info changes regularly in the HIV sector so each session will require some research to ensure all is up to date, but there is nothing that can be done about that.

PAGE 3

Q3: Please comment on ways to improve the manual.

There are just a few spelling errors (that I have corrected now in my copy) but otherwise I am very impressed.

PAGE 4

Q4: Please leave any additional comments you have regarding the manual.

Respondent skipped this question
Evaluator Five

**PAGE 1**

**Q1:** Please comment on your overall impression of this manual.

Well organized. Easy to follow. Lay out will make it easy for individuals to follow

**PAGE 2**

**Q2:** Please comment on the limitations of this manual.

Can't think of any at this time

**PAGE 3**

**Q3:** Please comment on ways to improve the manual.

The way the manual is written is fine as it is.

**PAGE 4**

**Q4:** Please leave any additional comments you have regarding the manual.

Great resource. Excellent job