HIV/AIDS and Immigration

Service Advocate Training Manual

Committee for Accessible AIDS Treatment

August 2002

Foreword

The Committee for Accessible AIDS Treatment is a group of service providers from over 20 AIDS service organizations and other health and social service agencies across Toronto. In 2001, CAAT co-ordinated an action research project, *Improving Access to Health Care for People Living with HIV/AIDS Who Are Immigrants, Refugees or Without Status*, which documented the experiences of people with HIV/AIDS who were struggling with the immigration system. This manual was conceived as a response to some of the report's findings.

This manual was designed to train service providers to facilitate access to services for immigrants and refugees with HIV/AIDS. We hope to bring service providers from different fields together so that they can learn from each other's experiences, network with others, acquire knowledge and develop new skills. This manual was created using a train-the-trainer model: it is hoped that some participants will go on to lead workshops with their peers.

For copies of this manual, please contact:
Regent Park Community Health Centre
465 Dundas St West
Toronto, ON M5A 2B2
(416) 364-2261

Acknowledgements

- We would like to thank members of the Editorial Team of the manual for their ongoing guidance, support and encouragement in the development of this manual.

Debra Czegledi	Toronto Community Care Access Centre
Jordan Lewis	St Michael's Hospital – Positive Care Clinic
Lynn Muir	Casey House Hospice
Rebecca Penn	Women's Residence
Christina Strang	Voices of Positive Women

- Thanks to members of the Project Advisory Committee for their input and contributions. Please see Appendix 6 for a full list of agencies in the Committee for Accessible AIDS Treatment.

Sean Brennan	AIDS Committee of Toronto
Lisa Crawley Beames	Centre for Addiction and Mental Health
Zarine Dordi	Africans in Partnership against AIDS
Sue Edwards	Formerly of Casey House Hospice
Jose Franco	Alliance for South Asian AIDS Prevention
Janis Grierson	Toronto Public Health
Sue Hranilovic	410 Sherbourne Health Centre
Mohammed Khan	Alliance for South Asian AIDS Prevention
Jennifer Kindy	Teresa Group Child and Family Aid
Lea Narciso	Ontario AIDS Network
Fanta Ongoiba	Africans in Partnership against AIDS
Sally Simpson	St Michael's Hospital – Positive Care Clinic
Lena Soje	Black Coalition for AIDS Prevention
Ross Smith	Toronto Community Care Access Centre
Patrick Truong	Asian Community AIDS Services

- Thanks to the following agencies and individuals for their assistance and support: Pamela Bowes at the Ontario AIDS Network, Wendy Crolla, Anna Demetrakopoulos at the Ontario Bereavement Project, Sam Dunn at Access Alliance Multicultural Community Health Centre, Kevin Hill, Heather Jessome and the librarians at the AIDS Committee for Toronto, Gloria Murrant, Charlotte Reeve, the Catalyst Centre, the Community Linked Evaluation AIDS Resource Unit, and finally, staff at St. Stephen's Community House, Women's Residence and Fife House.

- **Finally, thanks to GlaxoSmithKline in partnership with Shire BioChem, and the Health Canada ACAP Program for providing the funding for this project.**

Researcher and Manual Writer	**Kate Reeve**
Project Co-ordinator	**Robin Silverman**
Project Supervisor	**Dr. Alan Li**
Sponsoring Organization	**Regent Park Community Health Centre**

Table of Contents

Overview 7

Glossary of Terms 9

Section One: Information on HIV/AIDS and Immigration 9

Unit 1: Introduction to HIV/AIDS 10
- Learning Objectives 12
- Introduction 12
- Icebreaker 12
- Medical Aspects of HIV 15
- Social Aspects of HIV 30
- Communication Skills: Facilitating Discussion of HIV Status 37
- Conclusion 46
- Evaluation 46
- References and Resources 47

Unit 2: Introduction to the Immigration and Refugee Experience 49
- Learning Objectives 51
- Introduction 51
- Icebreaker 53
- Attitudes and Values 55
- The Immigration and Refugee System 56
- Communication Skills: Facilitating Discussion of Immigration Status 64
- Conclusion 73
- Evaluation 73
- References and Resources 74

Unit 3: HIV/AIDS and Immigration 75
- Learning Objectives 76
- Introduction 76
- Icebreaker 78
- Sharing Experiences 78
- Referrals and Resources 79
- Case Management 83
- Conclusion 90
- Evaluation 90
- References and Resources 91

Section Two: Skills Development 93

Unit 4: Cultural Competence 94
Learning Objectives 95
Introduction 95
Icebreaker 97
Exploring Identity 97
Theoretical Concepts 99
Applying the Concepts 103
Conclusion 113
Evaluation 113
References and Resources 114

Unit 5: Advocacy 115
Learning Objectives 116
Introduction 116
Icebreaker 116
Advocacy: What is it? 119
Individual Advocacy: Skills and Strategies 122
Systemic Advocacy 136
Conclusion 142
Evaluation 142
References and Resources 143

Section Three: Peer Education 144

Unit 6: Facilitation Skills 145
Learning Objectives 147
Introduction 147
Icebreaker 148
Ways of Learning 149
Encouraging Participation 155
Applying the Concepts 158
Conclusion 160
Evaluation 160
References and Resources 162

Unit 7: Follow-up for Peer Trainers 163
Learning Objectives 164
Introduction 164
Icebreaker 164
Discussion and Feedback 164
Skills Development 165
Conclusion 165
Evaluation 165

Section Four: Appendices …………………………………………………….. 166

Appendix 1: Communication Skills for Discussing Sexuality ……………… 167

Appendix 2: Ground Rules ………………………………………………. 174

Appendix 3: Icebreaker Exercises ……………………………………… 175

Appendix 4: Exercises ………………………………………………………. 177
- A. Introducing Ideas ………………………………… 177
- B. Developing Ideas ………………………………… 178
- C. Synthesizing Ideas ………………………………… 178

Appendix 5: Evaluation Tools …………………………………………….. 180

Appendix 6: Members of CAAT ……………………………………….... 183

Appendix 7: CAAT Publications ……………………………………….. 185

Overview

Section One: Information on HIV/AIDS and Immigration

1. Introduction to HIV/AIDS
This workshop will introduce participants to basic information about HIV, including medical and social issues. Participants will also be introduced to communication skills that facilitate discussion of HIV status.

2. Introduction to the Immigration and Refugee Experience
This workshop will introduce participants to the structure of the immigration and refugee system, helping them to identify stages in the process, and the services and health coverage for which people are eligible. Also, participants will learn communication skills that can help facilitate discussion of immigration status.

3. HIV/AIDS and Immigration
This workshop will build on basic knowledge that participants have of the immigration and refugee process and of issues related to HIV/AIDS. Participants will identify and explore some of the more complex issues that arise for an immigrant or refugee PHA. Participants will use case studies to develop in-depth work plans.

Section Two: Skills Development

4. Cultural Competence
This workshop will encourage participants to carry out their work with an awareness of their social location and the broader context of socioeconomic inequalities and injustice. Tools will be developed to help participants work more effectively across difference.

5. Advocacy
This workshop will offer participants an opportunity to develop their advocacy skills, for work with individuals and on a systemic level. Participants will be able to tie together all the skills they have gained using case studies.

Section Three: Peer Education

6. Facilitation Skills
This workshop will be specifically aimed at participants who may not have experience in facilitation, but who would like to carry out outreach and provide advocacy training for immigrant/refugee PHAs.

7. Follow-up for Peer Trainers
This workshop is intended to facilitate the process of follow-up with participants who have led the workshops with their peers. Gaps in knowledge and skills can be addressed and feedback can be provided on the overall usefulness of the training manual.

Glossary of terms

ACT	AIDS Committee of Toronto
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retrovirals
ASO	AIDS Service Organization
CAAT	Committee for Accessible AIDS Treatment
CATIE	Community AIDS Treatment Information Exchange
CHC	Community Health Centre
HAART	Highly Active AntiRetroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Use
IFH	Interim Federal Health
MSM	Men Who Have Sex with Men
OCASI	Ontario Coalition of Agencies Serving Immigrants
OHIP	Ontario Health Insurance Plan
PHA	Person Living with HIV/AIDS
STD	Sexually Transmitted Disease
UNAIDS	Joint United Nations Program on HIV/AIDS

Section One:
Information on HIV/AIDS and Immigration

Unit 1: Introduction to HIV/AIDS

Unit 2: Introduction to the Immigration and Refugee Experience

Unit 3: HIV/AIDS and Immigration

Unit 1: Introduction to HIV/AIDS

1. Introduction

2. Icebreaker

2.1 Exercise Bingo
Handout *Bingo*

3. Medical Aspects of HIV

3A. Transmission and Prevention

3A.1 Exercise Brainstorm: Transmission
Handout *Transmission and Prevention*
Handout *Risk*

3A.2 Exercise Risk and Harm Reduction
Handout *Sexual Risk Spectrum Chart and Risk Model*

3A.3 Exercise Brainstorm: Harm Reduction Strategies
Handout *Harm Reduction*

3B. Progression

3B.1 Exercise Order the Stages of Progression
Handout *Stages in the Progression of HIV Disease*

3C. Treatment

3C.1 Exercise Brainstorm: Treatment Access
Handout *HIV Treatment*
Handout *HIV Medication*

3C.2 Exercise Speaker

3D. Global Perspective

3D.1 Exercise Map the Epidemic
Handout *HIV in the World*
Handout *World Map*
Handout *Global Stats*
Handout *Social Determinants of Health*

4. Social Aspects of HIV

4.1 Exercise Video

4.2 Exercise Speaker
Background *Speakers Bureaus*

4.3 Exercise Personal Testimony
Handouts *Personal Testimonies One-Four*

5. Communication Skills: Facilitating Discussion of HIV Status

5.1 Exercise Brainstorm: Definitions
Handout *Definitions*
Handout *The Pros and Cons of Disclosure*

5.2 Exercise Scenarios: Perspectives on Disclosure
Handout *Scenario Chart*

5.3 Exercise Role Play: The Tortoise and the Hare
Background *Role Cards*

5.4 Exercise Role Play: Sexuality Secrets
Handout *Instructions for Sexuality Secrets*

6. Conclusion

7. Evaluation

References and Resources

Learning Objectives

The primary goal of this unit is to introduce participants to key issues related to HIV/AIDS. Participants will be able to:

- ♦ Identify methods of transmission of the virus, stages in the progression of the disease, and various ways of treating HIV/AIDS
- ♦ Understand main social issues faced by people living with HIV
- ♦ Encourage discussion of HIV status with clients
- ♦ Understand why issues relating to HIV/AIDS are relevant to their work

Suggested Outline for 2.5-hour Workshop

1. Introduction – 5 min
2. Icebreaker – 10 min
3. Medical Aspects of HIV – 40 min
4. Social Aspects of HIV – 30 min
5. Break – 10 min
6. Communication Styles: Facilitating Discussion – 40 min
7. Conclusion – 10 min
8. Evaluation – 5 min

1. Introduction

- ♦ Why is the issue of HIV/AIDS among immigrants and refugees relevant to our work?
  - HIV is a well-established global phenomenon, present in every region of the world. (UNAIDS Population and Mobility)
  - Migration and mobility increase vulnerability to HIV/AIDS.
  - Stigma, discrimination and fear around HIV/AIDS affect access to treatment, care and support for PHAs.
- ♦ Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- ♦ Workshop agenda
- ♦ Ground rules and confidentiality (See Appendix 2.)
- ♦ Other housekeeping information (washrooms, smoking, break time)

2. Icebreaker

See Appendix 3 for a list of other Icebreaker exercises.

Exercise 2.1 Bingo

Materials Prizes, Bingo sheets, pens

Process

- Hand out Bingo sheets.
- Ask participants to find a person in the group who has one of the characteristics, and get them to write their name in that square.
- If it is a large enough group, participants should not have anyone write their name on their sheet twice.
- Offer a prize to the participant who completes their sheet the fastest.
- Change Bingo sheets to cater to different groups of participants and workshop topics. See an example of an HIV/AIDS Bingo hunt sheet below.

Questions Was anyone motivated by the prize? What are the prizes in our work?
How did participants feel asking the questions?
Did anyone have trouble remembering or identifying experiences?
Was it difficult to discuss or recall some experiences?
What tools or techniques can we use to make discussing these issues or experiences easier?

Handout 2: Bingo

Knows someone who is HIV-positive	Has worked at the agency for more than a year	Remembers the first time they heard about HIV/AIDS
Has looked at HIV/AIDS-related websites	Has experienced discrimination	Has discussed safer sex practices with a client
Has seen the movie *And The Band Played On*	Can name 2 AIDS organizations	Has participated in an HIV/AIDS training before

3. Medical Aspects of HIV

3A. Transmission and Prevention

Exercise 3A.1 Brainstorm: Transmission

Materials Flipchart paper and markers

Process

- Break participants into three groups. Give each group a flipchart sheet with one of these three questions written at the top:
  1. What is HIV/AIDS?
  2. How do you get HIV/AIDS?
  3. How do you protect yourself?
- Ask each group to list the information that they know about each category.
- As an alternative, the whole group can brainstorm answers to these questions.
- Post the sheets on the wall and, in the large group, review the information listed. Fill in any gaps in their knowledge by reviewing the handouts.
- When filling in the gaps for the third question, "How do you protect yourself?", review the handout on Risk. Let participants know that the next two exercises will also explore HIV prevention.

Handout 3A.1: Transmission and Prevention

What is HIV/AIDS?

Human Immunodeficiency Virus (HIV) is a virus that weakens a person's immune system. When a **Person Living with HIV/AIDS** (PHA) gets an opportunistic infection, they have **Acquired Immune Deficiency Syndrome** (AIDS). Being HIV-positive is also called having **HIV disease**.

- HIV gets into a cell and takes over its control centre. The virus then makes copies of itself. These copies then infect other cells. Up to 10 billion copies may be made every day. HIV then **prevents your immune system from working properly** by taking over parts of it.

- A **CD4+ or T4 cell count** measures a person's CD4+ or T4 cells, which are like the quarterbacks of the immune system. This test is the most important indicator of where a person is in the course of the disease. A healthy, HIV-negative person has between 400 and 1,800 CD4+ cells per cubic milliliter (or 400 to 1,500 for men). Above 500 is a normal healthy number.

- Another important test measures **viral load**, or how many copies of HIV are in a person's blood. Below 50 copies is considered *undetectable*.

How do you get HIV?

In order for transmission to occur, there must be:

1. **HIV-infected fluids:** HIV is found in semen, vaginal fluid, blood and breast milk, and pre-ejaculate. HIV is also found in urine, saliva and tears but in quantities too small to transmit HIV.

2. **A way for HIV to enter your bloodstream:** through mucous membranes or a break in the skin

3. **An activity that allows transmission to occur:**
   a. Having sex: when the blood, semen or vaginal secretions of an infected person enters your blood stream
   b. From mother to child: in utero, during birth or through breast milk
   c. Receiving an infected blood transfusion or other blood product
   d. Sharing needles or other drug equipment with an infected person

Adapted from *A Practical Guide to HAART* by CATIE

Handout 3A.1: Risk

Personal Risk Assessment Model

This model helps us to understand different factors affecting risk.

$$\text{Risk} = \frac{\text{Viral Dose} \times \text{Exposure}}{\text{Resistance}}$$

Viral Dose:
- How much virus in the fluid
- Stage of the disease affects the amount of virus present

Exposure:
- Where: penis, vagina, rectum, mouth or bloodstream
- If you are giving or getting
- How many times you do it
- The chance that your partner is infected

Resistance:
- If you have an infection or another STD, you are at higher risk

Adapted from *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions* by Toronto Public Health

Risks Associated with Mother to Child Transmission

If a woman is HIV-positive and doesn't take any HIV medication, the child has a 25-30% chance of getting HIV. If the woman takes anti-HIV medication, has the baby by C-section and bottle feeds instead of breast-feeding, the risk of HIV being passed to the baby is reduced to 1%.

Adapted from *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions* by Toronto Public Health

Exercise 3A.2 Risk and Harm Reduction

Materials Large wall, risk headings, masking tape, sexual activity sheets

Process

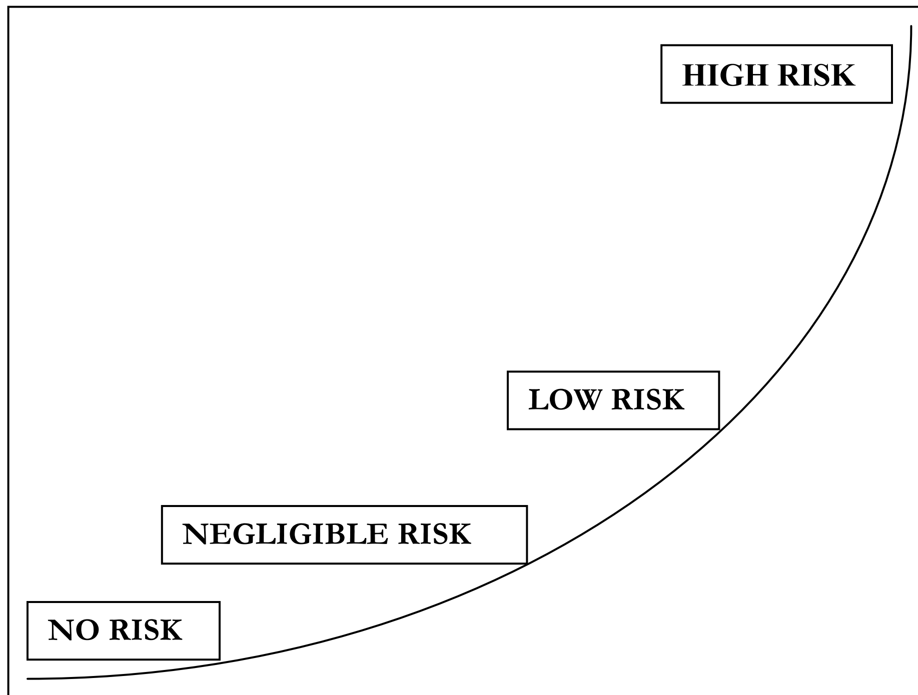
- ♦ In this exercise, participants should apply the abstract ideas learned in previous exercise and think critically about the concept of risk and transmission activities.
- ♦ On a large wall, create four areas with the headings: no risk, negligible risk, low risk, high risk. Explain what these categories mean in terms of potential for transmission and evidence of transmission.
- ♦ Hand out sexual activity sheets (sheets of paper with a different sexual activity written on each of them) and masking tape.
- ♦ Ask participants to tape their sexual activity sheet in the risk category in which it belongs. Remind them that this is not a test.
- ♦ When all the sheets are up, go through the four areas to explain why each activity is in that category and make any adjustments.
- ♦ If time is limited, select a few activities from the chart on Handout 3A.2: Sexual Risk Spectrum Chart and ask participants to explain why they might be in that specific risk category.
- ♦ Discuss the range of possible sexual activities and variables involved in transmission that can make assessing personal risk challenging. Discuss debates in the community surrounding the guidelines.
- ♦ Ask the group to identify the basic principle of Harm Reduction.
    - A commitment to reduce harm that stems from an activity rather than an attempt to stop that activity
- ♦ Brainstorm harm reduction strategies within each method of transmission: mother to child, injection drug use, sexual activity, contact with blood or blood products and workplace hazards.
- ♦ Ask the group to think of challenges that immigrants and refugees confront when trying to practice harm reduction strategies.

Source Transmission information adapted from *HIV Transmission: Guidelines for Assessing Risk: A Resource for Educators, Counsellors and Health Care Professionals* by Craig McClure and Ian Grubb.

Handout 3A.2: Sexual Risk Spectrum Chart

	No risk	Negligible risk	Low risk	High risk
Potential for transmission	*None*	*Yes*	*Yes*	*Yes*
Evidence of transmission	*None*	*None*	*Yes (certain circumstances)*	*Yes*
Examples of Activities	Being masturbated by partner	Anal fisting	Vaginal sex with condom	Vaginal sex without a condom
	S & M	Rimming	Anal sex with a condom	Anal sex without a condom
	Kissing	Getting a blow job	Going down on a man	Sharing sex toys without cleaning them
		Fingering a woman	Going down on a woman	

Risk Model



Adapted from *HIV Transmission: Guidelines for Assessing Risk: A Resource for Educators, Counsellors and Health Care Professionals* by Craig McClure and Ian Grubb.

3B. Progression

Exercise 3B.1 Order the Stages of Progression

Materials Progression sheets, handout

Process

- ♦ Write the stages of progression on sheets and ask participants to put them in order.
  - Point of infection
  - Primary or acute infection
  - Window period
  - Sero-conversion
  - Asymptomatic HIV infection
  - Early signs and symptoms of HIV infection
  - AIDS and opportunistic infections
- ♦ Review the information in Handout 3B.1. The most important points for participants to grasp are:
  - A person can be HIV-positive for many years and not know.
  - A person can test negative during the window period and be HIV-positive.
  - HIV/AIDS is medically very complicated, but most workers do not need to understand all the details in order to provide services.
- ♦ If time is limited, write the stages of progression on a flipchart sheet and review the handout information.
- ♦ Ask participants to brainstorm a list of factors they think might affect progression in general, and for immigrants and refugees specifically.

Source Adapted from *HIV+ Peers as Treatment Information Counsellors: Training Manual and Organizational Resource* by Craig McClure, pC45.

Background Information

AIDS-defining illnesses		
▪ Candidiasis of bronchi, trachea, or lungs ▪ Cervical cancer ▪ Coccidioidomycosis ▪ Cryptococcosis ▪ Cryptosporidiosis ▪ Cytomegalovirus disease ▪ Cytomegalovirus retinitis ▪ Encephalopathy ▪ Herpes simplex	▪ Histoplasmosis ▪ Isosporiasis ▪ Kaposi's sarcoma ▪ Lymphoma, Burkitt's ▪ Lymphoma, immunoblastic ▪ Lymphoma, primary, of brain ▪ Mycobacterium avium complex or M. kansasii ▪ Mycobacterium tuberculosis	▪ Mycobacterium ▪ Pneumocystis carinii pneumonia (PCP) ▪ Pneumonia ▪ Progressive multifocal leukoencephalopathy (PML) ▪ Salmonella septicemia ▪ Toxoplasmosis of brain ▪ Wasting syndrome

Handout 3B.1: Stages in the Progression of HIV Disease

Primary or acute infection

- HIV replicates very quickly during this stage
- HIV antibodies are not yet produced, so the HIV test which measures antibodies will be negative. This period is called *the window period.*
- Flu-like symptoms can include:
  - Aching joints and muscles
  - Sore throat
  - Fevers
  - Skin rash
  - Swollen lymph nodes
  - Fatigue
- Seroconversion, when antibodies start being produced, happens one to three months after infection. Antibody tests will now be positive.

Asymptomatic infection

- In this stage, you have few or no symptoms.
- This stage can last for up to 10 years.
- Some people have normal CD4+ counts and no symptoms for a longer than average period of time. They are called *long-term non-progressors*.
  - 6-10% of PHAs who have been infected for more than 10 years show no symptoms.

Symptomatic infection

- Symptoms can include:
  - Chronic fatigue
  - Weight loss
  - Skin problems
  - Diarrhea

Factors that affect progression

- A person's genes
- The strength of the virus
- The type of immune response
- Nutrient level
- Mental state and stress level
- Drug and alcohol use and smoking
- Access to care, treatment and support
- Access to a social support network
- Time of diagnosis
- Exposure to infections
- Socio-economic factors, like access to housing

AIDS

- In Canada, when a person with HIV develops one or more opportunistic infections, they are considered to have AIDS.
- In the US, when a person with HIV develops one or more opportunistic infections or when a person with HIV's CD4+ cell count drops to 200 or below, they are considered to have AIDS.

Created before we even knew there was a virus that caused it, the term "AIDS" doesn't mean much anymore. It is more accurate than Gay Related Immune Deficiency Syndrome (GRID), or gay cancer, which were among the medical community's first suggestions. But if you're looking to describe the medical realities of living with HIV, including the long periods when things happening inside your body don't show themselves outside, the term "HIV disease" is much more meaningful. **For government benefits, however, or entrance into a whole system of support structures created when most people found out they were sick by landing in the emergency room with an AIDS-related infection, the term "AIDS" remains highly important. Getting an AIDS diagnosis may mean you can get [access to certain benefits].** From http://gmhc.org/living/living.html

3C. Treatment

Exercise 3C.1 Brainstorm: Treatment Access

Materials Flipchart paper, markers, and handout

Process

- Brainstorm a list of ways to treat HIV, including complementary and alternative therapies, medication, good nutrition, etc.
- Briefly review HIV medications, covering issues around adherence, side effects and cost. Let participants know that the handout on medication contains more detailed information.
- Tie this information together by focussing on access issues. Brainstorm the different ways that people get medication. Make a list of people who cannot get medication through these channels.

Questions What are the factors in the life of an immigrant or refugee that could affect their ability to take meds regularly?

Handout 3C.1: HIV Treatment

I'm going quite often [to the hospital specialist] and the transport money is not enough for me, I haven't got enough money. And another problem is whenever I go there I have to buy medicine, medicine is expensive too and all these things when I get the money it's not really enough for my expenses…Most of the medicine I am taking, after I have it once or twice I have side effects from it and I have to change it and to get another new medicine also I have to buy, I have to pay and all these things are too much.

From *Silence and Secrecy: Refugee Experiences of HIV in New Zealand* by Heather Worth, et al.

Five Parts of HIV Treatment

1. **Maintain General Health:** eat well, get enough rest, avoid drugs and alcohol, get exercise and fresh air, maintain a low level of stress
2. **Use Supportive Therapies:** practice yoga, use visualization and other relaxation techniques, get psychological and spiritual support
3. **Attack the Virus:** take meds that attack the virus
4. **Boost the Immune System:** boost immune system functioning, for example by taking meds that increase CD4+ cells
5. **Prevent Opportunistic Infections:** take meds to prevent opportunistic infections

Adapted from *Treatment Strategy-Treatment Guidelines Information Package* by Project Inform.

Access

Medications to treat HIV are very expensive.
How do people get them?

- Ontario Drug Benefits (ODB) for people on social assistance (OW) and disability pension (ODSP)
- Trillium Drug Plan
- Indian Affairs (IA)
- Interim Federal Health Program (IFH)
- Private health insurance
- Personal funds
- Clinical trials
- Donations from drug companies through Patient Assistance Programs
- Other compassionate access programs

Basic Elements of Health

- Good nutrition
- Hormone replacement
- Exercise
- Stress reduction and a positive outlook

From *A Practical Guide to HAART* by CATIE

Handout 3C.1: HIV Medication

Between 1996 and 1997, the number of AIDS-related deaths [in the U.S.] dropped 42 percent.

From *The 2002 HIV Drug Guide* by Positively Aware.

