

PEER NAVIGATION TRAINING CORE MODULES



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LINKAGES

Across the Continuum of HIV
Services for Key Populations

fhi360
THE SCIENCE OF IMPROVING LIVES

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INTRODUCTION

The purpose of this toolkit is to train HIV-positive peers to engage and retain people living with HIV (PLHIV) in the health care system. This toolkit evolved out of several initiatives to incorporate peers in programming to improve HIV-related health outcomes. These include the National Institutes for Health (NIH)-funded HIV Prevention Trials Network (HPTN)-O61 study; the USAID-funded Key Populations Implementation Science study in South Africa, implemented by FHI 360 and Johns Hopkins University; and Building Blocks to Peer Success, a toolkit for training HIV-positive peers developed by a consortium of partners led by Boston University's School of Public Health.

Peer-led programs can help bridge the divide between people living with HIV and the health care system, especially given two important aspects of the global HIV epidemic:

1. The HIV epidemic is growing rapidly among key populations (KP), who include men who have sex with men, female sex workers, transgender people, and people who inject drugs.
2. Antiretroviral therapy can have a dramatic impact on the health outcomes of people living with HIV yet KP individuals living with HIV face challenges both in accessing treatment and maintaining adherence.

This facilitator's guide is part of a toolkit designed to train peer navigators to provide a package of interventions to link HIV-positive members of key populations to HIV care and support services, retain them in care, and support their adherence to antiretroviral therapy (ART) to achieve viral suppression. Trained peer navigators work as part of a team of providers within a network of services to ensure that their beneficiaries effectively access the full range of clinical and psychosocial services available to them, and maintain healthy, positive lives.

The toolkit includes the following components:

- **Peer Navigation** Implementation Guide — Program managers and peer navigators can use this document as a starting point to determine how their peer navigation programs will function within the larger service network. Programs should develop their own set of standard operating procedures (SOPs) and client flow algorithms to accompany this guide.
- **Participant handouts** — **Appendix 1** of this facilitator's guide includes handouts with key information for each training session and a complete set of tools that navigators can use to develop action plans with their beneficiaries, provide support and referrals, and monitor progress.
- **Presentations** — These editable PowerPoint slides have been kept simple so that they can be modified to fit a variety of contexts. The presentations are available at: <https://www.dropbox.com/sh/dtglg9inlwwx74r/AAAcG2zXTZ-HBoRUqsWkgf9Aa?dl=0>
- **Sample forms and guidance** — These documents (see **Appendix 2**) may be adapted by program designers, managers, and implementers to assist peer navigators to provide appropriate services for their beneficiaries and monitor their beneficiaries' outcomes.
- **Sample terms of reference for peer navigators** — Program managers can use a terms of reference document to ensure that navigators understand their roles within a services network.

NOTE: This training toolkit is divided into **core** and **optional** modules. The core modules are those that are essential for effective peer navigation and recommended for all navigators in training. Training on the core models will take two to three days. The optional modules can be included as needed; using all of them would increase this training to five full days. They consist of technical areas on which trainees may not already have been trained (such as the basics of HIV and AIDS and risk reduction) and address psychosocial and other potential needs. Country programs may find it necessary to adapt the training materials and modules to the local context. Each country program will need to adapt or develop the following modules for their own context:

- Introduction to the local program/organization
- Operationalization and implementation of peer navigation in country
- National guidelines and protocols
- Client flow algorithms
- Key legal/policy issues

This training is best implemented interactively with strong participation by trainees. Facilitators should encourage open discussion and exchange of ideas to reduce any stigma against key populations among participants and to help them better understand the needs of their beneficiaries. Facilitators should make use of the supplemental PowerPoint slides, the Peer Navigation Implementation Guide, and the tools included in the appendix of this document. Information on preparing for the training and on facilitation techniques is provided below.

PURPOSE OF THIS TOOLKIT¹

This toolkit provides a variety of materials and instructions on how to use them to build a custom training curriculum for peer navigators in your community.

What is a peer?

In this context, a peer is an individual who is affected by or living with HIV, shares similar background characteristics with the beneficiaries being served, and is not a clinically trained health care professional. Peer navigators who attend this training may be drawn from the community of peer counselors/educators, community health workers, promoters, outreach workers, treatment educators, advocates, and/or community members.

Who should use this toolkit?

The primary audiences of the toolkit are experienced trainers and training organizations who can use these materials to design, enhance, or refine their own training of peer navigators. A second audience—supervisors or program directors and the organizations that host peer programs—can use this toolkit to plan a training program for newly hired peer navigators or to provide continuing education for existing navigators. A third audience consists of policymakers, planners, and funders who can use the toolkit to help plan or fund peer navigator training activities in their countries or communities.

¹ Adapted from Building blocks to peer success: A toolkit for training HIV-positive peers. Boston: Boston University School of Public Health; 2009.

Underlying principles

Two core principles underlie the structure and content of this toolkit.

1. An interactive learning style. Peer training draws upon the principles of adult learning rather than lecture-style instruction. Researchers point out that learning occurs best when it is self-directed, participative, experiential, and applied. People will remember:
 - 10% of what they read
 - 20% of what they hear
 - 30% of what they see
 - 50% of what they see and hear
 - 70% of what they see, hear, and say
 - 90% of what they see, hear, say, and do

The training modules in this toolkit try to achieve a successful balance between what people see, hear, and do to maximize the learning that can happen.

2. No two trainings are ever the same. Trainers will adapt this curriculum to suit their own training styles and experience and the needs of their peers.

Quick tips for developing and implementing a training

Assess your community

Conducting a needs assessment is the first step to developing and implementing an effective peer training program. A needs assessment allows you to collect information on both the needs of the target beneficiary population and the organizational needs that must be met to successfully implement a peer program. A needs assessment also helps you determine which topics to cover in training, how long the training program should be, and what resources are available. There are two types of needs assessments:

1. For **organizations**: those who already have programs and those who are in the development phase.
2. For **peers**: those who are already working as peers and those who are interested in learning more about the role of a peer.

Adapt the training

Based on your completed needs assessment, identify how much time you have to conduct the training and plan your agenda accordingly. Be sure to consider the resources you have to fund and support the training, which will also affect how long your training can be.

Use the needs assessment to develop specific, measurable training objectives. These training objectives will help structure your training evaluation.

When determining the core content for your training, focus on the following criteria:

- The expectations you have for your peer navigators and what they expect from you
- The experience and knowledge of the navigators
- The characteristics of the beneficiary population that your navigators will serve
- The experience and knowledge of the trainers

Integrate introductions, icebreakers, energizers, summaries, and closures in your agenda. Also, choose an appropriate location to hold your training. A sample training agenda is provided in this toolkit on page 20.

Recruit participants

Before you begin the recruitment process, think about the following questions:

- How, where, and when will I recruit peer navigators?
- How many peer navigators do I need?
- Who is the target population for the navigation program?
- What resources and mechanisms do I have to recruit peer navigators? (for example, budget, outreach coordinators, etc.)

Once you have answered these questions, think about ways in which your KP community can help in the recruitment process. For example, KP communities can help publicize the training, recommend participants for training, and provide phone numbers or emails of potential participants.

Screen and select participants

Develop screening and selection criteria for your peer navigators before you begin choosing participants such as prior work with KP communities, HIV serostatus, communication skills (writing/oral), and/or KP member. These criteria may be based on the needs of the target beneficiary population or the needs of your organization. If you do not have a large pool of potential peers in your community, you may want to broaden your selection criteria. You can implement screening and selection before any training, which might involve an initial application process and a follow-up screening conducted in person or by telephone.

Implement and facilitate the training

When implementing and facilitating your training, keep in mind the following training tips:

- Carefully explain each activity and review the instructions with the group.
- Ask the group open-ended questions to stimulate discussion.
- Narrow and close a discussion when a topic has been exhausted.
- Divide the large group of participants into small groups to work on activities and share ideas.
- Explain how the key messages and lessons relate to the peers' work.
- Tie the activities to previously learned skills.
- Pay attention to the needs of the participants and take breaks when necessary.
- Debrief with participants at the end of each activity and at the end of each day.

Evaluate the training

To determine if the training has met its objectives, conduct an evaluation at the end of training. This evaluation will help determine if the training met the needs of the participants and if any improvements or changes are needed for future trainings.

There are several types of evaluations. Some evaluation techniques are structured to meet the measurable objectives that are outlined before the beginning of the training. For this type of evaluation, an evaluation instrument or tool is often used. Other evaluations are “softer,” or more qualitative, and pose open-ended questions to the training participants to capture their feelings, ideas, concerns, and suggestions about the training. You can combine different evaluation methods to get a full picture of the training experience. In addition, you can conduct an evaluation at the midpoint of the training and again at the end.