- As of 2002, there were 17 drugs (with 19 combinations and formulations) available in Canada.
- Drugs work by interfering in the virus's replication at four stages in the process.

1. When HIV enters a cell: **entry inhibitors**
2. When HIV takes control of the cell: **reverse transcriptase inhibitors**. There are three kinds of meds in this group:
   - nucleoside analogue reverse transcriptase inhibitors (called NRTIs or *nukes*)
   - non-nucleoside analogue reverse transcriptase inhibitors (called NNRTIs or *non-nukes*)
   - nucleotide analogue reverse transcriptase inhibitors (called Nucleotide RTIs)
3. When HIV becomes part of the infected cell: **fusion or integrase inhibitors**. The first drug in this class is about to be released.
4. When HIV tricks the infected cell into making copies of itself: **protease inhibitors**

- Drug resistance occurs when doses are skipped or meds are taken irregularly. The virus sometimes mutates and becomes resistant to that drug, or class of drugs.
- Long term use of treatment may lead to a decrease in the effectiveness of meds
- Genotyping and phenotyping are two tests to measure resistance in order to pick meds that will successfully treat HIV.
- Breaks from treatment, called Structured Treatment Interruption (STI) and Structured Intermittent Therapy (SIT) or *drug holidays*, are thought to be beneficial but all the effects of treatment breaks are not yet known. People should only take drug holidays with support and advice from their doctor.

From *A Practical Guide to HAART* by CATIE

Common Side Effects of HIV Medications

- Headaches
- Nausea
- Diarrhea
- Loss of appetite
- Hair loss
- Dry mouth
- Vomiting
- Kidney stones
- Insomnia
- Lipodystrophy: changes in metabolism and in fat distribution
- Poor cell functioning, e.g. tingling in extremities

From *AIDS 101* by CPA-VIH and Bristol-Myers Squibb

For more information, contact the Community AIDS Treatment Information Exchange (CATIE) at (416) 203-7122 or at www.catie.ca.

Exercise 3C.2 Speaker

Materials Honorarium for speaker

Process

- ♦ Ask a representative from Community AIDS Treatment Information Exchange (CATIE) to give a short presentation on treatment strategies and issues.

3D. Global Perspective

Exercise 3D.1 Map the Epidemic

Materials Handouts

Process

- ♦ Look at the world map with statistics about HIV infections.
- ♦ Review the social determinants of health. Discuss vulnerability to HIV infection given social determinants.
- ♦ Break into small groups to review questions below.

Group 1
A. How do social determinants of health affect rates of transmission in developing countries?
B. What kinds of treatment, care and support do PHAs in developing countries have access to?

Group 2
A. How is the epidemic different in developing countries?
B. What are the impacts of stigma on access to treatment, care and support?

- ♦ In the large group, discuss the small groups' answers.

Handout 3D.1: HIV in the World

Global Summary of the HIV/AIDS Epidemic, December 2001

Number of People Living with HIV/AIDS	**Total**	**40 million**
	Adults	37.2 million
	Women	*17.6 million*
	Children*	2.7 million
People newly infected with HIV in 2001	**Total**	**5 million**
	Adults	4.3 million
	Women	*1.8 million*
	Children*	800,000
AIDS deaths in 2001	**Total**	**3 million**
	Adults	2.4 million
	Women	*1.1 million*
	Children*	580,000

* Children under 15 years of age
From *AIDS epidemic update* by UNAIDS and WHO

HIV in the world

- 95% of all people living with HIV now live in the developing world.[1]
- It is estimated that there are 13 million AIDS orphans in Africa. This number is expected to rise to 40 million worldwide by 2010.[1]
- 40 million people now live with HIV. This number is expected to more than double to 85 million by 2010.[2]
- More than 300 million people cross international borders each year.[3]
- Of the 33 million people with HIV/AIDS in the world in 1998[3]:
  - 80% got HIV through sex; of these, 80% got HIV during sex between men and women
  - 10% got HIV during injection drug use
  - 5% are children infected by mothers who have HIV
  - 5% got HIV through blood transfusions or other blood sharing activities

1. From *To Share and to Learn: The Case for Canadians to Act Globally Against HIV/AIDS* by Health Canada, p2.
2. From UNAIDS website
3. From *HIV, Health and Your Community: A Guide for Action* by Reuben Granich and Jonathan Mermin.

Handout 3D.1: World Map

UNAIDS/WHO

Adults and children estimated to be living with HIV/AIDS as of end 2001

Region	Estimated number
North America	940 000
Caribbean	420 000
Latin America	1 400 000
Western Europe	560 000
North Africa & Middle East	440 000
Sub-Saharan Africa	28 100 000
Eastern Europe & Central Asia	1 000 000
East Asia & Pacific	1 000 000
South & South-East Asia	6 100 000
Australia & New Zealand	15 000

Total: 40 million

It is estimated that by 2010
an additional **45 million people**
will have become infected with HIV.

AIDS epidemic update: December 2001

From *AIDS epidemic update* by UNAIDS and WHO

Handout 3D.1: Global Stats

Regional HIV/AIDS statistics and features, end of 2001				
Region	**Epidemic started**	**People living with HIV/AIDS**	**% who are women**	**Main modes of transmission**
Sub-Saharan Africa	Late '70s – Early '80s	28.1 million	55 %	Hetero
North Africa and Middle East	Late '80s	440,000	40 %	Hetero, IDU
South and South-East Asia	Late '80s	6.1 million	35 %	Hetero, IDU
East Asia and Pacific	Late '80s	1 million	20 %	IDU, hetero, MSM
Latin America	Late '70s – Early '80s	1.4 million	30 %	MSM, IDU, hetero
Caribbean	Late '70s – Early '80s	420,000	50 %	Hetero, MSM
Eastern Europe and Central Asia	Early '90s	1 million	20 %	IDU
Western Europe	Late '70s – Early '80s	560,000	25 %	MSM, IDU
North America	Late '70s – Early '80s	940,000	20 %	MSM, IDU, hetero
Australia and New Zealand	Late '70s – Early '80s	15,000	10 %	MSM
TOTAL		**40 million**	**48 %**	

Hetero: heterosexual
IDU: Injection drug use
MSM: Men who have sex with men

From *AIDS epidemic update* by UNAIDS and WHO.

Handout 3D.1: Social Determinants of Health

What are the Social Determinants of Health?

1. Income and social status
2. Social support networks
3. Education
4. Employment/Working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetic endowment
10. Health services
11. Gender
12. Culture

From http://www.hc-sc.gc.ca/hppb/phdd/determinants

Even in the richest countries, the better off live several years longer and have fewer illnesses than the poor. These differences in health are an important social injustice, and reflect some of the most powerful influences on health in the modern world. People's lifestyles and the conditions in which they live and work strongly influence their health and longevity.

Medical care can prolong survival after some serious diseases, but the social and economic conditions that affect whether people become ill are more important for health gains in the population as a whole. Poor conditions lead to poorer health. An unhealthy material environment and unhealthy behaviour have direct harmful effects, but the worries and insecurities of daily life and the lack of supportive environments also have an influence.

From *Social Determinants of Health: The Solid Facts*
by Richard Wilkinson and Michael Marmot, p6-7.

4. Social Aspects of HIV

Exercise 4.1 Video

Materials TV, VCR, video

Process

- ♦ Show a short video or a portion of a video with a personal testimony from a PHA. Videos that have appropriate excerpts include:
  - *Not a Simple Story: AIDS in the Asian Pacific American Community*, available at the AIDS Committee of Toronto (ACT) library.
  - *Before Night Falls*, directed by Julian Schnabel, is the autobiography of Cuban dissident Reinaldo Arenas. It is available at most video stores.
  - ACT and the Canadian HIV/AIDS Clearinghouse also carry a wide range of videos.
- ♦ Discuss the issues that PHAs confront.

Exercise 4.2 Speaker

Materials Honorarium for speaker

Process

- ♦ Invite a person living with HIV/AIDS to speak to the group about his or her experiences.
- ♦ See Background Information for a list of organizations that provide speakers.

Background Information 4.2: Speakers Bureaus

These organizations can connect you with people with HIV who are willing to give presentations about issues relating to HIV/AIDS.

Black CAP
110 Spadina Ave, Suite 207
Toronto, ON M5V 2K4
Tel.: (416) 977-9955
Fax: (416) 977-2325
www.black-cap.com

Toronto People with AIDS Foundation
399 Church St, 2nd Floor
Toronto ON M5B 2J6
Tel.: (416) 506-1400
Fax: (416) 506-1404
www.pwatoronto.org

Other Agencies
African Community Health Services
Alliance for South Asian AIDS Prevention
Beth David B'Nai Israel Beth Am Congregation AIDS Committee
Beth Tzedec Congregation AIDS Committee
Casey House Hospice
Central Toronto Youth Services' Lesbian, Gay and Bisexual Youth Programme
Hassle Free Clinic
Positive Youth Outreach
Sunnybrook and Women's College Health Sciences Centre – Women's College Campus – Regional Women's Health Centre
Teresa Group Child and Family Aid
Toronto Public Health – The Works
Youthlink – Inner City

Listed in the AIDS Committee of Toronto's *The Living Guide,* July 2000.

Exercise 4.3 Personal Testimony

Materials Flipchart paper, markers, and handouts

Process

- Read a personal testimony written by a person with HIV.
- Identify some of the major psychosocial issues associated with their situation.
- For testimonies by PHAs who do not live in Canada, discuss the psychosocial issues that they may face if they moved to Canada.
- These cases will also be used in the next exercise.

Questions What barriers do these people face accessing services?

Handout 4.3: Personal Testimony One

Carole from Cameroon

My name is Carole and I live in Bel Air. I am from Cameroon. I am not giving you my real name because I wish to remain anonymous for now, maybe I will give my name later. I am 29 and I have three children. My family does not know yet, I want to prepare them first. I may let them know soon. I have been HIV positive since October 1988.

I went to have some tests done and the doctor informed me of the situation. I started crying and he let me cry until I had calmed down. I asked him if he could introduce me to a Cameroonian man who had been in the same situation for two or three years. He told me we could see each other from time to time. Every time we saw each other he boosted my morale. When I told me friend who had come to get the results with me she told me there was no problem. She has supported me, nothing has changed between us. On the contrary, our friendship has become stronger. When I have a problem she is the first to run to my side. My brothers do not know yet. I think I will try to tell them in the next few days. If I didn't tell them at the beginning, it's because I was scared of being rejected. It isn't easy to know you are HIV positive and start talking about it, particularly in our country. I hope they will understand me. I haven't told my friends either, because I am still scared of being rejected.

I've had a boyfriend for a long time. I haven't told him yet because I'm scared of rejection from him too. I try to talk to him about AIDS from time to time, but he isn't ready to accept it. He would rather die by accident than have the AIDS virus. So I refrain. It is very hard, but I hope that people will understand with time.

When I contracted the virus, I did not know what I was going to live through. I've now had the virus for five years and I've only had malaria once, I wasn't hospitalized. Which means that you can live as long as possible with AIDS. You have to control yourself. I don't have any health problems; on the contrary, I've put on weight since. Having HIV does not mean you are dead. When I drink, I drink well; I can go clubbing nearly twice a month and I can dance 'til dawn. There is no problem: I live normally just like everyone else. I would like my friends to try to understand. If they meet someone who has AIDS one day I hope they won't reject them, that they will consider them like anyone else, because you don't only die of HIV, there are many other diseases.

My boyfriend has not had a test. I advised him to do it, but he sees HIV as the plague. I ask those people who haven't had a test yet not to be afraid. Even if they are HIV positive, it doesn't matter, people do live with it. If they want to meet people in the same situation as them, they should go to the central hospital, there is a doctor there for that purpose.

From "Testimonial." *Revue Noire/African Contemporary Art: AIDS and African Artisits*. Dec. 95-Jan/Feb 96.

Handout 4.3: Personal Testimony Two

Ouattara Vadji from Ivory Coast

My name is Ouattara Vadji. I am from the far north of the Ivory Coast. I am an only child. I live in Abidjan. My father is dead but my mother is still alive. I was married to two women. I had four children with one and two with another.

I met a woman. We heard about AIDS from time to time but we did not know what it was. I sometimes tried to talk to her about condoms, but she told me there weren't any. I went to see her one day, I even talked about the condom problem…Because I hadn't seen her in a while, but I didn't to talk about it and I wanted to stay with her. Then a time came when I felt tired on my way to work and I sometimes had problems getting on the bus. I was feverish. So the doctor thought it best for me to do a test. It was March 25th 1994. When the results came he didn't want to tell me. He was shaking his head. So I asked him what was wrong. He showed me a letter. As I don't know how to read I asked him if I had AIDS and he said yes. I kept a level head and thought it over. I thought about what had happened with the woman, so I wasn't really surprised. The doctor asked me to have my wives examined. The results were negative for them and for two of my children.

When I had no money I went back home to my village. Everyone would stare at me. No one gave me anything to eat or drink. And when people ask my wife, the one who has become a shopkeeper, why she isn't with me any more, she tells them that I am an AIDS carrier and how do you expect me to go off with someone like that? I can't even express myself anymore to tell people about my situation.

And now I am alone. That is what has nearly killed me. I met a Catholic nun, she is a State nurse in my village and she took care of me. It's thanks to her I am still alive and I am a member of Light Action. There was a death before AIDS and there will still be death after AIDS. We are going to die, with or without AIDS. Everyone will die one day once they have agreed to be born. My wives all left without thinking about the children's future. Today I have a lot of problems claiming my rights. There are places where it's a real problem trying to express myself.

From "Testimonial." *Revue Noire/African Contemporary Art: AIDS and African Artisits*. Dec. 95-Jan/Feb 96.

Handout 4.3: Personal Testimony Three

Sundaram from Sri Lanka

The reason I want to tell my story is to let people know that there may be people who are infected with HIV who do not know it…I will not mention my last name or allow the faces of anyone in my family to appear in this publication because I do not want to needlessly hurt my wife and two children because of my HIV status. But I want people to know what it feels like to be HIV-positive…

My wife was three months pregnant and my first child 11 months old, when I went to the doctor for a check-up. During the visit, I found myself telling him about the time I was working on a ship and the fact that I had sex with women whom I did not know, at some of the ports where the ship stopped. The he asked me whether I had undergone any testing for HIV. I did not understand what HIV meant, but I had heard about AIDS. He told me HIV infection often leads to AIDS. I consented to testing and shortly after I found out I was HIV-positive. The doctor explained a little about the disease. He said my wife and child should also be tested.

I left his clinic shocked and confused. I was waiting for the bus at the bus stop and thinking "Oh God! What sins did I commit? What wrong things did I do to other people to deserve this punishment? Did I pass it on to my innocent wife and child?" When I reached home, I immediately told my wife and she made appointments for testing for her and our child. When the report came negative for them, we could only think of thanking God.

I worried all the time, more about my two little children than about myself. What would happen if I become too ill to work or if I die. I want to live to see them married. I started drinking in order to forget but I stopped drinking when I realized that I needed to be as healthy as possible – for their sake if not for mine. I feel guilty all the time for bringing this upon my family. The atmosphere in our house has become permanently gloomy.

I became sick and had to take time off from my job at the factory. I was fired when I returned.

I was desperate to learn all I could about AIDS. My doctor gave me a booklet on the disease and I found the name and address of ACT (the AIDS Committee of Toronto). I went to ACT and a counselor gave me some information, but I did not understand the terminology he used and I did not feel comfortable telling a white man that I did not understand. Some time later, at a Scarborough hospital I saw a brochure in Tamil about AIDS and ASAP (the Alliance for South Asian AIDS Prevention). I read the whole thing and then I called ASAP and had a long conversation with a Tamil staff member. Since then I have visited ASAP several times and have learned much more about AIDS. I think God gave me this disease because I have not done enough charity…I am also telling my story so that other people can learn from my experience.

From *Forward Looking: 1989-1999* by Alliance for South Asian AIDS Prevention.
Translated from Tamil by Senthil Kandiah.

Handout 4.3: Personal Testimony Four

Reinaldo Arenas from Cuba

Reinaldo Arenas was a poet, novelist, and playwright. He fled Cuba in 1980 after being imprisoned and persecuted for his opposition to the government and his homosexuality. He went to the United States as a refugee and settled in New York. The film Before Night Falls *by Julian Schnabel chronicles his life. When Arenas became ill, he flew from New York to Miami so that he could die by the beach.*

I was…sorry about leaving some of my friends, such as Lázaro, Jorge and Margarita. I felt sorry for the pain that my death would cause them, and my mother too. But death was knocking at my door and the only thing I could do was face it.

When my friend Lázaro found out how sick I was, he flew to Miami to bring me back, and delivered me unconscious to New York Hospital. Getting me admitted, as he told me later, was an ordeal because I had no medical insurance. My pockets were empty except for a copy of my will, which I had just sent to Jorge and Margarita in Paris. I was practically dying, but hospitals refused to admit me because I did not have the means to pay. Fortunately, there was a French doctor at the hospital who was acquainted with Jorge and Margarita, and he helped to get me in. In any event, another physician…announced to me that I had only a ten percent chance of surviving.

In the emergency room all the patients were in the throes of death. I had tubes coming in and out of everywhere – my nose, my mouth, my arms. I looked more like a being from another planet than a patient. I will spare the reader all my vicissitudes at the hospital. The important fact is that I managed not to die that time as expected.

The same French physician…suggested that I write the words for some songs and he would set them to music. With all those tubes and a mechanical respirator I managed as best I could, to scribble two songs. Once in a while [the physician] would come to the intensive care unit, where all of us were dying, and he would sing the songs that I had written, for which he had composed the music…I thought he was more talented as a musician than as a doctor.

Arenas spent three and a half months in the hospital before being released. He died in 1990.

From *Before Night Falls* by Reinaldo Arenas.
Translated from Spanish by Dolores M. Koch.

5. Communication Skills: Facilitating Discussion of HIV Status

The goal of this section is to help participants to understand issues around discussion of status, to become aware of their own ways of working with clients and to develop communication skills that facilitate disclosure.

Exercise 5.1 Brainstorm: Definitions

Materials Flipchart paper, markers, and handouts

Process

- ♦ Brainstorm definitions of key terms using the handouts as a guide.
  - Confidentiality
  - Trust
  - Disclosure
  - Barriers to disclosure
- ♦ Consider the following questions.
  - Debriefing after intense emotional experiences that may be raised while working with clients in distress is an important part of taking care of oneself. How can debriefing with a colleague be done without violating confidentiality?
  - How can referrals violate confidentiality? What can a worker do to protect a client's confidentiality?
- ♦ Using the personal testimonies presented in the previous exercise, explore barriers to building trust, maintaining confidentiality, and disclosing status that those individuals may face. Link these situations to the definitions developed by the group and presented in the handouts.

Questions Why is confidentiality important when working with immigrants or refugees? With PHAs particularly? With immigrant or refugee PHAs?

Handout 5.1: Definitions

Confidentiality and Trust

The principle of confidentiality encompasses the view that a person should be entitled to privacy with regard to his or her most personal physical and psychological secrets; but it is also the basis for an effective relationship between patient/client and health care provider, and hence the basis for the effectiveness of many public health interventions which rest on these relationships. Only if a person feel sure that the health care provider will keep confidential any information provided will he/she come forward and share information that may be critical to making decisions about effective clinical care and treatment.

From *Opening up the HIV/AIDS Epidemic* by UNAIDS, p10.

An assurance of mind or firm belief in the trustworthiness of another or in the truth and reality of fact; trust; reliance. Someone or something in which trust is placed. Something told in secret; a private communication. The belief that another will keep a secret; assurance of secrecy.

From *National HIV/AIDS Volunteer Training Kit* by the AIDS Committee of Toronto, p5.

Disclosure

Disclosure refers to the act of informing any individual or organization (such as a health authority, an employer, or a school), of the serostatus of an infected person, or it refers to the fact that such information has been transmitted, by any means, by the person him or herself, or by a third party, with or without consent. Except in exceptional circumstances, when disclosure to another person is required by law or ethical considerations, the person with HIV has the right to privacy and to exercise informed consent in all decisions about disclosure of his/her status.

From *Opening up the HIV/AIDS Epidemic* by UNAIDS, p12.

UNAIDS and WHO encourage beneficial disclosure. This is disclosure that is voluntary; respects the autonomy and dignity of the affected individuals; maintains confidentiality as appropriate; leads to beneficial results for those individuals, and for their families and sexual and drug-injecting partners; leads to greater openness in the community about HIV/AIDS; and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV.

From *Opening up the HIV/AIDS Epidemic* by UNAIDS, p12.

Barriers to disclosure

- What are aspects of a PHA's situation that may reduce likelihood of disclosure of status to a health professional?
- How do systemic issues like racism, sexism, homophobia, AIDSphobia, xenophobia affect a client's willingness to disclose?

Handout 5.1: The Pros and Cons of Disclosure

How do I decide?

It's very important to think carefully about your own reasons for wanting to disclose your HIV status. The idea of being completely open with someone, especially if they are close, can be very tempting. Doing this without thinking through your expectations, their reactions and the possible consequences is something that some people have come to regret. These are some useful questions to ask yourself when you are thinking about whether to tell someone that you have HIV:

- Why do you want to tell them?
- Why do you feel they need to know?
- What are they likely to do with the information?
- Will they understand the importance of keeping it to themselves?
- What benefits do you hope to get out of telling them?
- What disadvantages might there be for you after you've told them?
- How realistic are these expectations?
- What are the benefits or disadvantages for them?
- Are you likely to regret having told them?
- In the future, are you likely to regret not having told them?

From *Should I tell people I'm HIV-positive?* by Terrence Higgins Trust

The Pros and Cons of Disclosure:
Possible reasons for disclosing or not disclosing HIV status

Pros	Cons
To get social and emotional support	Fear of being abandoned by family and old friends
To meet other HIV+ women	Loss of job, housing or income
To prepare friends and family for the possible progression of illness	Abuse from partner/ex-partner
To get peer support and validation	Cultural stigma
To establish rights and responsibilities clearly	Denial
To gain peace of mind	Fear of losing children
To obtain services and access resources	Fear of being ostracized
To establish a sense of community	Unwanted advice from others (especially unqualified others)
T o be free from isolation	Fear of being persecuted or judged by others
To get information	Fear of being rejected by new friends
To reduce stigma and shame	Fear for personal/physical safety
To assist other women	Loneliness
	Painful to talk about
	Repercussions from insurance companies
	Fear of how people will treat children of HIV+ parent
	Loss of sexuality
	Fear of being pressured into treatment

From *Peer Mentor Training Manual* by Voices of Positive Women

Exercise 5.2 Scenarios: Perspectives on Disclosure

Materials Scenario chart, pens

Process

- Ask participants to take a few minutes to review the scenario chart regarding disclosure and decide whether they think the client should disclose their status.
- If the group is large, break into small groups.
- Go through each scenario and discuss participants' answers and the issues that come up in that scenario.
- Ask participants to consider their opinions regarding disclosure for clients who are HIV-negative.

Questions

What does the word "should" imply?
What assumptions did participants make about clients' identities?
Did participants assume that clients were HIV-positive?
Do their opinions change if clients are HIV-negative?
What conditions did participants feel were necessary for disclosure?
Are participants' opinions about disclosure different if clients are contemplating disclosing to people other than their sexual partners or children?
What are a worker's legal responsibilities regarding disclosure?
What are a worker's ethical responsibilities regarding disclosure?

Handout 5.2: Scenario Chart

Do you agree or disagree that your client should disclose their HIV status to their sexual partners, their children or their injection drug use partners? Under what conditions do you agree that they should disclose?			
Client	**Agree**	**Agree under the following conditions:**	**Disagree**
Pregnant woman			
Mother			
Single straight woman who has casual sexual encounters			
Injection drug user			
Sex worker			
Single gay man who has casual sexual encounters			
Teenager beginning to be sexually active			
Married man who secretly has sex with men			

Exercise 5.3 Role Play: The Tortoise and the Hare

Materials Role cards and prizes or a room with lots of space

Process

- Give each participant a role card and ask them to form a line. Be sure to distribute the roles so that a range of experiences will be covered.
- The facilitator then reads out questions, to which the participants must answer "yes" or "no".
- Each time they say "yes", they may take a step forward.
- For every "no" answer, they stay where they are.
- If space is limited, participants may be given a prize or may write a checkmark for every "yes" answer.
- When the questions have all been asked, have each participant disclose their role and discuss the questions listed below.

Questions How do you feel about the position you are now in?
Would you rather be somewhere else? Where?
How do you feel about the position of anyone else in the room?
Is there anything you would like to say to anyone else in the room?
What have you learned from this activity about yourself?
What have you learned about the discrimination people face on the basis of their sexuality or serostatus?

Source Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p84.

Examples of questions to ask participants

If your HIV status or sexual identity were known, would you be able to:

- have the sex you want when you want it
- feel safe walking the streets after dark
- ask your sexual partners to use condoms
- participate in community functions
- expect to be fairly treated by the police
- participate in community functions with your lover
- expect to have sex education classes at school be relevant
- hold your lover's hand in public without fear of violence
- marry your partner or be honest with your co-workers
- see people like you portrayed positively in mainstream media images
- adopt a child
- see a doctor
- work in a children's nursery
- obtain private medical insurance
- expect support from your family
- know that your job is secure

If you are better off with this label than you are in real life, take a step forward.

Background Information 5.3: Role Cards

HIV+ 16 year old gay man	16 year old heterosexual man	heterosexual married man
16 year old lesbian	16 year old heterosexual woman	heterosexual married woman
single heterosexual man	bisexual man	HIV+ female sex worker
HIV+ gay man	HIV+ married man who secretly has sex with other men	male to female transsexual
single heterosexual woman	bisexual woman	male sex worker

Exercise 5.4 Role Play: Sexuality Secrets

Materials Secrets handout

Process

- Break into pairs, one worker and one client.
- The client should pick a sexuality secret from the list below, either Real or Borrowed. The client should answer as themselves as frequently as possible.
- The worker must try to encourage the client to disclose their secret.
- Explore what aspects of the interaction made the client feel comfortable disclosing their secret.
- Come back together as a group to discuss the essential components of facilitating disclosure.

Handout 5.4: Instructions for Sexuality Secrets

In this scenario, your partner will try to find out what your secret is. Pick one of the following secrets to use:

1. A Real Sexuality Secret:

Pick a personal experience or situation **related to health or sexuality** that you do not frequently disclose to other people but are willing to disclose in this scenario.

OR

2. A Borrowed Sexuality Secret:

Pick an experience or situation **related to health or sexuality** that has not happened to you but that is real for other people. Make one up or pick one from the list below. Examples:

- You have been diagnosed with breast cancer and told that you will have to consider having a mastectomy.
- You recently realized that you are gay or lesbian and are now struggling to come to terms with this.
- You have been told you are infertile as a result of an untreated STD.
- You are transgendered.
- You are a married man who secretly sleeps with other men.
- In keeping with the norm for women from your culture, you were circumcised when you were a girl.
- You are HIV-positive.

6. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- Where can participants get a copy of the Living Guide?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?

7. Evaluation

See Appendix 5 for evaluation tools.

References and Resources

AIDS Committee of Toronto. *National HIV/AIDS Volunteer Training Kit.* 1998.

Alliance for South Asian AIDS Prevention. *Forward Looking: 1989-1999.* Toronto. July 1999.

Arenas, Reinaldo. *Before Night Falls.* Trans. Dolores M. Koch. Toronto: Penguin. 1993.

Canadian AIDS Treatment Information Exchange. *A Practical Guide to HAART for People Living with HIV/AIDS*. First edition. Toronto. 2002.

CPA-VIH. *AIDS 101*. Second Edition. Quebec. 2000.

Granich, Reuben and Jonathan Mermin. *HIV, Health and Your Community: A Guide for Action.* Stanford, CA: Stanford University Press, 1999.

Health Canada. *To Share and to Learn: The Case for Canadians to Act Globally Against HIV/AIDS*. Ministry of Health. Ottawa. 2000.

McClure, Craig. *HIV+ Peers as Treatment Information Counsellors: Training Manual and Organizational Resource.* CATIE. 1995.

McClure, Craig and Ian Grubb. *HIV Transmission: Guidelines for Assessing Risk: A Resource for Educators, Counsellors and Health Care Professionals.* Third edition, January 1999.

McKay Armstrong, Ewan and Peter Gordon. *Sexualities*. London: Family Planning Association. 1992.

Positively Aware: The Journal of Test Positive Aware Network. *The 2002 HIV Drug Guide.* January/February 2002.

Project Inform. *Treatment Strategy-Treatment Guidelines Information Package.* AIDS Committee of Toronto. 1996.

Toronto Public Health. *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions.* Third Edition, Winter 2001.

Terrence Higgins Trust. *Should I tell people I'm HIV-positive?* March 1998.

UNAIDS and WHO. *AIDS Epidemic Update.* December 2001.

UNAIDS. *Opening up the HIV/AIDS Epidemic: Guidance on Encouraging Beneficial Disclosure, Ethical Partner Counselling and Appropriate Use of HIV Case-Reporting.* Geneva. November 2000.

Valy Ouattara and Carole. "Testimonial." *Revue Noire/African Contemporary Art: AIDS and African Artisits.* Dec. 95-Jan/Feb 96.

Voices of Positive Women. *Peer Mentor Training Manual*. July 2002.

Wilkinson, Richard and Michael Marmot. *Social Determinants of Health: The Solid Facts*. World Health Organization Europe. 1998.

World Health Organization. *Teaching Modules for Basic Education in Human Sexuality: Volume 7*. Regional Office of the Western Pacific. Manila: 1995.

Worth, Heather, Alison Reid, Judith Ackroyd, and Etetu Tamirate-Bowden. *Silence and Secrecy: Refugee Experiences of HIV in New Zealand*. University of Auckland. February, 2001.

Websites

These websites can provide you with more information on HIV/AIDS and on some of the services available to people with HIV/AIDS.

AIDS Committee of Toronto	http://www.actoronto.org
Alliance for South Asian AIDS Prevention	http://www.asaap.ca
Asian Community AIDS Services	http://www.acas.org
Black Coalition for AIDS Prevention	http://www.black-cap.com
Canadian AIDS Society	http://www.cdnaids.ca
Canadian HIV/AIDS Clearinghouse	http://www.clearinghouse.cpha.ca
Centre for Spanish-Speaking Peoples	http://www.spanishservices.org
Community AIDS Treatment Information Exchange	http://www.catie.ca
Gay Men's Health Crisis	http://gmhc.org
Joint United Nations Program on HIV/AIDS	http://www.unaids.org
Ontario AIDS Network	http://www.ontarioaidsnetwork.on.ca
Toronto People with AIDS Foundation	http://www.pwatoronto.org
Voices of Positive Women	http://webhome.idirect.com/~vopw

Videos

Not a Simple Story: AIDS in the Asian Pacific American Community [videocassette] 1995.

Before Night Falls [videocassetee], dir. Julian Schnabel, 2001.

Unit 2: Introduction to the Immigration and Refugee Experience

1. Introduction

1.1	*Handout*	*Statistics on Immigrants and Refugees*

2. Icebreaker

2.1	Exercise	Find Someone
	Handout	*Find Someone Statements*

3. Attitudes and Values

3.1	Exercise	Personal Immigration History

4. The Immigration and Refugee System

4.1	Exercise	Brainstorm: Stages and Definitions
	Handout	*Immigration Flow Chart*
	Handout	*Immigration Definitions*
	Handout	*Immigration Definitions (continued)*
4.2	Exercise	Health Coverage
	Background	*Role Cards*
	Handout	*Health Coverage*
	Background	*Health Coverage Answers*

5. Communication Skills: Facilitating Discussion of Immigration Status

5A. Identifying Barriers

5A.1	Exercise	Brainstorm: Barriers
	Handout	*Quotes about Barriers*

5B. Building Skills

5B.1	Exercise	Role Play: Immigration Secrets
	Handout	*Instructions for Immigration Secrets*
5B.2	Exercise	Role Play: Working with a Translator
	Handout	*Instructions for Translator Role Play*
	Handout	*Questionnaire*
	Handout	*Client's Answers to Questionnaire*
	Handout	*Cultural Interpreting*

5B.3 Exercise Brainstorm: Tips and Tools

6. Conclusion

7. Evaluation

References and Resources

Learning Objectives

The main goal of this unit is to introduce participants to the immigration and refugee system. Participants will be able to identify:

- categories in the immigration and refugee system
- rights and services, including health coverage, available to people in each category
- aspects of the immigration or refugee process that may be affected by being HIV-positive
- strategies to facilitate discussion of immigration status and to work with translators

Suggested Outline for 2-hour Workshop

Introduction – 10 min
Icebreaker – 15 min
Attitudes and Values – 20 min
Immigration and Refugee System – 20 min
Break – 10 min
Communication Skills: Facilitating Discussion of Immigration Status – 30 min
Conclusion – 10 min
Evaluation – 5 min

1. Introduction

- What is CAAT?
- Why are immigrant/refugee issues relevant to our work?
  - Immigration has an important role in Canadian society.
  - Review the information on the handout.
- Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- Workshop agenda
- Ground rules and confidentiality (See Appendix 2.)
- Other housekeeping information (washrooms, smoking, break time)

Handout 1.1: Statistics on Immigrants and Refugees

- In Toronto in 1996, there were 1,125,000 immigrants, accounting for one in four of all Canadian immigrants. 878,000 of these were recent immigrants, accounting for over 40 percent of all recent immigrants in Canada. (p6)
- Toronto has 1/12th of Canada's population, but ¼ of Canada's immigrants and 1/3 of Canada's recent immigrants. (p37)
- Three quarters of all household heads in the city have at least one parent that was born outside of Canada, ranging from 170 countries and speaking over 100 languages.

From *Towards a Framework for Local Responsibility* by Mwarigha M.S.

As many as 80,000 new immigrants and refugees come to Toronto annually. This is more than one third of the Canadian total and half the Ontario total. Of these, **8,000 a year (10 percent) are refugees**. [Many] of these are non-sponsored refugees who claim asylum [once already in Canada]. These refugee claimants receive no assistance from government or private sponsors [until their claims are acknowledged] and [this] can take years...Because they are not entitled to health benefits or education/social assistance, many claimants live in poverty and in overcrowded and unsafe housing. These refugees are most at risk of becoming homeless (Golden 1999: 71-75).

Toronto also has the highest percentage of immigrants in the country and an even greater proportion of recent immigrants. Until 1989, the incidence of poverty among immigrant headed families was the same as that of Canadian-headed families. **Since 1989, the incidence of poverty for immigrant-headed families has increased by 128 percent as compared to 36 percent for Canadian headed families.** This can be attributed to shifts in the labour market, rising unemployment, restrictions and cutbacks in income security programs and the lack of affordable housing, all of which put immigrants at great risk for homelessness (Golden 1999).

As a result, increasing numbers of immigrants and refugees are requiring shelter and other services (Canada Mortgage and Housing Corporation 1999b: 13). Between 1988-1996, refugee claimants constituted 1.4% of shelter users (1889 individuals) (Springer et al. 1998: 14). During the same time period, **13.6% of shelter users (18,072 individuals) indicated their residence one year before admission as "Another Country"** (Springer et al. 1998: 14).

From *Best Practices for Working with Homeless Immigrants and Refugees: A Community-Based Action Research Project, Research Report, September 2002* by Access Alliance Multicultural Community Health Centre

2. Icebreaker

See Appendix 3 for more Icebreaker exercises.

Exercise 2.1 Find Someone

Materials Paper and pens

Process

- ♦ Ask participants to write several statements about themselves on an piece of paper. Select the statements based on participants' level of familiarity with each other. Examples:
  - where they work
  - the number of years they have worked in their field
  - what ethnocultural group they identify most with
  - what languages they speak
  - what country they were born in
  - what citizenship they hold
- ♦ Pass out the cards randomly and ask participants to find the person whose card they have by only asking open-ended questions (questions that cannot be answered with a "yes" or a "no", such as "Where were you born?").

Handout 2.1: Find Someone Statements

Last movie you saw: ____________________

Languages you speak: ____________________

Where you were born: ____________________

Last movie you saw: ____________________

Languages you speak: ____________________

Where you were born: ____________________

Last movie you saw: ____________________

Languages you speak: ____________________

Where you were born: ____________________

Last movie you saw: ____________________

Languages you speak: ____________________

Where you were born: ____________________

Last movie you saw: ____________________

Languages you speak: ____________________

Where you were born: ____________________

3. Attitudes and Values

Exercise 3.1 Personal Immigration History

Materials Flipchart paper and markers.

Process

- ♦ Break into pairs.
- ♦ Write the following questions on a piece of flipchart paper and review them with participants. Ask participants to elicit information about their partners' personal immigration history using the following questions as a guide:
  - Where were you born?
  - How long have you lived in Canada?
  - When did your family come to Canada? Why?
  - What have been some of the losses and gains leaving your home country?
  - If you or your family do not have an immigration experience, reflect on experiences living in other countries or cities, or in neighbourhoods with diverse communities.
  - Immigrants are frequently judged on what they can contribute to Canadian society. Can you determine what contributions to Canadian society you have made? How about your family? What does "Canadian society" mean? How do you define "a contribution"? Why is this question asked of immigrants?
- ♦ In the large group, make a list of the countries that were raised during the discussions in pairs. Highlight the diversity of immigration experiences among participants. Link this to the diversity of experiences among clients. Brainstorm a list of clients' countries of origin, ethnicities and/or linguistic backgrounds.
- ♦ Talk about the process of discussing immigration histories with another person.

Questions What is the range of immigration experiences within the group?
Did anyone feel uncomfortable or hesitant about discussing their immigration history? Why?
What made participants feel more comfortable discussing these topics?
How do these experiences affect client/worker relationships in the context of immigrant and refugee access to health services?

4. The Immigration and Refugee System

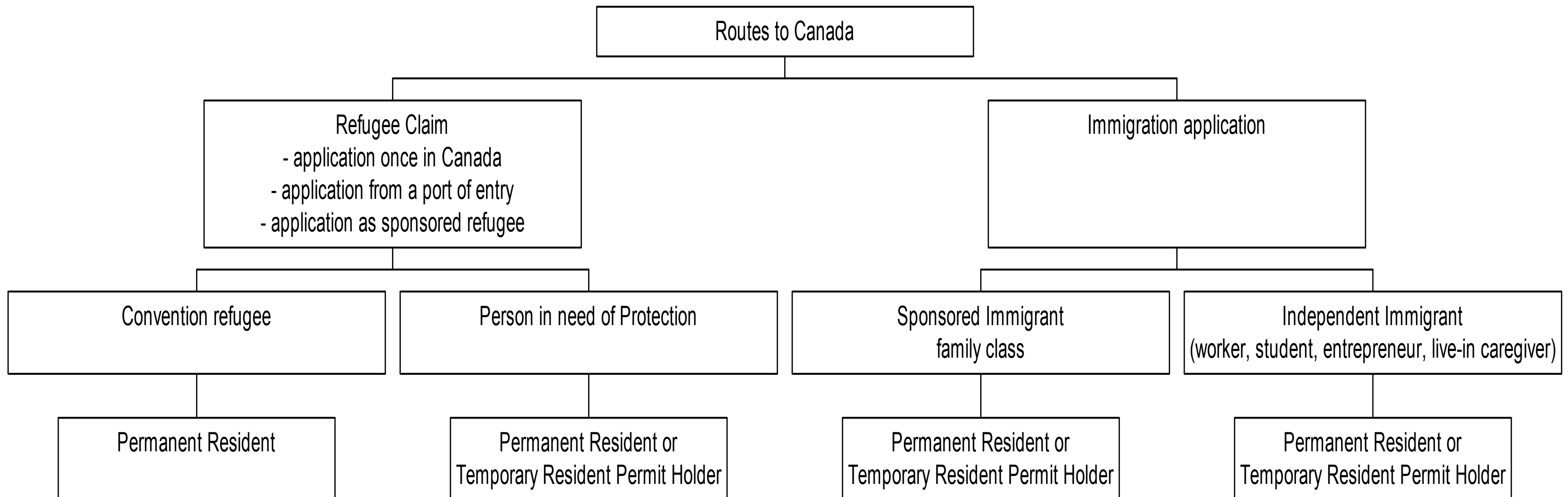
Exercise 4.1 Brainstorm: Stages and Definitions

Materials Flipchart paper and markers

Process

- Using the model on the flow chart handout, brainstorm different routes people can take to get to Canada throught the immigration system.
- Look at the handout and fill in the details, discussing the various stages in the refugee/immigration process.
- Brainstorm a list of immigration terms that participants would like to know more about. Review the definitions of terms on the handout.
- Use the information in the *HIV and Immigration Q and A* booklet to discuss the implications that being HIV-positive might have on a person's immigration or refugee process.

Handout 4.1: Immigration Flow Chart



Handout 4.1: Immigration Definitions

Who are Refugees?

As defined in the UN's 1951 *Convention Relating to the Status of Refugees*, a **refugee** is:

> a person who has left his or her country and cannot return because of a well-founded fear of being persecuted due to race, religion, nationality, political opinion or membership of a particular social group.

War and **persecution** force people to flee their homes in many parts of the world. Refugees leave their countries because their basic **human rights** have been violated or are in jeopardy. Persecution may be for a variety of reasons, such as political opinion, ethnicity or religious belief. Refugees cannot count on protection from their own government, including the police and the courts. Their only exercise is to seek safety in another country.

An **internally displaced person** is similar in many ways to a refugee, but has not crossed an international border. Internally displaced persons flee within their own countries because of war, human rights violations or natural disasters. There are more internally displaced persons in the world today than there are refugees.

Immigrants [unlike refugees] choose to leave their countries voluntarily to make a new life elsewhere. They can return home at any time, and can still count on the protection of their own government.

From *Refugees: A Canadian Perspective – Teacher's Guide*
by the United Nations Association in Canada, p2.

Immigration Definitions

Canadian Citizen: Someone born in Canada, someone born outside Canada to a parent who is a Canadian citizen, someone who becomes a citizen through naturalization.

Permanent Residency or Landed Status: A permanent resident has been granted landing – the right to live permanently in Canada.

Naturalization: The process by which a non-citizen becomes a Canadian citizen.

Sponsor: Sponsors must be a Canadian citizen or a permanent resident and be at least 19 years of age and living in Canada. They must meet Immigration requirements and sign an Undertaking of Assistance to provide for someone who plans to immigrate to Canada.

Temporary Resident Permit (formally called Minister's Permit): This permit gives a person temporary status and lets them stay in Canada, though they normally would not normally be allowed to do so. For example, someone who is medically inadmissible might be given a Minister's Permit; this would then allow them to apply for landing.

A person without status: A person who does not have immigration status.

Handout 4.1: Immigration Definitions (continued)

Personal Information Form: A form that each refugee claimant must complete detailing their story. The form asks questions such as who you are, where you went to school, where you worked, what route you took to get to Canada, and what the events surrounding your fear of persecution were.

Interim Federal Health: IFH is a federal program to cover medical care for refugee claimants. IFH provides essential health services for the prevention or treatment of serious medical and dental conditions, as well as contraception, prenatal and obstetrical care. It does not cover all routine medical or dental services.

Visitor: A visitor is someone in Canada temporarily and for a specific reason. Visitors include tourists, students and temporary workers. They must hold a valid visitor's visa.

Humanitarian and Compassionate Applications: Sympathetic grounds related to someone's personal circumstances that might justify their exceptional favourable treatment under immigration law.

Medically inadmissible: If you are found to be medically inadmissible, it means an immigration officer has found that you are a danger to public health or safety and/or that you might place excessive demand on Canadian health or social services.

Danger to public health or safety: People with highly contagious and dangerous diseases, like tuberculosis. People with HIV are generally not considered threats to public health and safety.

Excessive demand on health/social services: This means that, in the five years after the medical exam, a person would cost the health and social services more than the average Canadian. For HIV, a ten-year window is considered.

A person in need of protection: A person who is not a Convention refugee but who faces a risk of torture, a risk of cruel and unusual treatment or punishment or a risk to your life if you return to your country. This does not include risks stemming from a country's inability to provide adequate medical or health care.

Spouse: Someone you are married to.

Common-law partner: Someone you live with in a conjugal relationship, and have lived with for at least one year. You can still be considered common-law even if you haven't lived together if the reason for not living together is persecution or any form of penal control.

Conjugal partner: Someone you have had a conjugal relationship with for at least one year but with whom you don't live.

Adapted from *Terms and Definitions* by CLEO and *HIV and Immigration Q and A* by Matthew Perry

Exercise 4.2 Health Coverage

Materials Immigration Status role cards, *HIV and Immigration Q and A* booklet and Health Coverage Chart handout

Process

- Give each participant an Immigration Status role card.
- In pairs, ask them to determine what health coverage and social assistance they are eligible for (OHIP, IFH, drug and dental card). They can use the Health Coverage Chart handout and the booklet *HIV and Immigration Q and A* as a reference.
- Participants should work together to find ways to get access to health care, social services and drug coverage for themselves and their partner.

Questions Where can participants find more information on coverage?
How is access to coverage complicated by being HIV positive?

Background Information 4.2: Role Cards

Student	Refugee claimant	Immigrant who just received permanent residence status
Person without status	Person in need of protection	Child born in Canada to a parent without status
Canadian citizen who just moved to Ontario from another province	Temporary Permit Holder	Worker with work permit
Convention refugee who just received status	Refugee claimant who has been rejected	Homeless person without status
Person applying to immigrate who is sponsored by an abusive partner	Visitor with Temporary Resident Permit	Person who just applied for refugee status but has not received acknowledgement of their claim

Handout 4.2: Health Coverage

Immigration Status	Document	Eligible for Provincial Health Coverage (OHIP)	Eligible for Social Assistance (includes drug and dental card)
Permanent Status			
Canadian Citizen	Birth certificate or citizenship card	Yes Eligible for full OHIP 3 months after becoming resident in Ontario. Drug coverage possible through Trillium Drug Program	Yes (but if sponsorship agreement in place, will have to go to sponsor first)
Permanent Resident Or Landed Immigrant	Permanent resident card or record of landing	Yes Eligible for full OHIP 3 months after becoming permanent resident. Drug coverage possible through Trillium Drug Program	Yes (if sponsorship agreement still in effect, will have to go to sponsor first)
Temporary Status			
Visitor	None, or Temporary Resident Permit	No (Community Health Centres only)	No
Worker	Work Permit	No (some temporary foreign workers are eligible for OHIP)	No
Student	Study Permit	No	No
Permit Holder	Minister's Permit or Temporary Resident Permit	No (Community Health Centres only)	Yes (but receipt of social assistance may affect eligibility for permanent resident status)
Other status			
Refugee Claimant or person in need of protection	Notice of Eligibility / acknowledgement of claim	Eligible for Interim Federal Health Program (IFH) until claim is finally decided	Yes

From *HIV and Immigration Q and A* by Matthew Perry

Background Information 4.2: Health Coverage Answers

Person	Health Coverage	Social Assistance Eligible
Student	None (except CHCs)	No
Person without status	None (except CHCs)	No
Refugee claimant	Interim Federal Health	Yes
Child born in Canada to a parent without status	OHIP	Yes
Immigrant who just received permanent residence status	• OHIP after 3 months • Trillium	Yes (although sponsor must be approached first)
Canadian citizen who just moved to Ontario from another province	• Provincial coverage should be portable between provinces. • OHIP after 3 months	Yes
Convention refugee who just received status	OHIP	Yes
Person applying to immigrate who is sponsored by an abusive partner	None (except CHCs)	No
Visitor with Temporary Resident Permit	None (except CHCs)	No
Refugee claimant who has been rejected	None (except CHCs)	No
Homeless person without status	None (except CHCs)	No
Temporary Permit Holder	None (except CHCs)	Yes
Worker with work permit	Some workers qualify for OHIP	No
Person in need of protection	Interim Federal Health	Yes
Person who just applied for refugee status but has not received acknowledgement of their claim	None (except CHCs)	No

5. Communication Skills: Facilitating Discussion of Immigration Status

5A. Identifying Barriers

Exercise 5A.1 Brainstorm: Barriers

Materials Flipchart paper and markers

Process

- Brainstorm a list of barriers to disclosure of immigration status.
- Have a volunteer read the quotes from the handout on barriers. Ask participants to identify barriers to disclosure faced by the people quoted.
- Ask participants to recall the feelings that were brought up when they were asked to disclose their immigration experiences in the exercise on Personal Immigration History.

Questions What are the links between barriers to access and barriers to discussing immigration status?

Handout 5A.1: Quotes about Barriers

Agencies who are working to facilitate the access of immigrants and refugees to their services, must take seriously this population's heightened concerns about disclosure and confidentiality. It is particularly important to clearly differentiate community-based services from services provided by the government. Immigrants and refugees have well-founded fears of government agencies and services:

> I was not approaching the immigration I was approaching the health department. I said I need my health card so that I can access the medication. I went to some office. When they typed into the computer they discovered that I am a wanted person. Yes! I go there to ask them to renew my health card, they punch the computer, and there is a warrant for me. They don't tell me. They tell me to go to Airport Road. They say Ok, your health card issue, you sort it out in an office, number so-so, Airport Road. I go there innocently. I do not suspect anything. I get there, the woman punch the computer again after giving her my name and my phone number. She say Ok, wait. So the next time, one officer comes in the waiting room. And says Oh you know, I have got bad news for you.
>
> I thought he was going to tell me that they can't give me a card [instead he says there is] a warrant for your arrest. It has been going on for the last eight months and it is still active as far as we are concerned, so we have no choice but to detain me. [They kept me] for seven days.

The threat of arrest, detention, and deportation increases the vulnerability of refugee and immigrant PHAs, and increases their distrust of any social service.

From CAAT's Action Research Report by Loralee Gillis, p37.

Health, social and legal systems in Canada are difficult to negotiate for any newcomer. Negotiating can be an insurmountable obstacle when compounded by serious illness: One PHA told us:

> The thing is, do you don't go up to immigration and say look, I have AIDS, I am dying. So how do you go about that? It is like a puzzle. You struggle in the middle and you don't know where you go. In my case it was very difficult and intense but within a reasonably short period of time... But to drag that out I would have died probably. Because it is not only handling or coping with the stress of the illness, you were also coping with the stress of immigration status, financial status. All the different stresses that come into play is quite intense.

From CAAT's Action Research Report by Loralee Gillis, p36.

5B. Building Skills

Exercise 5B.1 Role Play: Immigration Secrets

Materials Immigration secrets handout

Process

- Role play in pairs, one worker and one client.
- The client should pick an immigration secret from the list below, either Real or Borrowed.
- The worker must try to encourage the client to disclose their secret.
- Explore what aspects of the interaction made the client feel comfortable disclosing their secret.
- Come back together as a group to discuss the essential components of facilitating discussing of secrets.

Questions How do barriers to access affect disclosure?

Handout 5B.1: Instructions for Immigration Secrets

In this scenario, your partner will try to find out what your secret is. Pick one of the following secrets to use:

1. A Real Immigration Secret:

Pick a personal experience or situation **related to immigration or citizenship** that you do not frequently disclose to other people but are willing to disclose in this scenario.

OR

2. A Borrowed Immigration Secret:

Pick an experience or situation **related to immigration or citizenship** that has not happened to you but that is real for other people. Make one up or pick one from the list below. Examples:

- You recently passed through customs at the Canadian-U.S. border without declaring that you were carrying marijuana.
- You came to Canada as a visitor and never left. As a result, you have no immigration status.
- While in another country, you worked "under the table" and did not pay tax.
- You smuggled your HIV meds from Canada into the U.S. and did not disclose your status to the border guard although you know that they do not let people with HIV into the country.
- You came to Canada as a student but dropped out of school. You now have no status.
- You married a friend in order to facilitate their immigration process.
- You are transgendered. You filed your claim in your male name, but identify as a woman.

Exercise 5B.2 Role Play: Working with a Translator

Materials Handouts and pens

Process

- Break into three groups: workers, clients and translators.
- The worker's task is to conduct a short questionnaire with the client. However, in order to address the client, the worker must use the translator and can only do this by whispering their questions to the translator. The translator then whispers the questions to the client. The client responds by whispering to the translator.
- Give each group their instructions handouts and explain them.
- If the group does not divide equally into groups of three, create a group of four, with two workers.
- When the exercise is complete the clients and workers should compare answers to see how many were accurately captured by the workers.
- Bring the group back together and discuss the questions listed below.
- Review the handout on Cultural Interpreting.

Questions

How do you use a translator effectively?
How do you assess when it may not be appropriate for a client to disclose to another professional?
How do you ensure your client's safety and confidentiality when disclosing their immigration status or serostatus to other professionals?

Handout 5B.2: Instructions for Translator Role Play

Clients

- You may only speak to the translator and only by whispering.
- When asked a question, you can choose to tell the truth or lie.
- You are encouraged to mumble some of their statements or say them in another language if you speak one.
- You have only one chance to hear what the translator is saying and you cannot ask for clarification.
- After you give each answer, write it down on the answer sheet.

cut here_ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _cut here

Workers

- You may only speak to the translator.
- You can choose to gather the answers to the questions by asking whatever questions you would like.
- You are encouraged to mumble some of their statements or say them in another language if you speak one.
- You have only one chance to hear what the translator is saying and you cannot ask for clarification.

cut here _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ __ _ cut here

Translators

- The client and the worker are not allowed to speak to each other; they must speak through you.
- You must whisper all the statements and questions.
- You cannot ask the worker or the client for clarification.
- You may change the client's statements or the worker's questions if you disagree with them.

Handout 5B.2: Questionnaire

Find out as much as you can from the client about the following topics.

1. Full name: ______________________________

2. Nicknames: ______________________________

3. Date of Birth: ______________________________

4. Place of Birth: ______________________________

5. Hometown: ______________________________

6. Marital Status: ______________________________

7. Occupation: ______________________________

8. When you were a child, what did you want to be when you grew up? ______________
____
____

9. What is the best advice ever given to you? ______________________
____
____

Handout 5B.2: Client's Answers to Questionnaire

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

____

Handout 5B.2: Cultural Interpreting

A Note on Cultural Interpreting

Cultural Interpreters are mediators of language and culture between a service provider and client. A Cultural Interpreter is trained to be sensitive and attuned to the cultural implications of certain factors and the ensuing consequences, and to be able to clarify such situations for others. **Using a Cultural Interpreter can help to communicate a client's rights, privileges and responsibilities; facilitate a process; or advocate for a client.**

Cultural Interpreters need to understand the cultural values and beliefs affecting the behaviour of their clients and of the institutional workers they come in contact with. They have to be able to communicate these meanings to each side. Settlement counsellors need to be aware of how the dynamic of cultural interpreting, a three-way process, is a different from two-way dynamic of counselling.

One theory suggests **how three-way communicating in two languages works**:

When we have three people together in a confined space, using two different languages in a structured task such as problem solving or counselling on a particular issue, three distinct interactions are occurring. What develops is **a triangle with three sets of pairs**, each one operative at a given point in time. Although only one of these pairs is operating at any given moment, non-verbal interaction is taking place at all times within each pair.

There is a **shifting power balance within the triangle**. There is a qualitative change from the nature of two-way communication when a third party is included in an interaction. If the balance of power between two people was more or less even, the introduction of a third will shift it in favour of the person with whom the third identifies, feels loyal or is professionally committed to. If there was previously an imbalance, the addition of a third presence could make the established pattern more pronounced, or it could even it out, depending on the "bias" of the third person.

A common tendency is for the service provider to have greater power, and the client to be relatively passive. This would be accentuated in a situation where the client spoke little of the mainstream (institution and usually provider's) language.

From *Immigrant Settlement Counselling: A Training Guide* by OCASI, p235.

Exercise 5B.3 Brainstorm: Tips and Tools

Materials Flipchart paper and markers

Process

- Brainstorm a list of tips and tools that facilitate discussion of immigration status.
- Since the immigration and refugee system is so complex, many people may be unclear as to the various stages they will have to pass through and to their rights along the way. Brainstorm a list of questions that will help both workers and clients to identify where a client is in the immigration process.

6. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?

7. Evaluation

See Appendix 5 for evaluation tools.

References and Resources

Canadian Centre for Victims of Torture. *Befriending Survivors of Torture: Building a Web of Community Support: Participant's Manual.* CCVT. 2000.

Canadian Council for Refugees. *Best Settlement Practices: Settlement Services for Refugees and Immigrants in Canada.* CCR. February 1998.

Canadian Council for Refugees. *Facing Facts: Myths and Misconceptions about Refugees and Immigrants in Canada.* CCR. 1999

Community Legal Education Ontario. *Immigration and Refugee Fact Sheet: Terms and Definitions.* August 2001.

Access Alliance Multicultural Community Health Centre. *Best Practices for Working with Homeless Immigrants and Refugees: A Community-Based Action Research Project. Research Report.* September 2002.

Gillis, Loralee. *Action Research Report: Improving Access to Legal Services and Health Care for People Living with HIV/AIDS who are Immigrants, Refugees or without Status.* Committee for Accessible AIDS Treatment. July 2001.

Hyman, Ilyene. *Immigration and Health.* Health Canada. September 2001.

Ku, Leighton and Alyse Freilich. *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston.* Kaiser Commission on Medicaid and the Uninsured. February 2001.

Mwarigha M.S. *Towards a Framework for Local Responsibility: Taking Action to End the Current Limbo in Immigrant Settlement – Toronto.* Maytree Foundation, 2002.

Ontario Council of Agencies Serving Immigrants. *Immigrant Settlement Counselling: A Training Guide.* 2000.

Perry, Matthew. *HIV and Immigration Q and A.* Committee for Accessible AIDS Treatment. Draft. July 2002.

United Nations Association in Canada. *Refugees: A Canadian Perspective – Teacher's Guide.*

Websites

Citizenship and Immigration Canada	http://www.cic.gc.ca/
Canadian Council for Refugees	http://www.web.net/~ccr/
CERIS Research on Immigration and Settlement	http://ceris.metropolis.net/
Government of Ontario	http://www.settlement.org/
Ontario Council of Agencies Serving Immigrants	http://www.ocasi.org/
National Immigration Law Centre (U.S.)	http://www.nilc.org/

Unit 3: HIV/AIDS and Immigration

1. Introduction

1.1 *Handout* *Immigrants and Refugees with HIV*

2. Icebreaker

2.1 Exercise Camps

3. Sharing Experiences

3.1 Exercise Discussion: Experiences and Learning Goals

4. Referrals and Resources

4.1 Exercise Scavenger Hunt
Handout *Scavenger Hunt Cards*
Handout *Scavenger Hunt Worksheet*
Handout *Scavenger Hunt Answers*

5. Case Management

5.1 Exercise Case Management
Handout *Case Management Models*
Handouts *Cases One-Five*

6. Conclusion

7. Evaluation

References and Resources

Learning Objectives

During this workshop, participants will:
- integrate knowledge of the immigration/refugee process and of HIV/AIDS
- explore some of the more complex issues that arise for an immigrant or refugee PHA
- learn about resources and services available to PHAs
- begin to feel confident referring clients

Suggested outline for 2.5-hour workshop

Introduction – 10 min
Icebreaker – 15 min
Sharing Experiences – 20 min
Referrals and Resources – 20 min
Break – 10 min
Case Management – 60 min
Conclusion – 10 min
Evaluation – 5 min

1. Introduction

- Review statistics on the handout about HIV and immigrants and refugees.
- Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- Workshop agenda
- Ground rules and confidentiality (See Appendix 2.)
- Other housekeeping information (washrooms, smoking, break time)

Handout 1.1: Immigrants and Refugees with HIV

Between 1985 and 1998:

- 11.4% of HIV diagnoses in Ontario were attributed to immigrants from HIV-endemic countries
- 46% of HIV infections among immigrants from the Caribbean and 30% of infections among immigrants from Sub-Saharan Africa were **acquired in Canada**

From *Immigration and Health* by Health Canada, p27-29.

Which countries are HIV-positive immigrants in Ontario from?

87% of infections among immigrants from the Caribbean are from:

- Jamaica
- Guyana
- Trinidad and Tobago
- Haiti

72% of infections among immigrants from Sub-Saharan Africa are from:

- Ethiopia and Eritrea
- Somalia
- South Africa
- Uganda
- Kenya

Immigrants from HIV-endemic regions in Toronto:

- Toronto is the primary location of residence for all persons arriving from HIV-endemic regions, with the exception of Haitians… (p16)
- 75% of immigrants from sub-Saharan Africa live in Toronto (p10)
- 85% of immigrants from the Caribbean live in Toronto (p10)

Both from *The HIV/AIDS Epidemic Among Persons from HIV-Endemic Countries in Ontario* by R. Remis and E. Whittingham

Risk for HIV infection among immigrant populations is attributable to:

- variables associated with living conditions
- demographic and behavioural differences within the immigrant community
- difficulties in interactions with and/or integrating into the host society
- less access to medical services
- communication problems with health care personnel

Since immigrants who are HIV-positive are subject to stigmatization and discrimination, available support services may not always be used.

From *Immigration and Health* by Health Canada, p27-29.

2. Icebreaker

See Appendix 3 for examples of Icebreaker exercises.

Exercise 2.1 Camps

Materials None

Process

- Explain to participants that they should group themselves into camps based on different categories. The idea is to get participants chatting with each other.
- Once in their categories, ask them to introduce themselves.
- Try a few categories to make sure participants are grouped into a few different camps.
- Use categories relevant to the participants and to the workshop topic. Be sure to add less serious categories as well. Categories could include:
  - First language
  - Birthplace
  - Ethnic background
  - Favourite dessert
  - Favourite food
  - Number of years at the agency
  - Favourite colour
  - Astrological sign
  - Last time you saw a movie (in the last month, between one to six months ago…)
  - Last time you did volunteer work
- An alternative could be to line up according to most recent/least recent time participants did volunteer work or went to a movie. Participants could then introduce themselves along the line.

3. Sharing Experiences

Exercise 3.1 Discussion: Experiences and Learning Goals

Materials Flipchart paper and markers

Process

- Break into pairs or groups of three and share one experience related to providing services for an immigrant or refugee with HIV.

- If participants have not had experience working with an HIV-positive person, ask them to discuss an experience working with an immigrant or refugee with a health problem.
- As they share experiences, have each group create two lists: the first of the skills needed to work with immigrant and refugee PHAs, and the second of the challenges they have faced working with immigrant and refugee PHAs.
- In the larger group, review the lists.
- Use the points raised in the lists to create a list of learning goals for the workshop.

4. Referrals and Resources

Exercise 4.1 Scavenger Hunt

Materials Scavenger Hunt Worksheet, prizes, pens, and referral guides (the Blue Book, the Living Guide, the Resource Listing)

Process

- Distribute the Scavenger Hunt cards so that each participant has a unique collection of cards. If the group is large, give some cards out twice.
- Ask participants to fill them out based on their own knowledge, by consulting other participants or reference guides, or by coming up with new strategies.
- Ask participants to yell "Bingo!" when they are finished.
- Offer a prize for the person who completes their cards the fastest. Offer prizes to those who came up with creative strategies for finding referrals.
- Hand out a blank copy of the solution table and go over participants' answers. Have participants fill in the table with the answers. Discuss some of the questions listed below.

Questions What were the most difficult referrals to find? Why?
Were there any referrals that participants couldn't find?
What creative strategies did participants use to find available resources?
Did the prize provide a useful incentive?
What are the prizes in our real work?
What makes a good referral? A challenging referral?

Handout 4.1: Scavenger Hunt Cards

WHAT: A food bank for someone who lives at Dundas and Parliament **HOW:** **WHERE:**	**WHAT:** An AIDS organization that offers counselling services in Tagalog **HOW:** **WHERE:**	**WHAT:** A health clinic that offers free viral load testing **HOW:** **WHERE:**
WHAT: Child care for an HIV positive child who only speaks French **HOW:** **WHERE:**	**WHAT:** Legal advice for a non-status PHA **HOW:** **WHERE:**	**WHAT:** A primary care physician who speaks Vietnamese and treats PHAs **HOW:** **WHERE:**
WHAT: A shelter for a homeless refugee **HOW:** **WHERE:**	**WHAT:** A shelter that offers services for homeless transgendered people **HOW:** **WHERE:**	**WHAT:** Free Post-Exposure Prophylaxis (short term HIV meds) for non-insured person **HOW:** **WHERE:**
WHAT: AIDS hospice for non-insured person who only speaks Amharic **HOW:** **WHERE:**	**WHAT:** Drug detox for non-insured person **HOW:** **WHERE:**	**WHAT:** Health care for non-insured child with HIV **HOW:** **WHERE:**

Handout 4.1: Scavenger Hunt Worksheet

WHAT? The service you need to find	HOW? Strategies for finding the service	WHERE? Where the service is available
A food bank for someone who lives at Dundas and Parliament		
An AIDS organization that offers counselling services in Tagalog		
A health clinic that offers free viral load testing		
Child care for an HIV positive child who only speaks French		
Legal advice for a non-status PHA		
A primary care physician who speaks Vietnamese and treats PHAs		
A shelter for a homeless refugee		
A shelter that offers services for homeless transgendered people		
Free Post-Exposure Prophylaxis (short term HIV meds) for non-insured person		
AIDS hospice for non-insured person who only speaks Amharic		
Drug detox for non-insured person		
Health care for non-insured child with HIV		

Handout 4.1: Scavenger Hunt Answers

WHAT? The service you need to find	HOW? Strategies for finding the service	WHERE? Where the service is available
A food bank for someone who lives at Dundas and Parliament	The 519 Community Centre, Regent Park Community Health Centre, 416 Women's Drop-in, ACT, Street Helpline, Blue Book	Anishnawbe Street Health
An AIDS organization that offers counselling services in Tagalog	Asian Community AIDS Services (ACAS), Alliance for South Asian AIDS Prevention (ASAP), AIDS Committee of Toronto (ACT)	ACAS
A health clinic that offers free viral load testing	Toronto People with AIDS Foundation (PWA), Voices of Positive Women, ACT	SHOUT Clinic, 410 Sherbourne Health Centre
Child care for an HIV positive child who only speaks French	Blue Book, ACT	Voices, Teresa Group, Le petit chaperon rouge
Legal advice for a non-status PHA	PWA, Voices, ACT	El-Farouk Khaki, HIV/AIDS Legal Clinic of Ontario
A primary care physician who speaks Vietnamese and treats PHAs	ACAS, ACT, any pharmacy	410 Sherbourne
A shelter for a homeless refugee	Street Helpline	Women's Residence, Sojourn House, Salvation Army, Seaton House
A shelter that offers services for homeless transgendered people	Meal Trans (519), Street Helpline, Blue Book, ACT	Nellie's, YWCA-Stop 86, Native Men's Residence, Fred Victor Centre, Women's Residence
Free Post-Exposure Prophylaxis (short term HIV meds) for non-insured person	Regent Park CHC, Voices, St. Mike's Hospital, ACT	Casey House, Ontario Works
AIDS hospice for non-insured person who only speaks Amharic	PWA, ACT	Casey House
Drug detox for non-insured person	PWA, ACT, Blue Book	Women's Own
Health care for non-insured child with HIV	PWA, ACT	Hospital for Sick Children

5. Case Management

Exercise 5.1 Case Management

Materials Case study handouts, paper and pens

Process

- Review information about case management outlined on the handout.
- Present case studies to participants. Explain that the words in italics are actual quotes from refugees with HIV.
- Break into small groups. Make sure participants have markers and flipchart paper as well as paper and pens.
- Each group should work on a case to identify the barriers to access and build a work plan to help support the client.
- Come back into the large group to discuss the work plans.

Source Quotes in the case studies are from *Silence and Secrecy: Refugee Experiences of HIV in New Zealand* by Heather Worth, et al. and CAAT's *Action Research Report* by Loralee Gillis.

Questions

What is case management?
How do you encourage clients to take an active role in their own case management?
How are referrals made more difficult by systems currently in place?
How could referrals be facilitated?
What issues of confidentiality arise when service providers share clients?

Handout 5.1: Case Management Models

Social work case management is a method of providing services whereby a professional social worker assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.

A professional social worker is the primary provider of social work case management. Distinct from other forms of case management, social work case management addresses both the individual client's bio-psychosocial status as well as the state of the social system in which case management operates. Social work case management is both micro and macro in nature: intervention occurs at both the client and system levels. It requires the social worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide him or her with needed services, resources, and opportunities. Services provided under the rubric of social work case management practice may be located in a single agency or may be spread across numerous agencies or organizations.

From National Association for Social Work's
Standards for Social Work Case Management

What is case management? Case management is a client-centered service approach, which coordinates the provisions of service within a community to effect more positive and sustained outcomes. Its goals are to access health and mental health care for patients; obtain social support services; and empower patients, family members, and significant others.

How does the Pennsylvania Department of Health, Bureau of HIV/AIDS support case management services in Pennsylvania? The Pennsylvania Department of Health, Bureau of HIV/AIDS recognizes that the majority of HIV case management services are provided in a non-medical setting. The Bureau of HIV/AIDS supports the principles of a biopsychosocial case management model that is client-focused, encourages client autonomy, and protects confidentiality. Simultaneously, the Bureau recognizes and supports the importance of medical provider involvement in working toward the improvement of the quality of life for persons with HIV. As such, the Bureau of HIV/AIDS further defines case management, as a service, to include the following key activities:

- assessment of the client's needs and personal support systems;
- development of a comprehensive, individualized service plan;
- coordination of the services required to implement the plan;
- client monitoring to assess the efficacy of the plan;
- periodic re-evaluation and adaptation of the plan as necessary.

From http://www.aidslibrary.org/case.htm

Handout 5.1: Case One

"I have lots of problems in my mind. I have no immediate family. We all come from the same country but we are related, not family. Sometimes I feel very lonely."

Clara is a 31 year old transgendered woman who is a citizen of Romania and a refugee claimant in Canada. She does not speak English. She graduated from a Nursing College in Romania as a nurse's assistant and worked for 4 years in this capacity. She was raised in an orphanage until the age of 18. She left Romania in December 2001 and is currently in the process of making a refugee claim. She has silicon breast implants and is experiencing pain in her left breast, possibly due to a leakage. Her doctor in Romania prescribes clonazepam as a "permanent solution to his neurotic complaints" (sic). Clara would like to see a plastic surgeon here. She has experienced suicidal feelings since arriving in Canada and has a history of alcohol abuse and a possible dependency on clonazepam. Clara disclosed that she found out she was HIV+ in Romania 2 years ago but has not followed up on this. She believes she was infected through a client while she was working in the sex trade. Her refugee claim is in her male name.

1. List the barriers that Clara faces in accessing health services.
2. How do you address these barriers?
3. What else would you need to know about Clara's case?
4. Create a work plan.

Handout 5.1: Case Two

"When I found out I had HIV I was very upset and crying always, and more than that, my husband was very upset and crying. And a couple of times I was looking for an electric wire to kill myself. I hated myself so much. My husband was disappointed too. The first plan was to have another baby here and after I told him my news he got very upset, and after we left the centre his character is changed, he is not supportive like before, and I lost my hope too… The thing that make me feel bad is that I get [HIV] from God. I have to accept that…I never had any relationship outside my husband. I didn't have any contact with anybody from home to church to home, I didn't go anywhere else. That is why I believe I got it from God to punish me."

Fatima is a woman in her late-30s from Angola. She is married with one child, a 9 month old girl. She has been in Canada for two years and is in the process of getting landed status. Her husband is her immigration sponsor. During her pregnancy, she was diagnosed with HIV. Both her child and her husband tested negative. Fatima speaks Umbundu and only a little Portuguese.

Fatima's husband works midnight shifts and does not allow her out of the apartment without him. As a result, she does not know her address or how to use the TTC. Her husband blames her for her HIV-positive status, and has recently started to punish her by not letting her eat or go to the doctor.

Fatima has one female friend in Toronto, an Angolan woman named Adelina. Adelina knows that Fatima is HIV-positive, but agreed that it was best not to tell her husband. When Fatima's health deteriorates, Adelina contacts an agency for help.

1. List the barriers that Fatima faces in accessing health services.
2. How do you address these barriers?
3. What else would you need to know about Fatima's case?
4. Create a work plan.

Handout 5.1: Case Three

"Because of my sexuality I always have problems through my whole childhood. They called me to the army, and I went into the army. [W]hen they called me to a physical they asked about me and I said besides being healthy I am gay. Because of that they give me a hard time and keep me for a week in segregation. And I don't know if you can consider it rape or abuse by one of the sergeants for a whole week to prove that I was gay and that I wasn't just saying that to leave the army. And they discharged me with a letter which I have with me where it says for medical reasons that I am not allowed to stay. And then after that my Mom didn't like it and the guys from the army knew of course what I did and they were coming and shouting in front of my house and trying to continue their sexual stuff. And so my Mom said, you have to get out of the country. Just from one week to the next I was on the plane, I was not allowed to tell anybody that I was leaving and just like that I came here not knowing what Canada was or where I was coming or nothing.

I also learned that it is better to keep myself silent because there is evidence that people who speak their minds get killed. Like Jesus Christ and many others. So if I stick out, I'll get killed. They will find a way to kill me."

Gonzalo is a 22 year-old HIV-positive gay man. He fled Honduras last year. Although he was fleeing persecution, he did not make a refugee claim for fear that an investigation in Honduras might have repercussions for his family. He currently has no status in Canada and has been living in a shelter for homeless men for the past several months. He has mental health issues.

1. List the barriers that Gonzalo faces in accessing health services.
2. How do you address these barriers?
3. What else would you need to know about Gonzalo's case?
4. Create a work plan.

Handout 5.1: Case Four

"Today I've been thinking about it…drinking a lot… "Am I exposed to more if I kill myself"? Because the government can even tell after I die, "because he caught this kind of illness – that is why he killed himself". It's going to be exposed and my family's going to hear it – my wife – everybody. That is why – rather than doing that- I just keep going. Especially for my wife – I don't want somebody to talk because I got this kind of illness and I killed myself."

Lan is a 41 year-old man originally from Vietnam. He was recently tested for HIV after he was hospitalized with *Pneumocystis carinii* pneumonia (PCP). He had a CD4+ count of 40 and was diagnosed with AIDS.

Lan immigrated to Canada 4 years ago. Recently, he sponsored his wife, Tien, and three children, aged five, seven and eleven. Lan refuses to tell Tien that he has HIV as he is afraid that she will think that he was not faithful to her. He thinks he contracted HIV in his twenties before he met Tien, when he was injecting drugs and sharing needles. He refuses to accept any referrals to AIDS organizations because of the stigma associated with the disease.

Lan's wife, Tien, does not speak English. Under the new immigration law, Tien and the children will have to be tested for HIV.

1. List the barriers that Lan faces in accessing health services. What barriers does Tien face?
2. How do you address these barriers?
3. What else would you need to know about Lan's case?
4. Create a work plan.

Handout 5.1: Case Five

"My family doctor – I have a language problem and one day he asked me does my family know about my problem. If I took my daughter with me he might say something."

Yvette, an 8 year-old girl of Haitian descent, is acting out in school. She is getting into fights, refusing to listen to her teachers, and falling behind in her work. Her mother, Fabiana, came to Canada from Haiti fourteen years ago. She made a refugee claim but was refused. She stayed in Canada without status and has worked under the table as a cleaning woman and nanny since then. Her three children, including Yvette, were born in Canada.

Fabiana tested positive for HIV after her husband, Yvette's father, died of AIDS five years ago. Yvette was not tested. Fabiana did not disclose her status or tell Yvette how her father died. Fabiana did tell her oldest child, a thirteen-year old boy.

A counsellor at an AIDS organization provides support for Fabiana. The counsellor feels that Yvette would benefit from speaking with a counsellor. Fabiana insists that Yvette not be told about her status.

1. List the barriers that Fabiana faces in accessing health services. What barriers does Yvette face?
2. How do you address these barriers?
3. What else would you need to know about Fabiana's case?
4. Create a work plan.

7. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?

8. Evaluation

See Appendix 5 for evaluation tools.

References and Resources

Cain, Roy and Sarah Todd. *Shifting Sands: The Changing Context of HIV/AIDS Social Services in Ontario.* School of Social Work, McMaster University. January 2002.

Canadian Council on Refugees. *HIV Testing of Immigrants and Refugees.* January 31, 2001.

Canadian HIV/AIDS Legal Network. *HIV/AIDS and Immigration: Frequently Asked Questions.* 2nd revised version, June 2001.

Canadian HIV/AIDS Legal Network. *Brief to the House of Commons Standing Committee on Citizenship and Immigration.* January 28, 2002.

Canadian HIV/AIDS Legal Network and Alana Klein. *HIV and Immigration: Final Report.* Canadian HIV/AIDS Legal Network. 2001.

Gillis, Loralee. *Action Research Report: Improving Access to Legal Services and Health Care for People Living with HIV/AIDS who are Immigrants, Refugees or without Status.* Committee for Accessible AIDS Treatment. July 2001.

Health Canada. *Health Policy Working Paper Series: Immigration and Health.* September 2001.

Hyman, Ilyene. *Immigration and Health.* Health Canada. September 2001.

Mykhalovsky, Eric and George Smith. *Hooking up to Social Services: A Report on Barriers People Living with HIV/AIDS Face Accessing Social Services.* CATIE March 1994.

Narciso, Lea. *Casey House Access Project: Barriers to Accessing HIV/AIDS Services for Underserved Populations: a Community-Based Research Project.* Casey House. October 2001.

Pendleton, Gail. *HIV and immigrants: A Manual for AIDS Service Providers.* 2002 edition. National Immigration Project of the National Lawyers' Guild. Boston, MA 2002.

Remis, Robert and Elaine Whittingham. *HIV/AIDS Epidemic among Persons from HIV-Endemic Countries in Ontario, 1981-1998: Situation Report.*Department of Public Health Sciences, University of Toronto. November 1999.

Rudiak, Dana. *Newcomer Orientation to the Health System: A Resource Manual for Settlement Workers, Service Providers and Community Volunteers. Pilot Project – Toronto – March, 2000.* Four Villages Community Health Centre. Toronto, 2000.

Rudiak, Dana. *Health Care in Canada: A Guide for Ontario Newcomers. Toronto – March 2002*. Four Villages Community Health Centre. Toronto, 2002.

UNAIDS. *UNAIDS Technical Update: Population Mobility and AIDS*. UNAIDS Best Practice Collection. February 2001.

Worth, Heather, Alison Reid, Judith Ackroyd, and Etetu Tamirate-Bowden. *Silence and Secrecy: Refugee Experiences of HIV in New Zealand*. University of Auckland. February, 2001.

Section Two: Skills Development

Unit 4: Cultural Competency

Unit 5: Advocacy

Unit 4: Cultural Competence

1. Introduction

1.1 *Handout* *Definitions of Cultural Competence*

2. Icebreaker:

2.1 Exercise Common and Different

3. Exploring Identity

3.1 Exercise Power Flower
Handout *Power Flower*

3.2 Exercise Iceberg

4. Theoretical Concepts

4.1 Exercise Oppression Tree

4.2 Exercise Differences between Culturally Specific and Culturally Competent Approaches
Handout *Table: Differences between Culturally Specific and Culturally Competent Approaches*
Handout *Casey House Diagram*

5. Applying the Concepts

5.1 Exercise Cultural Competency: Self-Assessment
Handout *Cultural Competency Self-Assessment Chart*

5.2 Exercise Homophobia Porcupine

5.3 Exercise Case Studies
Handout *Cases One-Four*

5.4 Exercise Policies
Handout *Anti-Discrimination Policy*

6. Conclusion

7. Evaluation

References and Resources

Learning Objectives

During this workshop, participants will:

- ♦ Develop an awareness of personal privilege and oppression
- ♦ Acknowledge the complexities of cultural identity
- ♦ Identify the main differences between cultural sensitivity and cultural competence
- ♦ Analyse various anti-oppression policies in order to use them to advocate for clients' rights

Suggested outline for 2.5-hour workshop

Introduction – 10 min
Icebreaker – 15 min
Exploring Identity – 20 min
Theoretical Concepts – 20 min
Break – 10 min
Applying the Concepts – 60 min
Conclusion – 10 min
Evaluation – 5 min

1. Introduction

- ♦ What is cultural competence?
  - Practicing in a culturally competent way is an ongoing process.
  - Review definitions of cultural competence on the handout.
- ♦ Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- ♦ Workshop agenda
- ♦ Ground rules and confidentiality (See Appendix 2.)
- ♦ Other housekeeping information (washrooms, smoking, break time)

Handout 1.1: Definitions of Cultural Competence

The term "cultural competence" embodies the knowledge, attitudes, skills and protocols that allow an individual or system to render services across cultural lines in an optimal manner. Cultural competency permits individuals to respond with respect and empathy to people of all cultures, classes, races, religions and ethnic backgrounds in a manner that recognizes, affirms and values the worth of individuals, families and communities. It has been characterized as a continuum that encompasses several stages that include:

1. understanding one's own cultural background
2. acknowledging the patient's different culture, value systems, beliefs and behaviours
3. recognizing that cultural difference is not synonymous with cultural inferiority
4. learning about the patient's culture
5. adapting optimal health care delivery to an acceptable cultural framework

From http://learn.gwumc.edu/iscopes/Cultcomp.htm

Cultural competency refers to: A set of complementary behaviors, practices, attitudes and policies than enable a system, agency or individuals to effectively work in and serve pluralistic, multiethnic and linguistically diverse communities. Cultural competency is best achieved when organizations and people work closely with knowledgeable persons from the community to develop health care services that reflect the diverse values, traditions and customs to the clients. Cultural competency adds value to the health care delivery system by demonstrating improvement in quality of care.

From http://www.bphc.hrsa.dhhs.gov/cc/cc-activities.htm

The cultural competency continuum:

1. Cultural destructiveness
2. Cultural incapacity
3. Cultural blindness
4. Cultural pre-competence
5. Cultural competency
6. Cultural proficiency

From http://www.ccsi.org

Six reasons for cultural competence:

1. To respond to current and projected demographic changes
2. To eliminate long-standing disparities in the health status of diverse racial, ethnic and cultural backgrounds
3. To improve the quality of services and health outcomes
4. To meet legislative, regulatory and accreditation mandates
5. To gain a competitive edge in the market place
6. To decrease the likelihood of liability/malpractice claims

From *Rationale for Cultural Competence in Primary Health Care* by Elena Cohen and Tawara Goode.

2. Icebreaker

See Appendix 3 for more Icebreaker exercises. Bingo (an example is given in Unit One) and Name Exchange could also be used.

Exercise 2.1 Common and Different

Materials Flipchart paper and markers

Process

- ♦ Break into small groups.
- ♦ Ask participants to determine four things that are the same and four things that are different about all the members of the small group.
- ♦ Write these in two lists on a flipchart.
- ♦ Bring the large groups back together and display the lists. Discuss the lists.

Questions Were there any similarities in the categories that the groups selected?

3. Exploring Identity

Exercise 3.1 Power Flower

Materials Power Flower Handout, pens

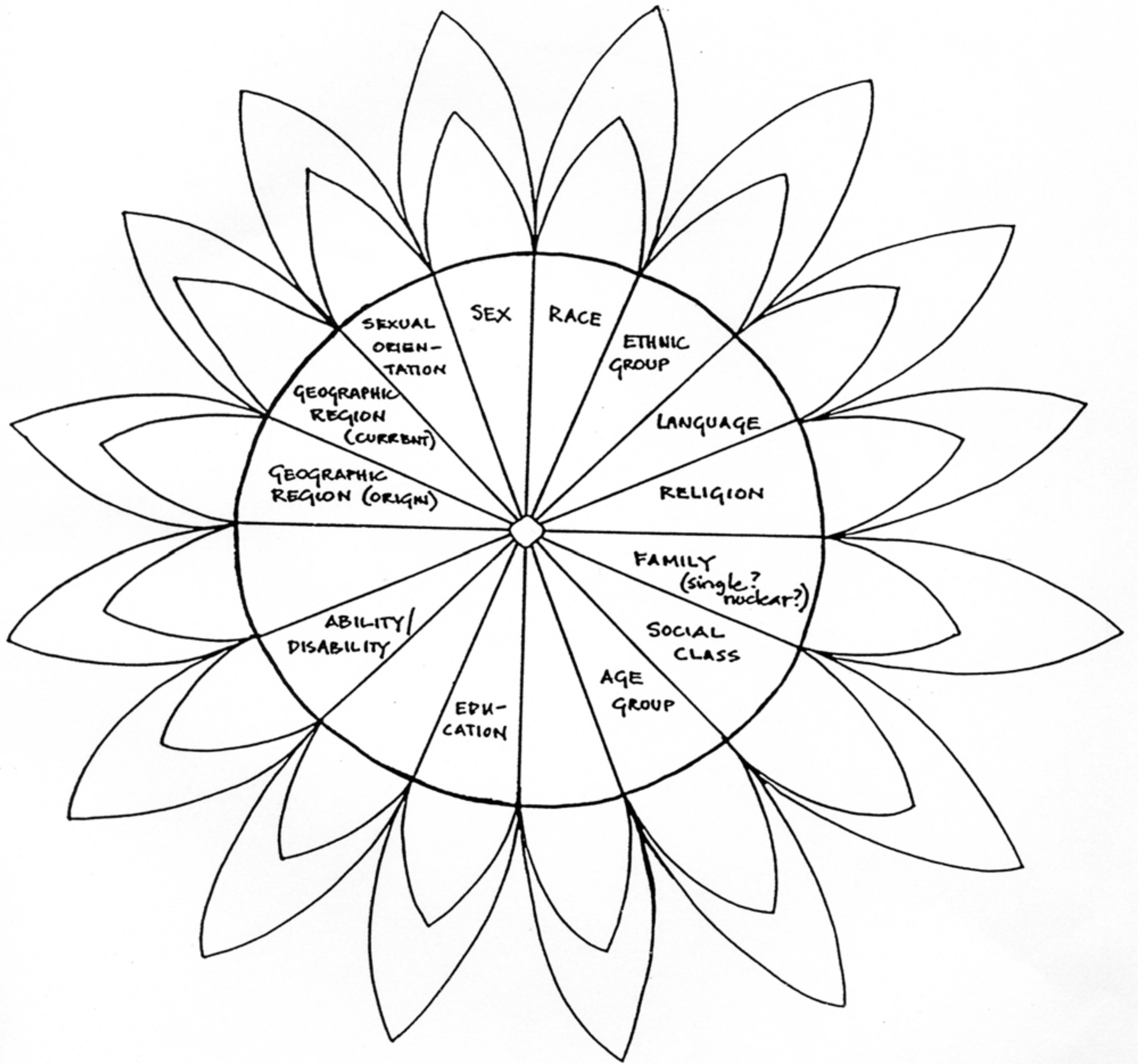
Process

- ♦ Ask participants to fill out the Power Flower handout: the inner petals represent participants' identity and the outer petals represent the dominant or mainstream identity. Choose categories relevant to the group to put in the three blank petals.
- ♦ Discuss in the large group.

Source Adapted from *Educating for a Change* by Rick Arnold and Bev Burke.

Questions How many participants have inner petals that match outer petals?
Do most match? Are most different?
How does this affect our lives? Our work?

Handout 3.1: Power Flower



Adapted from *Educating for a Change* by Rick Arnold and Bev Burke.

Exercise 3.2 Iceberg

Materials Iceberg diagram handout, photos or willing facilitator, flipchart paper and markers

Process

- ♦ Draw an iceberg on a piece of flipchart paper. Make sure the majority of the iceberg is under the waterline.
- ♦ Ask participants to identify things they can tell about a person, either one of the facilitators or someone in a photograph.
- ♦ Write the perceived things above the waterline and the imperceptible things below the waterline.
- ♦ As a variation, display a number of photographs around the room with iceberg diagrams beside them. Ask participants to circulate and write perceived characteristics on each of the photographs' icebergs.
- ♦ During the discussion, draw a distinction between the aspects of a person that can be perceived and those that cannot be perceived.

Source Adapted from *Self Reflection: A Move Towards Culturally Competent Practice: Participant Workbook* by Len Lopez, Gloria Murrant and Doug Stewart.

Questions How do our perceptions and presumptions affect our relationships with clients?

4. Theoretical Concepts

Exercise 4.1 Oppression Tree

Materials Flipchart paper and coloured markers

Process

- ♦ Explain the tree of oppression model as a way of conceptualizing oppression:
  - the fruits represent pain and violence
  - the branches represent discrimination and oppression
  - the soil represent fear and ignorance
  - the roots represent power and domination
- ♦ Break into pairs and ask the pairs to draw their own version of an oppression tree, and to write examples in the appropriate places.
- ♦ Pin the trees on the wall.
- ♦ Ask the participants to circulate and see other pairs' trees.
- ♦ Discuss.

Source Adapted from *National HIV/AIDS Volunteer Training Kit* by the AIDS Committee of Toronto.

Exercise 4.2 Differences between the Culturally Specific and the Culturally Competent Approaches

Materials Casey House diagram handout, Differences table, flipchart paper, and markers

Process

- Review the definitions of cultural competence on Handout 1.1.
- Outline the differences between the models of cultural sensitivity and cultural competence using Casey House diagram and Murrant/Stewart table.
- Discuss why cultural competence is a useful model.

Sources Adapted from *Self Reflection: A Move Towards Culturally Competent Practice: Participant Workbook* by Len Lopez, Gloria Murrant and Doug Stewart. Diagram from Casey House.

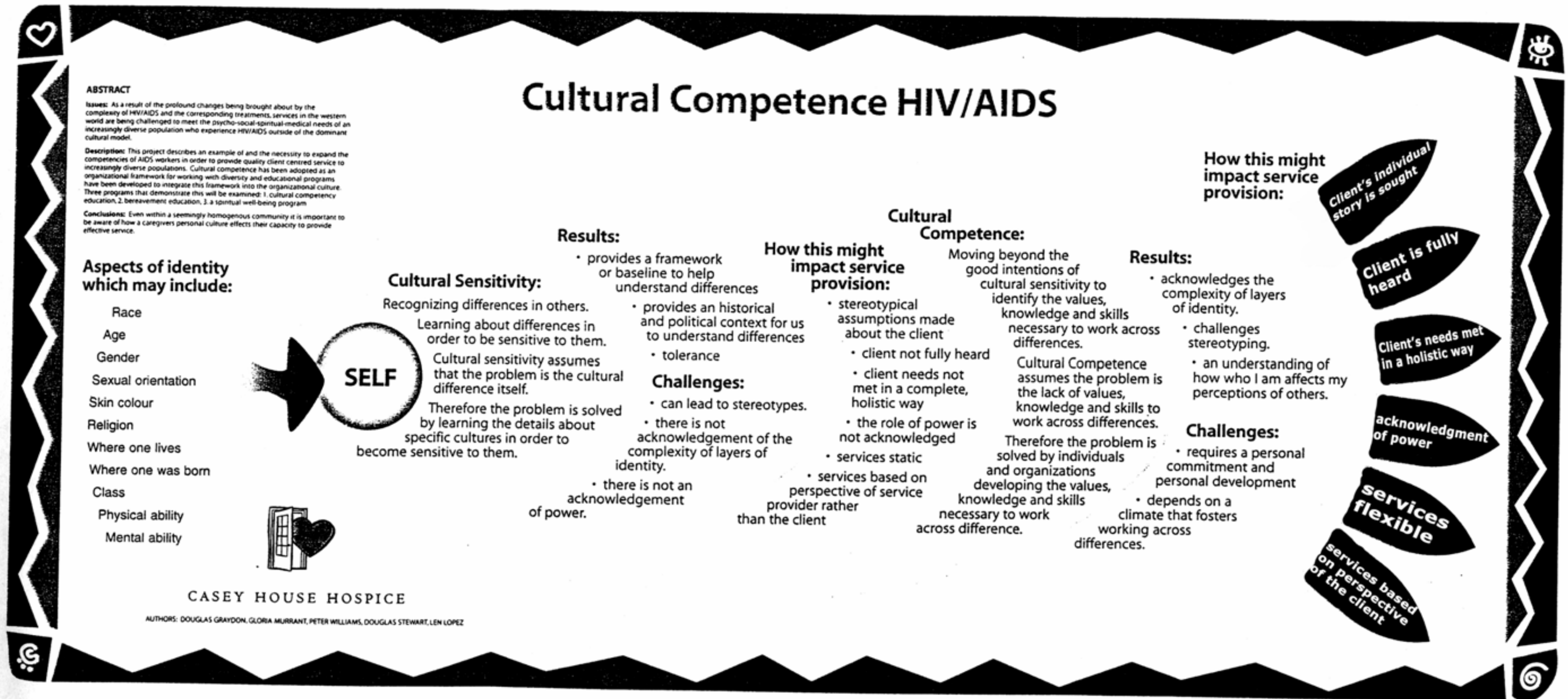
Questions What are the challenges inherent in working with a cultural competency framework given systemic discrimination?
What are the challenges working between these models given the history of the development of culturally specific ASOs and settlement services?

Handout 4.2: Table: Differences between Culturally Specific and Culturally Competent Approaches

Culturally Specific and Culturally Competent Approaches					
	How the Problem is Defined	**How the Problem is Solved**	**Acknowledges Power**	**Benefits**	**Disadvantages**
Culturally Specific Approach	The problem is the cultural differences themselves	Learn about the details of a specific culture	No	Provides a framework or baseline to help understand differences	• Can lead to stereotyping • Does not acknowledge the layers of identity
Culturally Competent Approach	Assumes the problem is lack of values, knowledge and skills to work across differences	Individuals and organizations develop the values, knowledge and skills to work competently with difference	Yes	Acknowledges the layers of cultural identity Prevents stereotyping	• Requires personal commitment and development • Depends on organizational climate that fosters working across differences

Adapted from *Self Reflection: A Move Towards Culturally Competent Practice: Participant Workbook* by Len Lopez, Gloria Murrant and Doug Stewart.

Handout 4.2: Casey House Diagram



5. Applying the Concepts

Exercise 5.1 Cultural Competency: Self-Assessment

Materials Assessment handout, pens

Process

- Explain the cultural competence assessment form and ask participants to fill it out.
- Have participants discuss it in pairs.

Source Adapted from *Self Reflection: A Move Towards Culturally Competent Practice: Participant Workbook* by Len Lopez, Gloria Murrant and Doug Stewart.

Handout 5.1: Cultural Competency Self-Assessment Chart

CULTURAL COMPETENCY	I have…	I need…
Knowledge		
Values		
Skills		

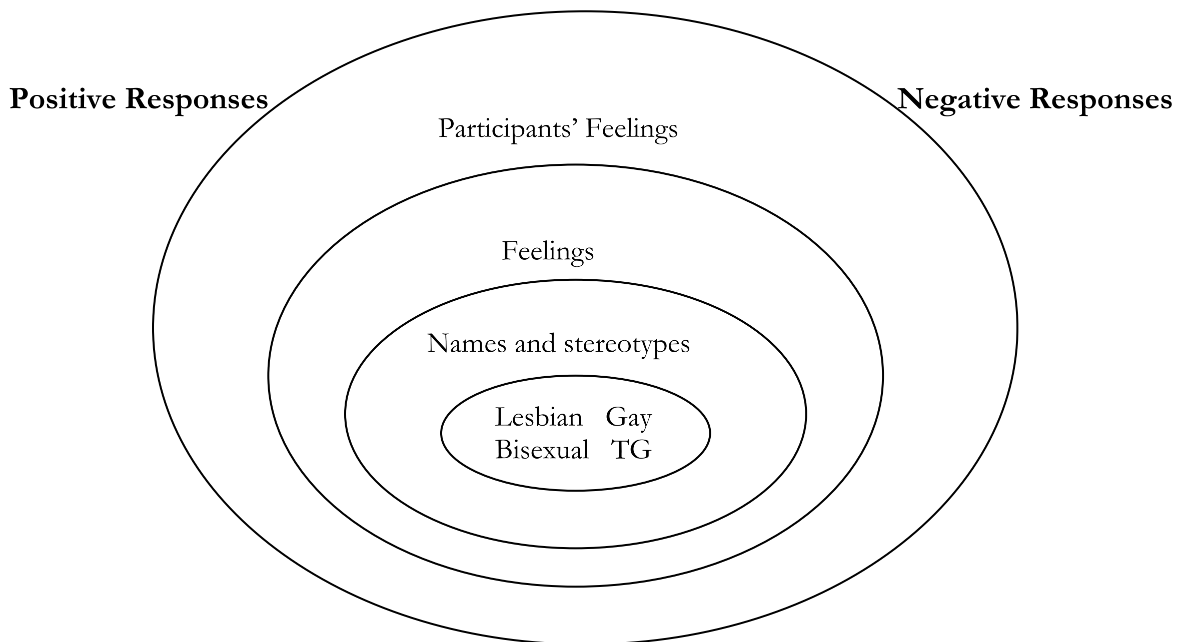
Exercise 5.2 Homophobia Porcupine

Materials Flipchart paper and markers

Process

- Draw a circle on the flipchart. Write lesbian, gay, bisexual and transgendered inside it.
- Brainstorm a list of names and stereotypes for lesbian, gay, bisexual and transgendered people. Write these names in the first ring around the inner circle.
- Next, brainstorm the ways that people might feel confronted with those names and stereotypes. Write these in the next ring around the circle.
- Next, cross out the words "lesbian, gay, bisexual, transgendered" written in the inner circle and replace them with the word "me". Ask participants how they would feel faced with those names and stereotypes. Record these responses in the next ring of the circle.
- In two columns next to the circle, make a list of the ways a person might act in response to the names and stereotypes. One column should be for negative responses and the other for positive responses. Some positive responses include: finding support or counselling, participating in a community, being honest with oneself, joining a group, educating people, finding more supportive friends, falling in love, participating in Pride Day festivities.
- Go back to the stereotypes in the first ring. Discuss and debunk them.

Source Adapted from *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions* by Toronto Public Health, p57.



Exercise 5.3 Case Studies

Materials Case study handouts, pens

Process

- ♦ Break into small groups.
- ♦ Assign each group a case study. Ask participants to review their case study and discuss the following questions.
  - What assumptions did the service provider make regarding this client?
  - How could this situation have been avoided?
  - What aspects of the cultural competence approach would you use in this situation?
- ♦ In the large group, discuss ways to practice that use the cultural competence model.

Handout 5.3: Case One

Sofia, a 29 year-old woman who recently emigrated from Greece, presents at a walk-in clinic with recurrent yeast infections. The doctor asks if she is sexually active or uses injection drugs. She says that she is a virgin and does not use drugs. What Sofia does not say to the doctor is that she has had a number of sexual partners, with whom she has had anal sex in an effort to preserve her virginity. It never occurred to her to use condoms as she perceives condoms as a method of contraception. The doctor does not give her an HIV test. She leaves with a prescription for her yeast infection and her HIV infection remains undiagnosed.

1. What assumptions did the service provider make regarding this client?

2. How could this situation have been avoided?

3. What aspects of the cultural competence approach would you use in this situation?

Handout 5.3: Case Two

Luis, 55, is an indigenous rights activist from Colombia. In Colombia, he faced persecution for his political involvement. With the help of an international non-government organization, he was able to flee the country. At the border, he filed a refugee claim.

Luis is staying at a shelter for homeless men. Luis does not speak English and only one of the staff members speaks Spanish. During the medical exam that is part of his application, he is forced to take an HIV test. Much to his surprise, he tests positive.

As part of the traditional indigenous healing rituals that he practices, he burns incense. The shelter staff ask him repeatedly to stop burning incense because it violates fire regulations. Luis decides to leave the shelter.

1. What assumptions did the service provider make regarding this client?
2. How could this situation have been avoided?
3. What aspects of the cultural competence approach would you use in this situation?

Handout 5.3: Case Three

Obax is a 21 year-old woman from Somalia. She came to Canada four years ago with her sister and her sister's husband. They began the process of filing for refugee status, but never followed through. Obax lives with her sister's family in a crowded apartment. Her sister's husband sometimes forces her to have sex with him. She speaks only a little English and she has no health insurance.

She collapses in the grocery store and is brought by ambulance to the Emergency Room. She has a fever, diarrhea, abdominal pain and vaginal discharge. She tests positive for HIV and has a CD4+ cell count of 40. Obax is diagnosed with Mycobacterium Avium Complex (MAC). The doctor suspects that she may also have Pelvic Inflammatory Disease (PID) but Obax refuses to allow the doctor to perform an internal exam. The last time she saw a doctor (again in an ER), the doctor invited the interns to see how she had been circumcised.

The social worker at the ER proposes a number of referrals, among them an immigration lawyer to advise her about her refugee claim, a Somali community agency for translation assistance, and the community health centre in her area for primary health care and other services.

Obax refuses all referrals and leaves the hospital without waiting to be discharged.

1. What assumptions did the service provider make regarding this client?

2. How could this situation have been avoided?

3. What aspects of the cultural competence approach would you use in this situation?

Handout 5.3: Case Four

Manu is a 19-year old injection drug user. He came to Canada when he was 15 and quickly turned to drugs as a way to cope with the stress of his new living situation. He decided to come out to his parents and after that his relationship with his family quickly degenerated. As a result, he has been living on the streets for several years. He sometimes turns tricks for money.

He makes contact with an outreach worker. She refers him to a primary care physician at a community health centre (CHC) as well as to a number of food banks. He misses several appointments at the CHC. He also finds that the food bank is never open when he needs it to be.

When he is diagnosed with Pneumocystis carinii pneunomia (PCP), the outreach worker finds him a bed in a hospice. However, the hospice finds him to be too disruptive. They ask him to leave and refer him to a shelter for homeless men.

1. What assumptions did the service provider make regarding this client?
2. How could this situation have been avoided?
3. What aspects of the cultural competence approach would you use in this situation?

Exercise 5.4 Policies

Materials Policies, flipchart paper, and markers

Process

- Get copies of anti-oppression or anti-discrimination policies that are in place at participants' agencies. If this is not possible, use the selection from Regent Park Community Health Centre's Anti-Discrimination Policy.
- Analyse the policies.
- Discuss how these policies help confront oppression at participants' agencies and how they could be changed to facilitate anti-oppression work.
- Compare policies to practices in the agencies.

Source Adapted from ACT/PWA Volunteer Core Skills Training

Questions How often do you use your agency's policy?
Is it useful?

Handout 5.4: Anti-Discrimination Policy

REGENT PARK COMMUNITY HEALTH CENTRE

SUBJECT: **Anti-Discrimination Policy**
EFFECTIVE: **November 20, 1998**

PURPOSE:

To recognize the dignity and worth of every person and to provide for equal rights and opportunities without discrimination, and having as its aim the creation of a climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community.

POLICY:

Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, body size, ethnic origin, citizenship, religion, creed, sex, sexual orientation, age, record of offences, marital status, family status, handicap, education or income.

Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, body size, citizenship, religion, creed, sex, sexual orientation, age, record of offences, marital status, family status, handicap or income.

ASSUMPTIONS:

All members of the Regent Park Community Health Centre are committed to creating and supporting an environment that fosters **accountability**, **respect**, **cooperation**, **trust** and **caring/commitment** towards our clients, community members and each other.

All members of the Regent Park Community Health Centre Community share responsibility for creating a welcoming environment and keeping RPCHC free of discrimination and harassment.

The Regent Park Community Health Centre Community is made up of all the people involved with Regent Park Community Health Centre. This includes staff, clients, Board Members, volunteers and students.

This policy also covers harassment and discrimination that happens ***outside*** RPCHC if it affects how people are taking part ***in*** RPCHC.

Different people/groups may respond to or deal with discrimination and harassment differently depending on such things as culture, traditions, gender power, beliefs and self-confidence.

Excerpt from Regent Park Community Health Centre's *Human Resources Policies and Procedures Manual*

6. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?
- Exercise C1 in Appendix 4, called *Now in the Real World,* could be used to help summarize the tools that participants have learned.

7. Evaluation

See Appendix 5 for evaluation tools.

References and Resources

AIDS Committee of Toronto. *National HIV/AIDS Volunteer Training Kit.* 1998

AIDS Committee of Toronto/Toronto People with AIDS Foundation. *Cultural Competency: Recognizing and Valuing Diversity in Service Delivery.* Volunteer Core Skills Training Handouts. Spring 2002

Arnold, Rick and Bev Burke. *Educating for a Change.* Between the Lines. Toronto: 1991.

Campinha-Bacote, J. *The Process of Cultural Competence in Health Care: Second Edition*. Wyoming, OH: Transcultural C.A.R.E. Associated Perfect Printing Press. 1994.

Cohen, Elena and Tawara Goode. *Rationale for Cultural Competence in Primary Health Care.* National Centre for Cultural Competence. Winter, 1999.

Evans, J. *Journey Towards Cultural Competency: Lessons Learned.* National Maternal and Child Health Resource Center on Cultural Competency, Texas Department of Health: MCH Bureau/HRSA.. 1995.

Gardenswartz, Lee and Anita Rowe. *Managing Diversity: A Complete Desk Reference and Planning Guide, Revised Edition.* Fredonia, NY: HR Press. 2002.

Graydon, Douglas, Gloria Murrant, Peter Williams, Douglas Stewart and Len Lopez. *Cultural Competence HIV/AIDS.* Casey House Hospice. Spring 2000.

Lopez, Len and Gloria Murrant and Douglas Stewart. *Self Reflection: A Move Towards Culturally Competent Practice: Participant Workbook.* Competence Consultants and Associates. 1999.

Regent Park Community Health Centre. *Human Resources Policies and Procedures Manual: Anti-Discrimination Policy.* 1998.

Toronto Public Health. *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions.* 3rd edition. Winter, 2001.

Unit 5: Skills Building: Advocacy

1. Introduction

2. Icebreaker

2.1	Exercise	Class List
	Handout	*Class List*

3. Advocacy: What is it?

3.1	Exercise 1	Brainstorm: Definitions
	Handout	*Advocacy Definitions*
	Handout	*Red Ribbon*

4. Individual Advocacy: Skills and Strategies

4.1	Exercise	Brainstorm: Skills for Effective Individual Advocacy
	Handout	*Individual Advocacy for Settlement Counsellors*
4.2	Exercise	Advocacy Tools Self-Assessment
	Handout	*Advocacy Tools Self-Assessment Chart*
4.3	Exercise	Case Studies: Developing Advocacy Strategies
	Background	*Overview of Cases*
	Handouts	*Cases One-Eight*

5. Systemic Advocacy

5.1	Exercise	Discussion: Recent Victories and Other Inspirations
5.2	Exercise	Brainstorm: Skills for Systemic Advocacy
	Handout	*Tactics and Strategies for Systemic Advocacy*
5.3	Exercise	Video
5.4	Exercise	Systemic Advocacy Action
	Handout	*Advocacy Action Instructions - Option One*
	Handout	*Patient Assistance Programs*
	Handout	*Advocacy Action Instructions - Option Two*

6. Conclusion

7. Evaluation

References and Resources

Learning Objectives

During this workshop, participants will:
- ♦ develop their understanding of the definition of advocacy
- ♦ develop their advocacy skills
- ♦ increase their knowledge of services
- ♦ make connections with workers from other organizations
- ♦ develop strategies to increase access to services

Suggested Outline for 3-hour Workshop

Introduction – 5 min
Icebreaker – 10 min
Advocacy: What is it? – 20 min
Individual Advocacy: Communication Skills –1 hr 20 min
Break – 10 min
Systemic Advocacy – 40 min
Conclusion – 10 min
Evaluation – 5 min

1. Introduction

- ♦ Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- ♦ Workshop agenda
- ♦ Ground rules and confidentiality (See Appendix 2.)
- ♦ Other housekeeping information (washrooms, smoking, break time)

2. Icebreaker

Exercise 2.1 Class List

Materials Prizes, paper and pens

Process

- Ask participants to circulate throughout the room. Their task is to collect the names, positions, workplaces, and phone numbers of all the other participants, or 10 of them if the group is large. If participants have business cards, they may exchange them instead.
- Before they begin, let them know how many people are in the class.
- The first person to complete their list should call out "Bingo" and receive a prize.
- Allow a few minutes for the others to complete their lists.
- Offer a prize to participants who thought to include the facilitators in the class list.
- Discuss the usefulness of networking in advocacy initiatives.

Source

Adapted from *National HIV/AIDS Volunteer Training Kit* by the AIDS Committee of Toronto.

Handout 2.1: Class List

	Name	Position	Workplace	Phone Number
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				

3. Advocacy: What Is It?

Exercise 3.1 Brainstorm: Definitions

Materials Handouts

Process

- Brainstorm definitions of advocacy, both individual and systemic, and empowerment.
- Look at the handout on the Red Ribbon campaign.
- Identify various advocacy strategies in the example. Identify the role that empowerment plays.
- Brainstorm a list of some of the results that we hope will come from advocacy initiatives.

Handout 3.1: Advocacy Definitions

Dictionary Definition

Verb: To speak, plead, or argue in favor of. See synonyms at support.

Noun: 1. One that argues for a cause; a supporter or defender: *an advocate of civil rights.*
2. One that pleads in another's behalf; an intercessor: *advocates for abused children and spouses.*
3. A lawyer.

Etymology: From Middle English *advocat*, lawyer, from Old French, *advocat*, from Latin *advoctus*, past participle of *advocre*, to summon for counsel: *ad-* +*vocre*, to call.

From http://www.bartleby.com

Definition from CATIE

Advocacy involves identifying and trying to reduce barriers to health care that may exist in institutions, government policies, or social systems. Advocacy can be done on an individual basis or systemically. In individual advocacy, an attempt is made to solve the problems of one person: for example, finding housing for someone. In systemic advocacy, an attempt is made to change the policies or behaviour of institutions or societies to improve the situation of many people: for example, finding government funds for housing projects. Advocacy can take many forms, including meetings with policy makers; research; using the media; demonstrations; legal challenges; and being persistent in getting answers from social assistance workers and health care providers.

From *Managing your Health* by CATIE.

Definition: Systemic Advocacy

An advocate is a person who argues for a cause – a supporter or a defender. To advocate is to act in support of a particular issue or cause…The power of grassroots advocacy comes from individual action and groups of committed constituents joining together to provide policy-makers with the expertise they need to make decisions.

From the *Advocates' Handbook: A Guide for Effective Public Health Advocacy* by the American Public Health Association

Handout 3.1: Red Ribbon

The Red Ribbon Project

The Ribbon Project was created in 1991 by the Visual AIDS Artists Caucus, a group of artists who wished to create a visual symbol to demonstrate compassion for people living with AIDS and their caregivers. Inspired by the yellow ribbons honouring American soldiers serving in the Gulf War, the colour red was chosen for its, "connection to blood and the idea of passion -- not only anger, but love, like a valentine." First worn publicly by Jeremy Irons at the 1991 Tony Awards, the ribbon soon became renowned as an international symbol of AIDS awareness, becoming a politically correct fashion accessory on the lapels of celebrities. While this has caused concern to many activists, who worry that its meaning has become trivialized, as well as denigrated by the proliferation of "kitsch" ribbon objects, the Red Ribbon continues to be a powerful force in the fight to increase public awareness of HIV/AIDS and in the lobbying efforts to increase funding for AIDS services and research.

From http://www.thebody.com/visualaids/about.html

The Red Ribbon Foundation

The Red Ribbon Foundation was founded in memory of singer/songwriter Paul Jabara, who conceived of and distributed the first Red Ribbon, and who died of AIDS. The Foundation was created to raise money for distribution to HIV/AIDS researchers, primarily in the field of pediatric AIDS research; to promote awareness of the disease through distribution of the Red Ribbon; and to educate the worldwide public through efforts such as this web site.

From http://www.redribbon.net

4. Individual Advocacy: Skills and Strategies

Exercise 4.1 Brainstorm: Skills for Effective Individual Advocacy

Materials Flipchart paper and markers

Process

- Review the handout outlining aspects of individual advocacy.
- In pairs, spend six minutes (three minutes each) discussing an experience that participants have had with a client that involved individual advocacy work. Be sure to let participants know when three minutes have passed so that they can switch speakers.
- In the larger group, brainstorm a list of the skills that were needed for those situations.

Questions To which agencies do you refer clients most? When? Why?
How do referrals work?
How are the advocacy strategies of those organizations different from yours?
When have your advocacy efforts been ineffective?
What barriers did you encounter?

Handout 4.1: Individual Advocacy for Settlement Counsellors

Individual Advocacy

1. **Which organizations do settlement counsellors and their clients need to contact most frequently regarding services?**
   a. Organizations providing social/health services
   b. Other immigrant service agencies with specialized expertise
   c. Organizations that can take on cases and provide advocacy

2. **What does a settlement counsellor need to find out about these organizations?**
   a. The services they offer
   b. Their policies (written) and their practices (unwritten)
   c. Their organizational chart (who is in charge of what)
   d. Whether the services offered by the organizations are linguistically and culturally appropriate, whether staff receive any kind of multicultural/race relations training
   e. Formal and informal appeal procedures

3. **How does the settlement counsellor get this information about organizations?**
   a. Obtaining copies of policies and pamphlets
   b. Making personal visits to institutions
   c. Inviting representatives from the institutions to make presentations at community agencies
   d. Doing informal networking with counsellors in the institutions
   e. Consulting with counsellors in other community agencies

4. **When should a counsellor advocate for a client?**
   a. When the service is available but there is an access problem
      i. The client does not speak the language
      ii. The service is culturally inappropriate
      iii. There is too much red tape
      iv. The client lacks self-confidence
      v. The client cannot take time (e.g. from work) to deal with the problem
      vi. When the service is unavailable
      vii. The client is overwhelmed by a recent diagnosis with HIV or AIDS
      viii. The client becomes too ill to access services
      ix. The client fears deportation

5. **What strategies should counsellors use when advocating with these organizations?**

   a. **Effective communication strategies (on the telephone and in person)**
      - Asking institutional workers to identify themselves and their positions
      - Identifying oneself by name and agency; explaining your agency's function and your position with your agency. [In the context of HIV work, this may not always apply, as disclosing your organization and its function may disclose your client's serostatus.]

- Having a list of points ready that the client and the settlement counsellor want to raise; having all necessary documents ready
- Indicating if the situation is urgent
- Obtaining commitment for action with a timeframe
- Indicating one's intentions to follow-up on a particular date and time
- If not satisfied, talking to the worker's supervisor
- Making a list of documents the client may have to submit, and things they are expected to do

b. Clarifying one's role as an advocate for the client

- Not allowing institutional workers to try to develop complicity between the settlement counsellor and themselves against the client
- Confronting racism

c. Educating decision-makers in other organizations re: the client's context

- Explaining cultural contexts circumstances relevant to immigrant and refugee experiences, which pertain to the client's case and may change the perceptions of the decision-makers

d. Linking with other organizations

- Finding out what services other organizations provide that can be used to help advocate for a client (e.g. cultural interpreter services)

e. Keeping accurate records of the steps taken in an individual client's case (which feeds into collective advocacy strategies). Detailed records are important for:

- Asserting the client's case, when different institutional workers are involved and a period of time elapses before the case is resolved
- Back-up evidence if the case merits an appeal or legal action
- Proving that a constant need exists for individual advocacy (to support further collective advocacy efforts to change regulations or practices, implement new services, or increase funding for settlement agencies)

Adapted from *Immigrant Settlement Counselling: A Training Guide* by OCASI, p228.

Exercise 4.2 Advocacy Tools Self-Assessment

Materials Assessment handout, paper, pens

Process

- Ask participants to spend a few minutes identifying what knowledge, attitudes and skills they have for effective advocacy work and what they need to be more effective. Have them fill out the Advocacy Self-Assessment Chart.
- Break into groups of three or four to discuss the charts.

Source Adapted from *Immigrant Settlement Counselling: A Training Guide* by OCASI, p232.

Handout 4.2: Advocacy Tools Self-Assessment Chart

ADVOCACY SKILLS	I have…	I need…
Knowledge		
Attitudes		
Skills		

Exercise 4.3 Case Studies: Developing Advocacy Strategies

Materials Case study handouts

Process

- In small groups, review the cases. Be sure to select cases based on participants' knowledge and skill sets.
- Explain to participants that the cases are pulled directly from interviews with immigrant and refugee PHAs who participated in the Committee for Accessible AIDS Treatment's Action Research Report.
- Ask participants to try to answer the questions listed at the bottom of the cases.
- In the large group, brainstorm two lists, one for barriers and the other for advocacy strategies.

Background Information 4.3: Overview of Cases

Overview of Cases

One	Pregnant woman does not receive pre-natal care
Two	PHA has trouble finding meds
Three	Stigma prevents a PHA from accessing ASOs
Four	PHA has trouble with IFH coverage
Five	Children of a PHA are denied citizenship
Six	Changing lawyers negatively affects PHA's case
Seven	Mother and her newborn infant do not receive post-natal care
Eight	PHA is forced to pay hospital bills while on social assistance

Handout 4.3: Case One

A refugee found out that she was HIV positive in her eighth month of pregnancy. She had gone to a CHC early in her pregnancy but had been refused service:

Interviewer: So at this point when you were 8 months pregnant you had no coverage, you had none?
Refugee: I had nothing. That's why I had stayed home and not be tested for anything until I was 8 months. Because I couldn't go anywhere in order to be turned back.
Interviewer: Even the Community Health Centre?
Refugee: They wouldn't take me at 6 months. That's when I said that, I'm going home. So I stayed at home…[Then I got] a yeast infection and I went to the women's clinic, which is a free service. So there was concern and she said you need to be seen. Who's your doctor…you need to have a doctor. But I don't have a health card? So she picked up the phone and spoke to [a CHC]. Now that's when [the CHC] sent me to their doctor…
Interviewer: So that was the first time [you went to that CHC]?
Refugee: Yes…No, No. That was not the first time. We were referred [there when I was 6 months pregnant].
Interviewer: Why couldn't they take you?
Refugee: They were full, they had a waiting list, they were over-stretched it was everything… So it was really hard to [go to that CHC] for anything.
Interviewer: And they didn't suggest for you to go to another community health centre?
Refugee: Nothing.
Interviewer: They just said, we can't take you?
Refugee: Hhmhm.
Interviewer: That's just devastating when you are 8 months pregnant….
Refugee: So that was from six months and I stayed at home until eight.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?

2. If you had met this client before this had happened, what would you have done?

3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Two

The work of compiling a combination of antiretrovirals each month is a formidable task for PHAs. This is one man's story:

Refugee: That was the worst time of my life. Because I am having my fingers crossed to survive. Now the doctor told me, you know what, you need serious HIV medication. But the medication we've been giving you here, is compliments of the hospital. They say they can only give me all that as long as I'm in the hospital. Because I survived the pneumonia, which was very bad, I left the hospital. So the doctor told me, this is what you need for your HIV. This is what everybody is getting.

Interviewer: So what did you do?

Refugee: I had to search all over, going to community places, phoning every place which has any name with HIV. That's how I came to know about [the ASO].

Interviewer: So you just went into a phone book and said I'm going to call?

Refugee: Yes!! Yes. When I called the office I spoke to somebody who sent me to somebody else for treatment, his name is [Joe]. When I spoke to him, he said to me, you know what? It is your own responsibility to find medication. So here, he was sort of telling me to be more strong. We [get] these donations. Don't ask us how these donations come, sometimes it's people who don't survive and we get their medication, but this medication here, we only check it if it is just expired, then we recycle it. So, if you want to join? So I say look, I'm available to come and collect medication. Sometimes I remember several times I would go and they say, look, unfortunately we don't have anything. If you are told it is not there, what does it mean to you? It means that you go back, I'm not a medical person, but [if you don't get your medication] it means that you [can develop] resistance.

Interviewer: So what did you do when they said, they don't have any?

Refugee: They don't have any, where can I get any? I have to check with other people.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?

2. If you had met this client before this had happened, what would you have done?

3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Three

One PHA indicated that she only accepted service from an ASO when she really had no choice:

Refugee: I used to go to [an ASO] for the groceries. But that time I was off work. When I got a job again I stopped.

Interviewer: Are there other organizations that you have gone to?

Refugee: No.

Interviewer: You are very independent.

Refugee: My friends say that I still don't accept things. But that is not true...[I'm afraid] people will know me [when I go to an ASO]. I think that is one of the reasons why I cannot go so low because I don't want people see me and people go there and say, Oh my God!

Interviewer: Is it easier to come to [a community health centre]?

Refugee: Yes, because I come in here for years and I never see anybody that I know.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?
2. If you had met this client before this had happened, what would you have done?
3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Four

Refugee applicants on IFH must prove that any tests or diagnostic procedures they need are for 'emergency' care. This is absurd burden of proof given that they cannot know the seriousness of their ailments until they have undergone diagnostic tests. One PHA suffered needlessly and nearly lost his sight because he could not afford diagnostic services:

Refugee: I was supposed to go for a CT scan at [a hospital] and they wanted me to pay because it wasn't an emergency. It wasn't life and death and therefore I had to pay. Well one of the regulations of the IFH was if the condition is not severe, they are not going to cover it. So they didn't cover it and in the end [a CHC] had to pay for everything. So I suffered. They didn't know what it was, I suffered for about six months and finally in December of '95 the microbes spread and went up my eyes and I couldn't see; I lost three quarters of my eyesight. It was very painful.

Interviewer: And did they ever accept that this was an emergency?

Refugee: No.

Interviewer: And did the specialist ever tell you what could happen if it had gone untreated?

Refugee: Well, it would lead to blindness.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?
2. If you had met this client before this had happened, what would you have done?
3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Five

Another woman told us that the only way she could ensure that her children received medical care was to surrender them to the Children's Aid Society:

Refugee: Yes, there were a lot of things that didn't make sense especially when it comes to my kids and their health card. They are Canadian citizens, come on, like. Whether I have status of not, even if I leave the country and I leave them here, they are going to give them a health card, right? If they end up going into foster care or whatever, they are going to have a health card, so that doesn't make sense to me at all. What do I have to do with them? You know they are Canadian citizens.

Interviewer: So essentially, if you leave them here, they will become Canadian citizens…

Refugee: Well, they're Canadian citizens. I guess they just going to give them their status.

Interviewer: But as long as you are taking care of them?

Refugee: They're not considered [Canadian Citizens].

Interviewer: But if you gave them up…?

Refugee: To foster care. Even if I stay here and I gave them to foster care they automatically get all that they should get.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?
2. If you had met this client before this had happened, what would you have done?
3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Six

PHAs who participated in our interviews and surveys reported that both lawyers and immigration officials often gave them inaccurate, misleading or incomplete information about the immigration process. PHAs and service providers reported that lawyers and community legal clinics have simply told HIV positive clients that they won't be allowed to immigrate to Canada -- that there is nothing they can do. The misinformation and uninformed guidance provided by lawyers can result in long delays or in the rejection of applications:

> Well we had one appeal but the lawyer changed jobs and then he gave our file to somebody else who was supposed to take over, and then I think that the time lapsed when we were supposed to have done the claim. You know they have a time limit. And then we found somebody else but by that time…they had already asked us to leave and they thought we had abandoned our claim. For a long time, maybe for two years, we didn't have any status and we were not doing anything, we were just sitting. And they had a warrant on us.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?
2. If you had met this client before this had happened, what would you have done?
3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Seven

Several women reported receiving inadequate pre and post-natal care. One woman who was not aware of her HIV status at the time of her son's birth, recounted the following experience:

> Pay? I had to pay. Every time I go to the doctor I had to pay. Even when he was born I had to pay the hospital, I think $3000.00…and you won't believe it, [he was] born about 3am, they let me out the next day because I didn't have coverage. And that was hard, because yes, I have a child already, but you know, but still, you [get] kind of frustrated. It is a baby. Well what do I do now? The thing is that I was breastfeeding him because I didn't really know much about [HIV] …you know that you can pass [HIV on], but I didn't know much about that. He was losing weight. Maybe that is what I said it is a miracle because I don't know when I brought him for testing he wasn't [positive].

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?
2. If you had met this client before this had happened, what would you have done?
3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

Handout 4.3: Case Eight

People who are living on social assistance are pressured into making some form of payment in order to cope with the harassment of collection agencies:

Refugee: [My husband] had pneumonia and there [was] nothing, so he stayed at home until he was really helpless, so I said you know what, lets go to the hospital, I had to go and walk him there and so he did that and they admitted him. He had to come home and stay in bed for another week or so before he was 100%. But he was better than when he left.

Interviewer: And they billed him for thousands of dollars?

Refugee: $13,000.00

Interviewer: $13,000.00. And how do you pay that back?

Refugee: [We're] on social assistance.

Interviewer: What do you do?

Refugee: Well now this is after we have gone to have the baby and we would rotate and this month let's pay $30 on your bill so that these people don't keep calling here. So maybe next pay he'll pay $40, next month $20 and then maybe another $20 and then maybe we stop another month… When they were phoning we would pay something so that at least it's quiet. So the hospital would also call and say it is going into collections now because there is two people and my baby had a bill too…[laughs]…he had a heart murmur and then he outgrew that, and then yes, he is billed too… Even him.

PHAs living on social assistance make significant sacrifices to provide small payments to hospital administrations. They are bullied and coerced by collection agencies into paying portions of their massive bills. Often PHAs are not aware that collection agencies have no power to garnish money that is received from social assistance.

From CAAT's *Action Research Report* by Loralee Gillis

1. What are the barriers that this client faced?
2. If you had met this client before this had happened, what would you have done?
3. What advocacy strategies could you use to facilitate access to services in this situation in the future?

5. Systemic Advocacy

Exercise 5.1 Discussion: Recent Victories and Other Inspirations

Materials World map, paper and pens, action in which to involve participants

Process

- Start the discussion by asking participants what advocacy initiatives have inspired them in their work and otherwise.
- Have participants write the names of the movements or organizations on a piece of paper, tell the group why this movement has inspired them and attach it to the world map in the appropriate location.
- Discuss broader advocacy initiatives undertaken by organizations, locally, nationally and globally, recently and historically that have inspired participants.
- Use examples directly related to participants' experiences, or from the AIDS movement, the gay community or the settlement movement.
- Offer participants a way to get involved in systemic advocacy initiatives during this workshop, e.g. by writing a letter, signing a petition, wearing a red ribbon, etc.

Questions Who were the major players in the field? Who are they now? What are recent significant achievements?
Does an achievement necessarily involve "winning"?
Can successful mobilization be seen as an achievement?
What are current advocacy challenges?
What do we hope will result from advocacy initiatives?
How can our efforts help organizations doing systemic advocacy work?
How can the participants' agencies support specific advocacy initiatives?

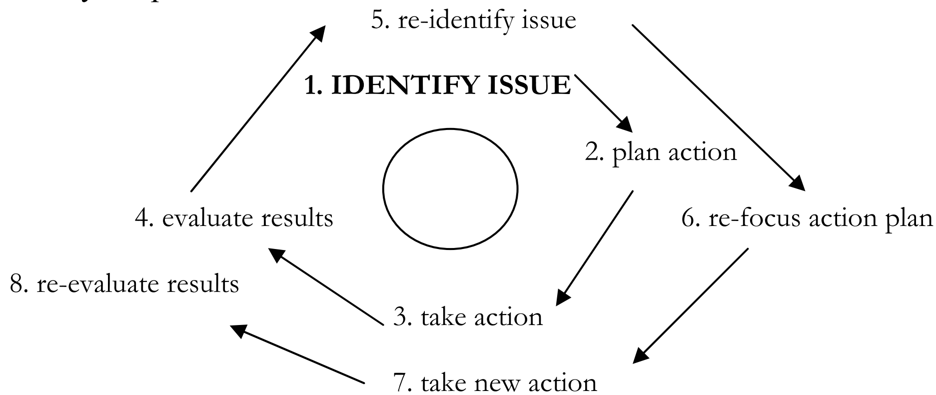
Exercise 5.2 Brainstorm: Skills for Systemic Advocacy

Materials Flipchart paper and markers

Process Brainstorm two lists: one of systemic advocacy tactics and strategies and the other of the skills required for each tactic or strategy.

Handout 5.2: Tactics and Strategies for Systemic Advocacy

The cyclic process:



Collective Advocacy for Settlement Workers

What strategies should counsellors/agencies use?

- Assess the environment of the advocacy initiative:
  - The cultural background of the community who will be involved in the campaign
  - The process of community development within that group – ie involving the community as partners in the process; advocating *with* not *for* the community
  - An inventory of financial and human resources available to the advocacy effort
- Decide on an action plan – steps should include:
  - Collect and present organized evidence of the problem
    - documenting cases
    - keeping statistics
    - maintaining up-to-date information re: client problems

    Note confidentiality issues: when can client information be used as part of an advocacy effort?
  - Identify who to influence
    - E.g. path might be: settlement counsellor – agency management – agency board of directors – networks and coalitions – power holders – recommendations re: legislation, policy and programs
  - Decide what level of campaign to conduct
    - Low profile: meetings, quiet negotiations, information-sharing
    - Medium profile: public briefs and meetings, letter-writing, alliances with other groups
    - High profile: demonstrations, ad campaigns, press coverage

From *Immigrant Settlement Counselling: A Training Guide* by OCASI, p231.

Exercise 5.3 Video

Materials TV, VCR, video

Process

- Show the video *Brian, Tim and Darien* (available at the ACT library) to give participants a glimpse into the lives of activists in the Toronto advocacy organization, AIDS Action Now!
- Discuss different strategies used by activists in the film.
- Explore some of the challenges faced by grassroots activists, generally, and AIDS activists, more specifically.
- Other films on AIDS activism are also available at ACT's library, including a number of short films on ACT UP's work in the late 1980s and early 1990s.

Exercise 5.4 Systemic Advocacy Action

Materials Flipchart paper, markers, four different colours of name tags, goodies, red ribbons

Process

- Divide participants into four groups: Advocates, Friends, Foes and Unconverted.
- Give each group their position cards and colour-coded name tags for each team. Ask them to put on their colour-coded name tags.
- Give each group an unequal number of goodies that they can use in their strategy. These goodies will represent resources at their disposal. Be sure to give the Foes the largest number of goodies.
- Ask the teams to spend a few minutes developing and writing on a flipchart sheet the arguments for their group. Advise them that they may want to each take their own notes during this process.
- The Advocates should develop an advocacy action. Their tactics can include actions as individuals, in small groups, or as a whole group.
- Ask the Friends, Foes and Unconverted groups to each create their own list of tactics or arguments that they would be convinced by and counter-arguments that they could put forward. Encourage participants from these groups to think about these arguments as individuals or in coalitions.
- Bring the large group back together and ask the Advocates to begin their advocacy action.
- The Friends, Foes and Unconverted group members, as individuals or in coalitions, are free to join the Advocates if they feel the arguments or tactics (or goodies!) put forward by them are convincing. They should wear a red ribbon to indicate their support.
- When the exercise is finished, post the strategy flipchart sheets and discuss the outcome of the exercise.

Handout 5.4: Advocacy Action Instructions - Option One

Instructions for Advocates

Scenario
The Advocates would like the Friends, Foes and Unconverted to sign a petition to lobby pharmaceutical companies to provide better access to medication. The Advocates want to focus their campaign on Patient Assistance Programs.

1. **Your goal is to develop a strategy for carrying out this Advocacy Action.**
   - Consider the following questions:
     - What are Patient Assistance Programs?
     - How could they be improved?
     - What would a petition ask for from pharmaceutical companies?
     - Who would the petition be sent to?
   - Read the handout and discuss Patient Assistance Programs.
   - Outline the main arguments behind why someone should sign your petition.
   - Assess your resources, including the goodies and red ribbons that you have.
   - Develop an action plan, as individuals, pairs or small groups or as a whole group.
   - Create a mock petition.

2. **Carry out the Advocacy Action**
   - Try to convince the Friends, Foes and Unconverted to sign your petition.
   - Remember to use your goodies in your strategy.
   - If they sign it, give them a red ribbon to wear.

---cut here

Instructions for Friends, Foes and Unconverted

Scenario
The Advocates would like the Friends, Foes and Unconverted to sign a petition to lobby pharmaceutical companies to provide better access to medication. The Advocates want to focus their campaign on Patient Assistance Programs.

1. **Your goal is to develop a position on Patient Assistance Programs.**
   - Read the handout and discuss Patient Assistance Programs.
   - Outline the main arguments behind why you would or would not support Patient Assistance Programs.
   - Assess your resources, including the goodies that you have.
   - Consider what might make you change your position on Patient Assistance Programs.

2. **Participate in the Advocacy Action.**
   - If the Advocates convince you to sign their petition, wear a red ribbon to demonstrate your support.

Handout 5.4: Patient Assistance Programs

In the U.S., there are many millions of people with no health insurance. There are many more people who, even though they have insurance, don't have the money to buy their medications. There is help available for these people. Many drug manufacturers have what's called **Patient Assistance Programs**. These programs are designed to help those who can't afford their medicines obtain them at no cost or low cost. Unfortunately, many people, including doctors, nurses, social workers, and patients, don't know that these programs exist.

Q: My doctor either doesn't want to or doesn't have the time to complete the forms. What can I do?
A: This is a common problem. A few suggestions that may help:

- ♦ Make sure you fill out as much of the form as you can – and all the material that the patient is responsible for completing.
- ♦ Read over the doctor's portion and see if there is any information the doctor will need – and make sure you have given this information to the doctor.
- ♦ Try to befriend a sympathetic staff member. Sometimes a staff member is able to get the doctor to complete and sign the form.
- ♦ Be sure your doctor knows your plight – that you just can't afford to buy the medicines you need.
- ♦ Let the doctor know you understand how busy he/she is and that you appreciate the time it takes to complete the forms.
- ♦ As a last resort, you may have to find another doctor who will help.

From www.NeedyMeds.com

What the U.S. pharmaceutical companies have to say:

We're proud to present this Directory of Patient Assistance Programs that PhRMA member companies offer to ensure that their medicines are made available to those who can't afford to purchase them. A number of our companies have pledged that no patients in need of their medicines will do without them. Our companies have long been worldwide leaders not only in pharmaceutical innovation, but also in philanthropic initiatives - and their long-standing patient assistance programs have been especially helpful.

The Directory lists the companies that conduct these programs and the medicines that are covered. It also describes how to request assistance. The application process and eligibility vary for each company.

The programs have become increasingly popular. In 2001, more than 3.5 million patients received prescription medicines through these programs, up from 1.1 million in 1997. Almost 10 million prescriptions, with a wholesale value of about $1.5 billion, were filled, up from about $2 million in 1997. While patient assistance programs are essential, they're not a substitute for expanded public access to life-saving, cost-effective medicines…

From www.phrma.org

Handout 5.4: Advocacy Action Instructions - Option Two

Instructions for Advocates

Scenario
The Advocates would like the Friends, Foes and Unconverted to join a coalition to work setting up a program to improve access to medication for people with HIV.

1. **Your goal is to develop a strategy for carrying out this Advocacy Action.**
   - ♦ Outline the main arguments behind why someone should join your coalition to help set up your program.
   - ♦ Consider the following questions:
     - What would participating in this coalition involve?
     - What are the goals of the coalition?
     - What would individuals have to offer the coalition?
   - ♦ Assess your resources, including the goodies and red ribbons that you have.
   - ♦ Develop an action plan, as individuals, pairs or small groups or as a whole group.

2. **Carry out the Advocacy Action.**
   - ♦ Try to convince the Friends, Foes and Unconverted to join your coalition.
   - ♦ Remember to use your goodies in your strategy.
   - ♦ If they join your coalition, give them a red ribbon to wear.

---cut here

Instructions for Friends, Foes and Unconverted

Scenario
The Advocates would like the Friends, Foes and Unconverted to join a coalition to work setting up a program to improve access to medication for people with HIV.

1. **Your goal is to develop a position on improved access to HIV medication.**
   - ♦ Outline the main arguments behind why you would or would not support improved access to HIV medication.
   - ♦ Consider what might make you join a coalition.
   - ♦ Assess your resources, including the goodies that you have.
   - ♦ Consider what might make you change your position on improved access.

2. **Participate in the Advocacy Action.**
   - ♦ If the Advocates convince you to join their coalition, wear a red ribbon to demonstrate your support.

6. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?

7. Evaluation

S*ee Appendix 5 for evaluation tools.*

References and Resources

AIDS Committee of Toronto. *National HIV/AIDS Volunteer Training Kit*. 1998.

American Public Health Association. *Advocates' Handbook: A Guide for Effective Public Health Advocacy.*

CATIE. *Managing your Health: A Guide For People Living with HIV or AIDS*.
Module 5: A Comprehensive Guide for the Care of Persons with HIV Disease,
1999 edition.

Davenport, Pamela. *Brian, Tim and Darien.* [Videocassette] Toronto : Actuality Films, 1997.

Gillis, Loralee. *Action Research Report: Improving Access to Legal Services and Health Care for People Living with HIV/AIDS who are Immigrants, Refugees or without Status.* Committee for Accessible AIDS Treatment. July 2001.

International Council of AIDS Service Organizations. *Adding Infrastructure to the Advocacy Agenda*. ICASO. 2002.

Ontario Council of Agencies Serving Immigrants. *Immigrant Settlement Counselling: A Training Guide*. OCASI. 2000.

Websites

http://www.phrma.org
http://www.needymeds.com
http://www.redribbon.net
http://www.thebody.com

Section Three:
Peer Education

Unit 6: Facilitation Skills

Unit 7: Follow-up for Peer Trainers

Unit 6: Facilitation Skills

1. Introduction

1.1 *Background* *What a Facilitator Should Do in an Introduction*

2. Icebreaker

2.1 Exercise What We Want to Know about Each Other
2.2 Exercise Discussion: Participant Disclosure

3. Ways of Learning

3.1 Exercise Fly on the Wall

3.2 Exercise Brainstorm: Definitions
Handout *Popular Education and Adult Education*
Handout *Spiral Model*

3.3 Exercise Our Experiences of Learning

3.4 Exercise Different Learning Styles
Handout *Multiple Intelligences*

4. Encouraging Participation

4.1 Exercise "I need a volunteer!"

4.2 Exercise Brainstorm: Facilitating Groups
Handout *Facilitator's Checklist*

4.3 Exercise Skit: Facilitation Nightmares

5. Applying the Concepts

5.1 Exercise Needs Assessments
Handout *Needs Assessment Tool*

5.2 Exercise Lead an Exercise

5.3 Exercise Design a Workshop

6. Conclusion

7. Evaluation

7.1 Exercise Guidelines for Feedback

References and Resources

Learning Objectives

This unit is intended for participants who are interested in facilitating the other workshops in this series and wish to improve their facilitation skills. Participants will:

- Become familiar with ideas and techniques used in adult and popular education
- Understand how to create a safe and non-judgmental space for group work
- Be able to encourage and guide discussions
- Learn how to plan and lead workshops

Suggested Outline for 3-hour Workshop

Introduction – 5 min
Icebreaker – 10 min
Ways of Learning – 40 min
Encouraging Participation – 40 min
Break – 10 min
Applying the Concepts – 60 min
Conclusion – 10 min
Evaluation – 5 min

1. Introduction

- Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- Workshop agenda
- Ground rules and confidentiality (See Appendix 2.)
- Other housekeeping information (washrooms, smoking, break time)

Background Information

What a facilitator should do in an introduction:

- offer opening remarks to set the tone of a workshop
- address any hangovers from previous sessions
- quickly recap what participants have learned in previous sessions
- introduce an agenda or develop one with participants
- make explicit the session's main learning objectives
- encourage participants to create a list of learning objectives
- review or create ground rules with participants
- mention break times and the location of washrooms

Adapted from *Counting our Victories* by Denise Nadeau, p28.

2. Icebreaker

Exercise 2.1 What We Want to Know about Each Other

Materials Flipchart Paper

Process

- Ask participants to brainstorm onto flipchart paper a list of things they would like to know about each other.
- Add to their list a question about what kind of learning style best suits them.
- Break into small groups.
- Ask participants to introduce themselves using as many points from the list as they feel comfortable with.

Source Sexualities Manual p18

Questions How did the icebreaker make participants feel?
Do they think they will feel more comfortable participating now?

Exercise 2.2 Discussion: Participant Disclosure

Materials Use Appendix 2 on Ground Rules as a handout

Process
- Discuss the process of creating ground rules to help make participants feel safe in the context of the group.
- Look at the ground rules that this group is using.

Questions How can we help participants feel safe in a workshop?
How do we make sure that we don't force participants to disclose?

3. Ways of Learning

Exercise 3.1 Fly on the Wall

Materials None

Process
- Select one person to act as an observer of the learning process, or a fly on the wall, during exercises. This person will be asked to report back to the group after the exercise and offer ideas as to how the exercise facilitated the learning process.
- An alternative to this is to let the group know that they are all flies on the wall. At the end of each exercise, select a person at random to report back on the learning process.
- Use the participants' comments to highlight specific teaching strategies.

Source Adapted from *Counting our Victories* by Denise Nadeau, p26.

Exercise 3.2 Brainstorm: Definitions

Materials Handouts, flipchart paper and markers

Process
- Ask participants to define popular education and adult education.
- Review the handouts.
- Introduce the Spiral Model Handout and link it to the definitions of popular and adult education.

Questions What are the essential components of popular education? Of adult education?
How does popular education differ from mainstream forms of education?

Handout 3.2: Popular Education and Adult Education

Popular education is an approach that critically examines and learns from the lessons of past struggles, and from concrete everyday situations in the present. It is a deeply democratic process, equipping communities to themselves name and create the vision of the alternatives they are struggling for.

Popular education values and respects people as their own experts, and challenges the notion that the educator or organizer's role is as an expert who works "for" people. It is based on the belief that people themselves have sufficient knowledge and that they can work out the solutions to their own problems.

Popular education is carried out within a political vision that sees women and men at the community and grassroots level as the primary agents for social change. It equips people to define their own struggles and make their voices heard. It involves a process whereby a group collectively analyses its problems and works collectively to solve them, including identifying the resources and skills they need. Popular education develops within this process the consciousness of, and commitment to, the interests of the most marginalized as part of the struggle…

Popular education brings ongoing "consciousness-raising" to organizing. It shifts the emphasis from organizing for single events to organizing a group of isolated individuals into a collective of people committed to acting together for justice. As the Filipino popular educator Ed de la Torre warned, "if organizing includes only mobilizing for rallies, demonstrations and protests, then when the space for organizing is again constricted there's not enough strength of conviction, clarity, and unity among the people. Because the issues never sank deeper, people join another power (often right-wing forces) when the power of the protest movements wanes."

The recent "popularity" of popular education brings with it the risk that it will be reduced to group dynamics and participatory training techniques. This is a misuse and a misreading of what popular education is about. Popular education is part of the wider process of organizing for social change and movement building.

From http://www.oneworld.org/cantera/education

Adult education tips from the Ontario AIDS Network

Learning something new takes energy, commitment and risk. In order to support people in this process it is helpful to incorporate all we know about the Principles of Adult Education and Learning Process.

1. **People learn in different ways and usually have one dominant style they prefer.** The more senses (hear, see, touch, taste, talk, smell) we involve in our teaching methods and the more ways we stimulate those senses increases the number of people we reach and the extent to which they may retain/integrate the learning.

- Be aware of your own learning style. This often dictates our preferred teaching style. Know that everyone else may not respond effectively to that style.
- Use a variety of styles or methods, delivering the same message in more than one style. For example a verbal or image presentation accompanied by a handout for reading.

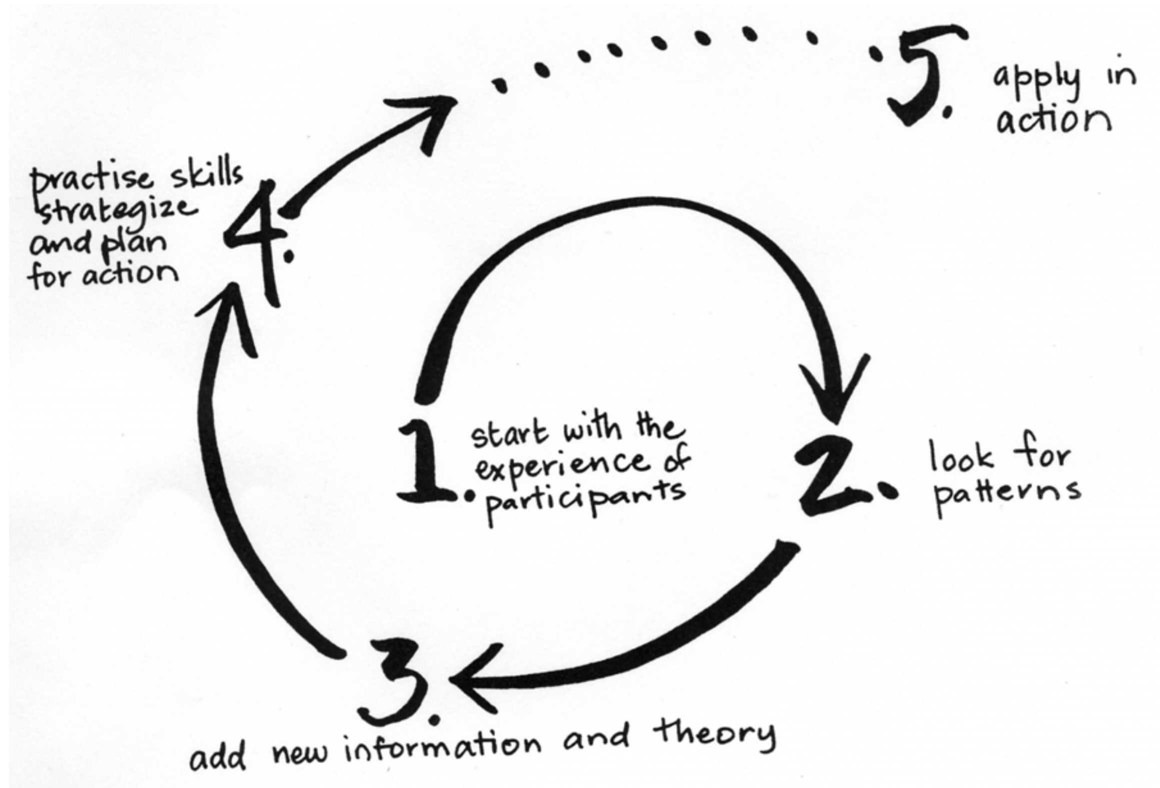
2. **Participants and presenters/facilitators becoming partners in the process is very effective.** It relieves some of the pressure from "teacher as expert" and encourages the participants to "buy-in" and take ownership for their own learning. Also where this interaction is well facilitated the process of exchange is itself a learning experience.
   - Please build opportunities for participants to share their knowledge and experiences with others into your session.
   - In introducing your session, you might acknowledge the various kinds of experience and knowledge in the room and identify how you hope to draw on it.
   - Establish the ground rules, expectations and role of facilitator and participant for the session.

3. **People learn best when they have opportunities to talk together.** Talking allows people to reframe information they are trying to absorb and to hear others share ideas, experiences, and interpretations that assist the learner to relate to, and integrate new information or concepts. Integrating new information requires process time, talking is only part of this. Silent reflection is another. Be prepared for, and allow, "dead air" to happen as people think about what they have heard and formulate responses. A synergistic effect may result where the group generates ideas that are more than the sum of the individual input.
   - Where possible design opportunities for small group activities as well as large group interaction.
   - Allow frequent opportunities for questions.
   - Ask people to relate experiences that support/have relevance to the topic

4. **People learn best when their sense of self worth and dignity is nurtured.** When they are encouraged to trust themselves, instead of experts alone. Validating people's experiences and perceptions allows them to seek learning from their experiences, to share experiences with others and support others learning.
   - Use activities that allow participants to demonstrate their expertise.
   - Make connections where the ideas/experiences of the group match the experts.
   - When asked for directing advice, ask a question back that encourages the participant to connect to their own feeling about the issue.

5. **Learning is a holistic process.** Learning is more likely to happen when the whole person – mind, body, senses, intuition, and emotion – is involved.
   - Relate new information to existing/current contexts
   - Make information relevant to real life situations today.

Handout 3.2: Spiral Model



Exercise 3.3 Our Experiences of Learning

Materials None

Process

- ♦ Break into pairs.
- ♦ Ask participants to pick an educational experience that they have had.
- ♦ Have participants share their experience with their partner.
- ♦ Ask them to identify different teaching techniques that were used and to determine if any popular or adult education strategies were used.

Questions What teaching techniques worked best for you?
Was it easy to identify popular or adult education techniques?

Exercise 3.4 Different Learning Styles

Materials Multiple Intelligences handout

Process

- ♦ Ask participants to identify different styles of learning. Use Howard Gardner's Multiple Intelligences Theory as a framework. Gardner identifies 8 main ways of learning:

  - Verbal/Linguistic
  - Logical/Mathematical
  - Visual/Spatial
  - Bodily/Kinesthetic
  - Intrapersonal
  - Interpersonal
  - Musical/Rhythmic
  - Naturalist

- ♦ Explore the links between a teacher's learning style and their teaching style.
- ♦ Break into small groups or pairs and ask participants to tell the group about their favourite learning experience or their favourite teacher.

Handout 3.4: Multiple Intelligences

Multiple Intelligences	
Intelligence	**Core Capacities**
Verbal/Linguistic	Good at explaining, teaching and learning, understanding the order and meaning of words, appreciating linguistically-based humour, speaking and writing persuasively, recalling things
Logical/Mathematical	Good at recognizing abstract patterns, inductive and deductive reasoning, discerning relationships and connections, performing complex calculations, thinking and investigating scientifically
Visual/Spatial	Good at imagining, forming mental images, finding your way in space, representing things graphically, recognizing relationships of objects in space, mentally manipulating objects, perceiving accurately from different angles
Bodily/Kinesthetic	Good at controlling voluntary body movement and pre-programmed body movement, connecting mind and body
Intrapersonal	Good at concentrating, being aware of and expressing different feelings
Interpersonal	Good at communicating verbally and non-verbally, being sensitive to others' moods, feelings, temperaments, and motivations, working co-operatively in a group, understanding the perspectives of another
Musical/Rhythmic	Good at appreciating the structure of music and rhythm, being sensitive to sounds and vibrational patterns, recognizing, creating and reproducing sounds, rhythm, music, tones and vibrations
Naturalist	Good at communing with nature, caring for, taming and interacting with creatures, being sensitive to nature's flora, growing things

From http://www.multi-intell.com

4. Encouraging Participation

Exercise 4.1 "I need a volunteer!"

Materials Flipchart paper and markers

Process

- Ask the group for five volunteers.
- Ask them raise their hand, stand up or come to the front of the room, if it is appropriate.
- Count the participants as they identify themselves as volunteers.
- When you have enough volunteers, tell them that the exercise is finished and that they can sit down again.
- Brainstorm reasons why participants volunteered or were reluctant to volunteer.

Source Adapted from *Learning on our feet* by Peter Gillies, p22.

Exercise 4.2 Brainstorm: Facilitating Groups

Materials Facilitator checklist handout, flipchart paper and markers

Process

- Brainstorm what it means to be an effective facilitator.

Questions What do we value in a facilitator? What makes a good facilitator?
How can facilitators guide discussions without interrupting or cutting participants off?
How does a facilitator provide a framework or context for discussion?
How can a facilitator manage conflict?

Handout 4.2: Facilitator Checklist

1. What techniques did the facilitator use/not use to move the group toward the objective?

The facilitator:

- Helped move group toward objective
- Motivated group actions and activities
- Attended to group tasks i.e. building the group interaction
- When appropriate,
- put forth ideas or questions
- generated ideas
- helped group to develop an understanding of the topic
- Asked questions that followed a logical sequence, i.e. simple to complex, concrete to abstract
- Kept the group activities on time
- Brought emotional and conceptual closure to the discussion
- Gave clear directions to the group
- Used a tool to collect information raised by the group, i.e. flipchart or overhead
- Attended to process needs of group, i.e. by bringing in the quiet member
- Made effective transitions:
  - Between ideas within the presentation
  - Between learner participation activities and instructor presentations

2. How did the facilitator include/not include participants in the discussion?

The facilitator:

- Remained neutral during discussion or acknowledged changing roles from facilitator to member facilitator
- Assessed the group's chemistry
- Kept the group involved in discussion, i.e allowed group to state their points of view, express feelings, move towards a sense of resolution.
- When appropriate, the facilitator successfully handled problematic behaviour by
  - Confrontation
  - Seeking group assistance in addressing the behaviour
  - Using non-verbal behaviour
  - Reinforcing acceptable behaviour

3. How did the facilitator incorporate adult learning principles into the presentation?

The facilitator:

- ♦ Introduced the topic in an engaging way.
- ♦ Sought participant agreement regarding agenda
- ♦ Developed a learning environment sensitive to the physical and psychological needs of the learners
- ♦ Allowed opportunities for learners to become resources for one another
- ♦ Insured that learners understood what was expected of them
- ♦ Presented information in a way that was readily understandable

4. What presentation techniques or skills did the facilitator incorporate into the presentation?

The facilitator:

- ♦ Spoke clearly and at an appropriate volume, i.e. varied his/her vocal inflections and volume.
- ♦ Did not allow his/her movements to distract from the presentation
- ♦ Used a variety of gestures and body movements
- ♦ Maintained eye contact, if culturally appropriate
- ♦ Did not use inappropriate language, such as medical jargon, and was sensitive to the audience, i.e. caring and courteous
- ♦ Used a variety of teaching strategies to meet the special needs of the group

5. How well did the facilitator address the information related to HIV/AIDS and immigration?

The facilitator:

- ♦ Provided accurate content related to HIV and immigration
- ♦ Addressed the requested content
- ♦ Adequately addressed questions and concerns raised by the audience.
- ♦ Had adequate data to support the presentation

Adapted from *HIV/AIDS Train the Trainer* by Toronto Public Health

♦ **Exercise 4.3** Skit: Facilitation Nightmares

Materials None

Process

- Break into small groups.
- Ask participants to share fears about facilitation or stories about challenging facilitation experiences.
- Ask groups to select one and develop a short skit to illustrate a facilitation nightmare.
- Have groups show their skit to the large group.
- Discuss why the scenarios were nightmares and what could be done in those situations to decrease facilitators anxiety and improve the experiences of participants.

Source Adapted from *Counting our Victories* by Denise Nadeau, p128.

5. Applying the Concepts

Exercise 5.1 Needs Assessments

Materials Needs Assessment handout, flipchart paper and markers

Process

- In small groups, ask participants to select a specific group with whom they would like to lead a workshop.
- Identify the skill sets, learning styles and learning goals of that group. Use the Needs Assessment Tool Handout to guide this process.
- Look at the Adult Learning Wheel on the handout. Discuss the importance of determining learner needs at the beginning of the process of designing a workshop.

Questions How can different learning styles be accommodated in the design of a workshop?
How can learning goals be met?

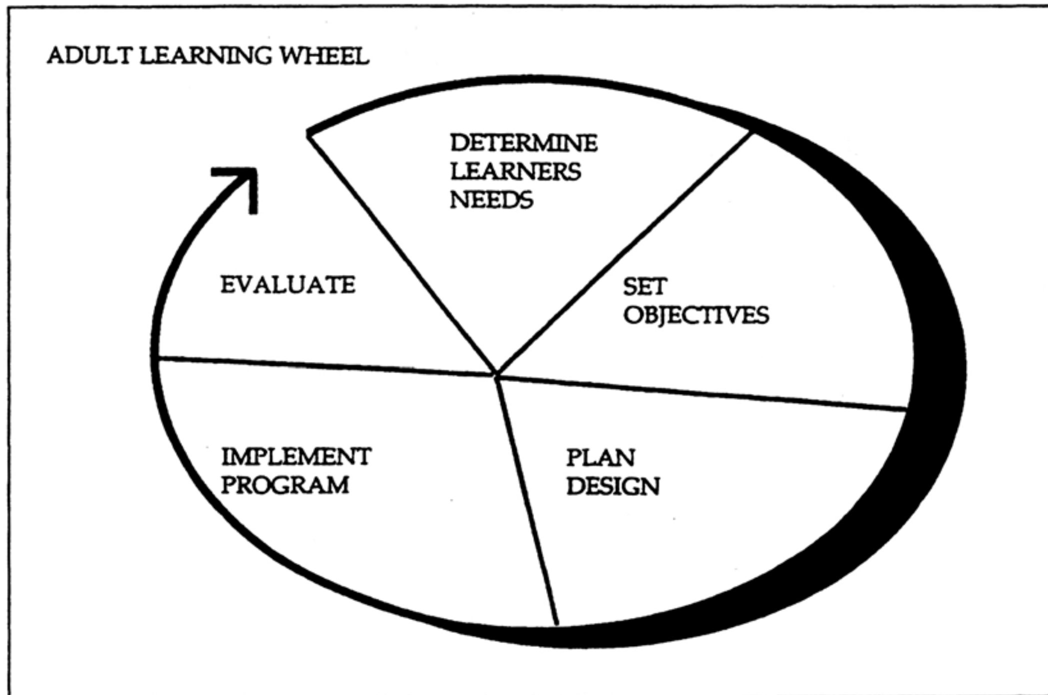
Handout 5.1: Needs Assessment Tool

Please answer the following questions so we can try to plan an HIV/AIDS and Immigration workshop geared to your needs.

1. What area do you work in and what do you do?
2. How has HIV/AIDS had an impact on your work or personal life?
3. How have immigrant or refugee issues had an impact on your life?
4. What HIV/AIDS education have you had to date?
5. How familiar are you with the immigration and refugee issues?
6. Three things I want to get out of this workshop are…
7. The worst thing that could happen in this session is…
8. Other comments:

Adapted from *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions* by Toronto Public Health.

Adult Learning Wheel



Adapted from *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions* by Toronto Public Health.

Exercise 5.2 Lead an Exercise

Materials List of topics, copies of this manual, other resources on popular education techniques

Process
- As a group, decide on a topic to use as a focus for the exercise.
- Facilitators may want to brainstorm a list of suggestions ahead of time to give participants an idea of the kinds of topics possible.
- Break into groups and design a short and interactive exercise that will teach participants about that topic.
- Ask participants to incorporate an evaluation exercise or tool into their presentation.
- Tell them they can use this training manual as a resource.
- Ask presenters to lead the group through the exercise and the evaluation process.
- Ask the group to provide feedback on the presenters' style.

Exercise 5.3 Design a Workshop

Materials Flipchart paper and markers

Process
- Break into two groups.
- Assign workshop topics and audiences, or ask participants to choose their own.
- Participants should then work together to design a workshop.
- Ask one person from each group to give a short presentation outlining their plan to the rest of group.
- Give time for the group to provide feedback.

6. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?

7. Evaluation

See Appendix 5 for evaluation tools.

Exercise 7.1 Guidelines for Feedback

Process

- Explain to participants that developing guidelines for feedback is important in order to make sure participants provide constructive feedback.
- Ask participants what kind of feedback they like to receive and what kind they don't like to receive.

Questions

Why is criticism valuable?
How can we use criticism to improve our work?

References and Resources

Catalyst Centre
Suite 500 - 720 Bathurst St. (1 block south of Bathurst Subway)
Toronto, ON M5S 2R4
phone: (416) 516-9546
1-888-521-1453
fax: (416) 588-5725
http://www.catalystcentre.ca
catalystcentre@web.ca

For more information, see the Popular Education Map on the Catalyst Centre's website, a comprehensive collection of links to websites related to popular and adult education and social justice issues. Some books from their library can also be purchased through their website.

Useful books available at the Catalyst Centre:

- *Educating for a Change* by Rick Arnold and Bev Burke
- *Counting our Victories: Popular Education an Organizing: A Training Guide on Popular Education and Organizing* by Denise Nadeau
- *Handbook on Fundamentals for Dynamic Meetings* by Mise au jeu
- *A New Weave: Popular Education in Canada and Central America* by Rick Arnold, Deborah Barndt and Bev Burke
- *Starting with Women's Lives: Changing Today's Economy: A Facilitator's Guide to a Visual Workshop Methodology* by Suzanne Doerge and Beverly Burke
- *Ready for Action: A Popular Theatre, Popular Education Manual* by Enviromaniacs and WPIRG

Other

Gillies, Peter. *Learning on Our Feet: A Simple Curriculum for Facilitator Training.* Second Edition. Canadian AIDS Society. 1998.

Toronto Public Health. *HIV/AIDS Train the Trainer: A Resource Manual for Planning HIV/AIDS Education Sessions.* Third Edition, Winter 2001.

Free Management Library http://www.mapnp.org/library/grp_skll/grp_skll.htm

Unit 7: Follow-up for Peer Trainers

1. Introduction

2. Icebreaker

3. Discussion and Feedback

3.1 Exercise Discussion

4. Skills Development

4.1 Exercise Brainstorm

5. Conclusion

6. Evaluation

Learning Objectives

The goals of this unit are to gather participants together for a debriefing session after they have facilitated workshops with their peers. Participants will have the opportunity to:

- ♦ discuss their experiences facilitating workshops with their peers
- ♦ identify gaps in their knowledge and skill set not covered by the workshops or the manual
- ♦ propose revisions to manual
- ♦ network with other service providers
- ♦ identify the skills they have gained

Suggested Outline for 2-hour Workshop

Introduction – 10 min
Icebreaker – 10 min
Discussion and feedback – 40 min
Break – 10 min
Skills Development – 40 min
Conclusion – 5 min
Evaluation – 5 min

1. Introduction

- ♦ Objectives of the workshop
  - Facilitator's objectives
  - Participants' objectives
- ♦ Workshop agenda
- ♦ Ground rules and confidentiality (See Appendix 2.)
- ♦ Other housekeeping information (washrooms, smoking, break time)

2. Icebreaker

See Appendix 3 for Icebreaker exercises.

3. Discussion and Feedback

Exercise 3.1 Discussion

Materials Flipchart paper and markers

Process
- Facilitate a discussion on participants' experiences leading workshops.
- Ask participants to provide feedback on using the manual.

Questions What were participants' experiences facilitating workshops?
Who attended them?
What parts of the Manual were most useful for developing workshops?
What exercises worked? Which ones did not?
How effective do you think the workshops were?
What gaps did you find in the Manual?
What else should be included?

4. Skills Development

Exercise 4.1 Brainstorm

Materials Flipchart paper and markers

Process
- Brainstorm a list of skills that participants have gained through the process of attending the workshops and leading them.
- Discuss how they have integrated these skills into their work or their lives.
- Ask participants to share experiences from their work or lives that show how they have integrated the skills they have gained.

Questions Did participants facilitate access to services for themselves or their clients?

5. Conclusion

- What have we learned? Did we meet the objectives set out at the beginning?
- How can we apply this to our work?
- What other resources are available?
- Follow-up Process: Are other workshops in this series being offered?

6. Evaluation

See Appendix 5 for evaluation tools.

Section Four: Appendices

Appendix 1: **Communication Skills for Discussing Sexuality**

Appendix 2: **Ground Rules**

Appendix 3: **Icebreaker Exercises**

Appendix 4: **Exercises**

A. **Introducing Ideas**
B. **Developing Ideas**
C. **Synthesizing Ideas**

Appendix 5: **Evaluation Tools**

Appendix 6: **Members of CAAT**

Appendix 7: **CAAT Publications**

Appendix 1: Communication Skills for Discussing Sexuality

Exercise 1 Charmed Circle: Understanding Personal Conceptions of Sexuality
Handout 1 *Charmed Circle*

Exercise 2 Quiz: Understanding Personal Conceptions of Sexual Identity
Handout 2 *Quiz*

Exercise 3 Communication Skills: Empathy Watch

Exercise 4 Legitimizing Professional Interest in Sexuality

Exercise 5 Barriers to Talking about Sexuality

Exercise 6 Comfort Continuum
Background *List of Sexual Activities Suggested for Discussion*

References

Exercise 1 Charmed Circle: Understanding Personal Conceptions of Sexuality

Materials Charmed Circle handout, pens

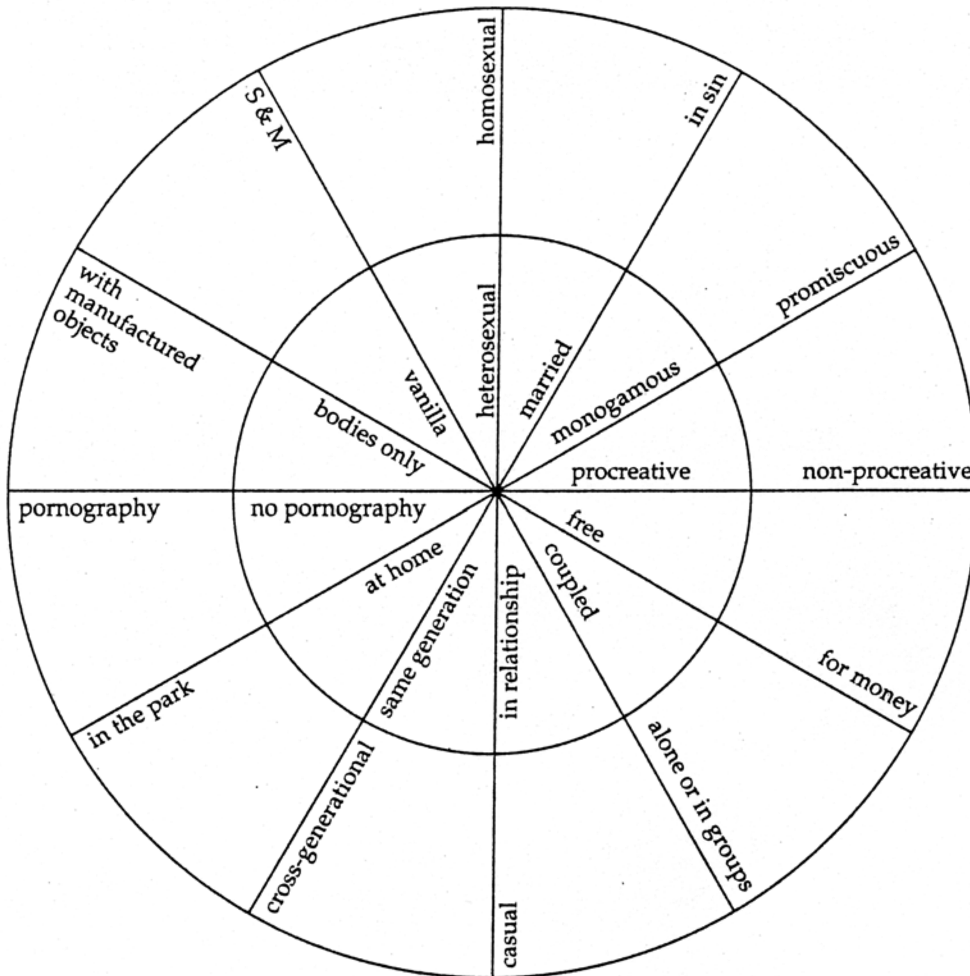
Process

- ♦ Discuss Gayle Rubin's Charmed Circle. It represents the relationship between mainstream and non-mainstream sexual values in Western society.
- ♦ Ask participants to create their own Charmed Circle.
- ♦ Be aware of the level of comfort participants have with each other before introducing this exercise.
- ♦ Select one of the following debriefing methods:
  - If participants do not want to disclose much personal information, ask them to complete their Charmed Circle, but not share it with other group members.
  - Pin the circles on the wall and have participants circulate.
  - Ask participants to discuss their circle with another group member.

Questions What have people learned about themselves from this exercise?
How do our ideas about sexual behaviour affect our work with clients?

Source Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p48.

Handout 1: Charmed Circle



Model from T*hinking Sex: Notes for a Radical Theory of Sexuality* by Gayle Rubin.

Exercise 2 Quiz: Understanding Personal Conceptions of Sexual Identity

Materials Sexual identity quiz, pens

Process

- Guide participants through quiz questions.
- Be sure to let them know that they don't have to share their thoughts with the group.
- If the group feels comfortable with each other, ask them to work in pairs and share their answers.

Questions Why are the questions in Part One and Part Two different?
Which questions from Part One are not relevant to Part Two? Why?
What are the implications of any question being relevant or not?
How do our ideas about sexual identity affect our work with clients?

Source Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p73.

Handout 2: Sexual Identity Quiz

PART ONE			
Which of the following contribute to your identity generally?	A lot	A little	Not at all
First name			
Last name			
Gender			
Hair colour			
Skin colour			
Accent			
Ethnicity			
Nationality			
Immigration status			
Social class			
HIV antibody status			
Occupation			
Age			
Degree of able-bodiedness			
Other			

PART TWO			
Which of the following contribute to your sexual identity?	A lot	A little	Not at all
Biological sex			
Gender			
Age			
Occupation			
Social class			
Skin colour			
Ethnicity			
Gender of sexual partners			
Fantasies			
Nature of sexual activity			
HIV antibody status			
Access to role models			
Experiences			
Others factors that contribute a lot: 1. 2. 3.			

Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p73.

Exercise 3 Communication Skills: Empathy Watch

Materials Paper and pens

Process

- Break into groups of three.
- Ask participants to take turns speaking for two minutes each on an aspect of sexuality, HIV/AIDS or immigration that concerns them.
- While each person is speaking, the other two must listen and note the feelings that the speaker is expressing.
- One of the listeners should give a signal to the speaker at the two-minute mark.
- After each group member has had a chance to speak, each participant then discusses the feelings they noted while the speakers were talking.

Questions Were the perceptions of the listeners accurate?
Did the speakers feel comfortable speaking?
Did they feel judged? Did they have trouble speaking?

Source Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p86.

Exercise 4 Legitimizing Professional Interest in Sexuality

Materials Flipchart paper and markers

Process

- In small groups, brainstorm a list of situations in which co-workers see discussions about sexuality as relevant or irrelevant in the context of work with a client.
- Ask participants to choose one situation from the irrelevant list and to discuss ways they could introduce and justify discussions about sexuality in that situation.

Questions When is discussing sexuality relevant? Why?
When is it not relevant? Why not?

Source Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p88.

Exercise 5 Barriers to Talking about Sexuality

Materials Flipchart paper and markers

Process

- In small groups, brainstorm the barriers and incentives to discussing sexuality with clients in the following categories: Personal, Professional, Religious, Social, Cultural.
- Remind participants not to spend too much time defining these categories, but rather to focus on the barriers and incentives.
- List strategies to overcome each barrier.

Source Adapted from *Teaching Modules for Basic Education in Human Sexuality* by WHO, p46.

Exercise 6 Comfort Continuum

Materials Flipchart paper and markers

Process

- Break into groups of three.
- Ask participants to brainstorm a list of sexual activities (such as anal intercourse, prostitution, masturbation).
- Have them write each one on a separate piece of paper.
- Participants then take turns placing the activities on a continuum that ranges from those activities they would feel comfortable discussing with a client to those they would feel uncomfortable discussing.
- Encourage them to talk about issues that come up as they place each activity.
- Come back together as a large group and discuss the exercise.

Questions Would they feel more comfortable discussing these activities with somebody who is not a client?
Are any activities uncomfortable for all or most group members?
Is it important to feel comfortable discussing these activities? Why?

Source Adapted from *Teaching Modules for Basic Education in Human Sexuality* by WHO, p73-96.

Background Information

List of sexual activities suggested for discussion		
Sexual abuse of children	Anal intercourse	Male homosexuality
Visiting prostitutes	Female homosexuality	Masturbation
Rape	Bisexuality	Group sex
Oral sex	Incest	Pedophilia

References

McKay Armstrong, Ewan and Peter Gordon. *Sexualities*. London: Family Planning Association. 1992.

Rubin, Gayle. "Thinking Sex: Notes for a Radical Theory of Sexuality" in *Pleasure and Danger: Exploring Female Sexuality*. 2nd edition. Edited by C.S. Vance. Pandora Press 1989.

World Health Organization. *Teaching Modules for Basic Education in Human Sexuality: Volume 7*. Regional Office of the Western Pacific. Manila: 1995.

Appendix 2: Ground Rules

Developing ground rules with a group can be an important opportunity for members to get to know each other. As well, participants coming to an agreement on ground rules will ensure that workshops are safe spaces for learning about and challenging ourselves and each other.

In Peer Training

1. Respect each other's opinions
2. Everyone has a right to pass
3. All disclosures by participants are confidential
4. Encourage participants to be open and honest and to raise issues that concern them

From *A Woman-Centered Approach to HIV Prevention: A Train-the-Trainer Curriculum* by New Jersey Women and AIDS Network.

In Cultural Competency Training

1. Have generosity of spirit
2. Listen to each other
3. Do not interrupt
4. Ask for clarification
5. Participate
6. Challenge respectfully
7. Honour confidentiality
8. Speak from your own perspective
9. Take care of yourself

Adapted from *Self Reflection: A Move Towards Culturally Competent Practice: Participant Workbook* by Len Lopez, Gloria Murrant and Doug Stewart.

For Sexuality-related Workshops

1. Try to negotiate with participants the course's aims and objectives
2. In developing ground rules with a group, consider things like confidentiality, smoking rules, punctuality, the right to pass, the opportunity to take risks, the right to challenge, making "I" statements.
3. Never ask participants to experience an exercise you have not experienced yourself and do not assume that because you have done it others should or can
4. In terms of confidentiality, suggest ground rules that encompass the following ideas:
    a. When I hear a contribution, I must remember that the contributor may wish this to be kept just to ourselves in this pair/group – I may want to ask them if I am unclear about this.
    b. When I contribute something that I would like to be kept confidential, I should try to remember to make clear what I mean by this.

Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon.

Appendix 3: Icebreaker Exercises

- *Icebreakers are an essential component of a successful workshop. They help to bring participants together, create a group dynamic and make participants feel comfortable participating in discussions.*
- *Choose a different icebreaker exercise each time you run a workshop with a group so that participants learn new things about each other each time they come together.*
- *Be sure to alter the exercises to fit the needs and context of your group.*
- *Many of these icebreakers can be adapted for use as exercises in the workshops to help participants develop their grasp of new concepts.*
- *Some of the quicker Icebreakers can be used to help participants de-role after a particularly intense role play or debate.*

1. Crossword

Ask participants to add their names and/or agencies consecutively to a flipchart in a crossword puzzle formation and to tell the group something about themselves, such as their position, their ethnicity, or their first language.

2. Personal name sheet

Ask each participant to write their name at the centre of a sheet of flipchart paper. In each of the four corners, ask participants to write about or draw something they enjoy doing, something they are good at, something they want to learn about and a pleasant memory, or four other things that are relevant to the workshop topic. In pairs or to the large group, participants should introduce themselves using their personal name sheet.
Source: From the *National HIV/AIDS Volunteer Training Kit* by the AIDS Committee of Toronto.

3. Who Am I This Time?

Each participant takes a piece of paper or index card and writes their name on one side. On the other side, participants must draw a picture or symbol representative of themselves, for example their job, their hobby, their family, or their country of origin. Put the cards in a pile and pick one at random. Describe what you know about the person from the symbol they have used. Then, identify the person and ask them what they thought of the description. They get to pick out the next card. This continues until everybody has been introduced.
Source: Adapted from *Learning on our feet* by Peter Gillies, p16.

4. The Wind Blows For Those…

Make a circle of chairs, with one less chair than total number in the group. The facilitator stands in the middle of the chairs and says a "The wind blows for those with glasses" – or some other characteristic that is true for the facilitator as well as other group members. Participants with glasses then have to find another chair. The person left in the middle has to name another characteristic that is true for themselves using the "The wind blows for

those…" statement. The characteristics can move toward more controversial topics, as participants get used to the game.
Source: Adapted from *Learning on our feet* by Peter Gillies, p19.

5. Name Exchange

In the centre of a sheet of paper, participants write the name they would like to have the group use for them. Around it, they write other names that they are called, including nicknames, titles, and names in other languages or scripts. Participants then introduce themselves and say something else about their name, for example what it means, who they were named after, or whether they like it. Sheets can then be used as nametags on tables or desks.
Source: *Immigrant Settlement Counselling: A Training Guide* by OCASI, p77.

6. Name Graffiti

Ask participants to take turns writing their name with coloured markers on a piece of flipchart paper and then to say something they like about their name. Display the paper.
Source: *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p17.

References

AIDS Committee of Toronto. *National HIV/AIDS Volunteer Training Kit*. 1998.

Gillies, Peter. *Learning on Our Feet: A Simple Curriculum for Facilitator Training*. Second Edition. Canadian AIDS Society. 1998.

McKay Armstrong, Ewan and Peter Gordon. *Sexualities*. London: Family Planning Association. 1992.

Ontario Council of Agencies Serving Immigrants. *Immigrant Settlement Counselling: A Training Guide*. OCASI. 2000.

Appendix 4: Exercises

A. Introducing Ideas

Exercise A.1 Fears and expectations

Process

- Brainstorm fears and expectations that participants have for the workshop on two sheets of flipchart paper.
- Discuss in the group.

Source Adapted from *HIV+ Peers as Treatment Information Counsellors: Training Manual and Organizational Resource* by Craig McClure, pC26.

Exercise A.2 Want to learn

Process

- Brainstorm a list of things that participants hope to learn from the workshops.
- Separate participants' statements into two lists, one for content and the other for process.
- Use the process list to establish ground rules.

Source From *OFA's Action on Health Barriers: Health Promotion with Low Income Women* by Jane Bremner, et al., p60.

Exercise A.3 Who is on my right?

Process

- Make a line across the room, designating one end for "yes" and the other for "no".
- Ask participants to think about their position on a statement, such as "HIV positive immigrants should not be allowed into Canada", or "There should be mandatory HIV testing for immigrants and refugees".
- Tell participants to place themselves at the point along the line which best reflects their opinion on the question at hand.
- They must determine their position along the line by talking to the other people in the line near them.
- When all the participants feel that they are in the right place, take a few minutes to discuss the process of the exercise.

Source From *Learning on Our Feet* by Peter Gillies, p24.

Exercise A.4 Myth, Fact and Confusion

Process

- ♦ In order to determine how much participants know about a specific workshop topic, brainstorm three lists:
  - Myth, or what participants don't know but have heard about;
  - Fact, or what participants know;
  - Confusion, or what participants aren't sure about.

B. Developing Ideas

Exercise B.1 Fishbowl debate

Process

- ♦ Divide participants into teams and give them debating cards with opposing positions on a given topic.
- ♦ Ask each team to consider their arguments and counter-arguments.
- ♦ When they are prepared, ask two opposing teams to step into the circle while the rest of the participants watch and listen.
- ♦ Each team should offer a two-minute statement, followed by a one-minute rebuttal.
- ♦ Lead participants in a discussion around what they thought about the opposing positions.

Source Adapted from *Sexualities* by Ewan McKay Armstrong and Peter Gordon, p66.

C. Synthesizing Ideas

Exercise C.1 Now in the Real World

Process

- ♦ In groups of 3 or 4, divide a flipchart sheet into four quadrants.
- ♦ Think of a conflict or challenge that could be addressed using tools learned in the workshop.
- ♦ Illustrate this scenario in comic book form, using dialogue and pictures.
- ♦ Show the large group and ask them to identify the issue and to give the comic strip a title.
- ♦ The facilitator can provide an example of this that they have prepared ahead of time.

Source Adapted from *Learning on Our Feet* by Peter Gillies, p28.

Exercise C.2 Give Us a Hand

Process

- Ask participants to write an acceptance speech for an award for successfully applying some of the concepts learned at the workshop.
- The speech should include key concepts learned and ways they have used those concepts in their work.
- Applaud after each speech.
- Distribute prizes or ribbons to participants.

Source Adapted from *Learning on Our Feet* by Peter Gillies, p30.

References

Bremner, Jane, Noreen Crawford, Beth Mairs and Elaine Minsky. *OFA's Action on Health Barriers: Health Promotion with Low Income Women.* Opportunity for Advancement. 1988.

Gillies, Peter. *Learning on Our Feet: A Simple Curriculum for Facilitator Training.* Second Edition. Canadian AIDS Society. 1998.

McClure, Craig. *HIV+ Peers as Treatment Information Counsellors: Training Manual and Organizational Resource.* CATIE. 1995.

McKay Armstrong, Ewan and Peter Gordon. *Sexualities.* London: Family Planning Association. 1992.

Appendix 5: Evaluation Tools

1. Check Out

Ask participants how they felt about specific exercises as well as the workshop more generally. What went well? What could be improved? Write their responses on a flipchart.

2. Head, Heart and Feet

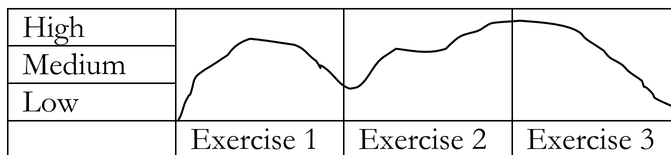
Ask participants to draw their head, heart and feet on a piece of paper. In their head, they should list new ideas, concepts or information that they learned. In their heart, they should list discoveries they have made about themselves or changes in their feelings or values that have occurred over the course of the workshop. In the feet, they should list new skills and approaches that will help them to do their work more effectively.

3. Keep, Stop and Start

Participants each get three pieces of paper. On one, they write three things they think were valuable (to keep) about the workshop. On the next, they write things they'd like to see changed (to stop). On the last sheet, they write any suggestions they have to improve the workshop (to start). The sheets are then put into three piles. Break into three groups. Each group gets a pile. They must read through the comments and summarize them for the rest of the group.

4. Lifelines

Individually or in small groups, ask participants to draw a lifeline of their experience in the workshop using a graph similar to this one.



5. Evaluation Spins

Ask participants to provide brief feedback by completing one of the following sentences:

I discovered that…
I learned that…
I was surprised that…
I want to find out…
I wonder why…

6. Evaluation Forms

Have participants fill out an evaluation form. See the example on the following page.

Evaluation Form #1

1 = strongly disagree
5 = strongly agree

	disagree				*agree*
The facilitator:					
Was effective	1	2	3	4	5
Was knowledgeable	1	2	3	4	5
Facilitated participation	1	2	3	4	5
The session:					
Was interesting and informative	1	2	3	4	5
Was a stimulating learning experience	1	2	3	4	5
Used language and concepts that were easy to understand	1	2	3	4	5
Presented useful materials and handouts	1	2	3	4	5
I found this workshop suitable to my needs	1	2	3	4	5
Were your expectations met?	1	2	3	4	5

Please explain: ____

____

What was the most useful or satisfying aspect of this session?

____

____

Was there anything about this session that was not helpful? If so, what?

____

____

Please use the other side for any other comments you have.

Thanks for your feedback!

Evaluation Form #2

1 = strongly disagree
5 = strongly agree

	disagree				***agree***
I found the workshop informative	1	2	3	4	5
I found the workshop well organized	1	2	3	4	5
I gained an understanding of the issues	1	2	3	4	5
I gained useful skills from the workshop	1	2	3	4	5
The material will assist me in my job	1	2	3	4	5
The facilitator was well prepared	1	2	3	4	5
The facilitators worked well with the group	1	2	3	4	5
I would recommend this workshop	1	2	3	4	5
My overall impression of the workshop is	1	2	3	4	5

Please explain: ____

____

Which part(s) of the workshop did you like best? Why?

____

____

Which part(s) of the workshop can be improved? How?

____

____

I would like to participate in further training session in this series: Yes __ No __

Name (optional): ______________________ Date: ________________

Please use the other side for any other comments you have.
Thanks for your feedback!

Adapted from ASAP Cultural Awareness Workshop

Appendix 6: Members of the Committee for Accessible AIDS Treatment

AIDS Committee of Toronto
399 Church St, 4th floor
Toronto, ON M5B 2J6
(416) 340-2437
www.actoronto.org

Africans in Partnership against AIDS
14 College St, Suite 401
Toronto, ON M5G 1K2
(416) 924-5256

Alliance for South Asian AIDS Prevention
20 Carlton St, Suite 126
Toronto, ON M5B 2H5
(416) 599-2727
www.interlog.com/~aids

Asian Community AIDS Services
33 Isabella St., Suite 107
Toronto, ON M4Y 2P7
(416) 963-4300
www.acas.org

Black Coalition for AIDS Prevention
110 Spadina Ave
Toronto, ON
(416) 977-9955
www.black-cap.com

Canadian Working Group on HIV and Rehabilitation
333 Sherbourne St
Toronto, ON M5A 2S5
(416) 324-4182
www.hivandrehab.ca

Casey House Hospice
9 Huntley St
Toronto, ON M4Y 2K8
(416) 962-7600
www.caseyhouse.com

Centre for Addiction and Mental Health
83 Russell St, Room 1094
Toronto, ON M5S 2S1
(416) 535-8501
sano.arf.org/hiv.htm

Centre for Spanish Speaking Peoples
517 College St, Suite 209
Toronto, ON M6G 4A2
(416) 925-2800
www.spanishservices.org

HIV/AIDS Legal Clinic of Ontario
65 Wellesley St East, suite 400
Toronto, ON M4Y 1G7
(416) 340-7790
www.halco.org

Ontario AIDS Network
25 Adelaide St East, Suite 915
Toronto, ON M5C 3A1
(416) 364-4555
www.ontarioaidsnetwork.on.ca

Ontario Coalition of Agencies Serving Immigrants
110 Eglinton Avenue West, Suite 200
Toronto, ON M4R 1A3
(416) 322-4950

Regent Park Community Health Centre
465 Dundas St East
Toronto, ON M5A 2B2
(416) 364-2261

Sherbourne Health Centre
333 Sherbourne St
Toronto, ON M5A 2S5
(416) 324-4180
www.sherbourne.on.ca

St Michael's Hospital – Health Centre at 410
410 Sherbourne St, 4th floor
Toronto, ON M4X 1K2
(416) 867-3728

St Michael's Hospital – Positive Care Clinic
30 Bond St
Toronto, ON M5B 1W8
(416) 864-5801
www.smh.toronto.on.ca

Teresa Group Child and Family Aid
790 Bay St, Suite 901
Toronto, ON M5G 1N9
(416) 596-7703
www.interlog.com/~teresag

Toronto Community Care Access Centre
250 Dundas St West, Suite 305
Toronto, ON M5T 2Z5
(416) 506-9888
www.torontoccac.com

Toronto People with AIDS Foundation
399 Church St, 2nd floor
Toronto, ON M5B 2J6
(416) 506-1400
www.pwatoronto.org

Toronto Public Health
277 Victoria St, 5th floor
Toronto, ON M5B 1W2
(416) 338-7600
www.city.toronto.on.ca/health

Voices of Positive Women
66 Isabella St, Suite 105
Toronto, ON M4Y 1N3
(416) 324-8703
webhome.idirect.com/~vopw

Women's Health in Women's Hands Community Health Centre
2 Carlton St, Suite 500
Toronto, ON M5B 1J3
(416) 593-7655

Women's Residence
674 Dundas St West
Toronto, ON M5T 1H9
(416) 392-5500

Appendix 7: CAAT Publications

HIV and Immigration Q and A by Matthew Perry

CAAT's Action Research Report by Loralee Gillis

G:\Clinical_Team\Itapha & CAAT\Service Advocate\Training Manual\The Manual\training kit final.doc