A sample evaluation instrument can be found in the appendix of this document (see **Peer Navigation Training Evaluation Form**).

USING THE CORE AND OPTIONAL TOOLKITS TO ADAPT THE TRAINING

Determining the core content

A sample evaluation instrument can be found in **Appendix 1** of this document (see **Peer Navigation Training Evaluation Form**).

1. What are the expectations of the peer navigators who will be trained, and what are they expected to do?
2. What is the experience and knowledge of the navigators who will participate in the training?
3. What are the characteristics of the beneficiary population that the navigators will serve?
4. How much time do you have to conduct the training?
5. What is the experience and skill set of the trainers?

The training sessions in this kit were designed to train peer navigators who will engage and retain people living with HIV in health care, with a focus on key populations. To implement navigation effectively, navigators will need to form supportive relationships with their beneficiaries and help them manage some of the daily stresses that accompany an HIV diagnosis, such as understanding the health care system, understanding the purpose of different lab tests and treatments and how HIV works in the body, handling relationships with friends, families and partners, and coping with stigma. These tasks will require three areas of “core competency,” including:

1. **HIV knowledge** (including HIV life cycle, medications, adherence, resistance, risk, and harm reduction)
2. **Communication skills** (including listening skills, open-ended questions, styles of communication, cultural awareness, and nonjudgmental behaviors)
3. **Clear understanding of roles and responsibilities** (including workplace expectations, boundaries, confidentiality, counseling, navigating the health care system, working as part of a case management team, communicating with providers, readiness to be a peer, and self-care)

The experience and knowledge levels of the peers who participate in a training are likely to vary. Thus, the

training design should accommodate individuals with no prior peer experience, as well as those with several years of experience, addressing a wide range of knowledge levels. Trainers can mix and match modules from both the CORE and OPTIONAL training toolkits to ensure that the subject matter and sessions meet the needs of the program and the participants.

What are the characteristics of the beneficiary population that the peer navigators will serve?

Beneficiary characteristics will influence the choice of training modules and the program design. For example, peer navigators working primarily with men who have sex with men may need to focus on different issues compared to those working with female sex workers (who must address issues such as family planning and violence perpetrated by clients). The same is true for navigators working with transgender individuals (for example, understanding hormones) or people who inject drugs (for example, substance use and treatment). The needs of recently incarcerated individuals, people with limited literacy, and people whose primary language is not the language of the training are all factors to consider when choosing modules and designing the program.

How much time do you have to conduct the training?

You are unlikely to have enough time to provide all the training a peer needs or wants. (Participant evaluations commonly include statements like “I wish we had more time...”.) However, a minimum of three days will allow you to cover the basics that a peer navigator with no or limited prior experience needs to begin working, as long as the navigator has a strong supervisor or mentor who can continue the training and provide supervision at the workplace.

What is the experience and skill set of the trainers?

Effective peer training programs generally have a training team of one to two experienced trainers and a peer who is either an experienced trainer or a trainer in training. Peers are invaluable members of the training team; they have an experiential connection with participants that case managers or other trainers may not have. Experienced peer trainers can use their own stories to help people connect with and adhere to care. Peer trainers are also role models and can model skills that are invaluable for participants. Content experts can be brought in for sessions on specific topics, such as treatment medications, family planning, legal or confidentiality issues, mental health, or other areas.

The best trainers are those with practical, first-hand knowledge and experience with peer work who also have excellent relationship-building and group-facilitation skills. LINKAGES recommends having experienced peers co-facilitate some of the peer navigation training as a capacity-building activity for the peer but also to add credibility by drawing on their experiences and ability to address questions and issues as they arise.

FACILITATION SKILLS

Training facilitators need a variety of skills and abilities to fulfill their role. Knowing the content and structure of the curriculum is not enough. Training requires facilitators to perform multiple tasks simultaneously, such as listening, observing, and remembering points of discussion. They must communicate clearly, analyze and synthesize key points, diagnose issues, and intervene effectively. They must also provide feedback without creating defensive reactions and accept feedback without reacting defensively. And they must develop

participant trust, provide support and encouragement, and have a whole lot of patience.

This section provides training tips, ideas, and principles, along with specific facilitation skills that will make the job of a facilitator easier. It is intended for new trainers or trainers with little experience.

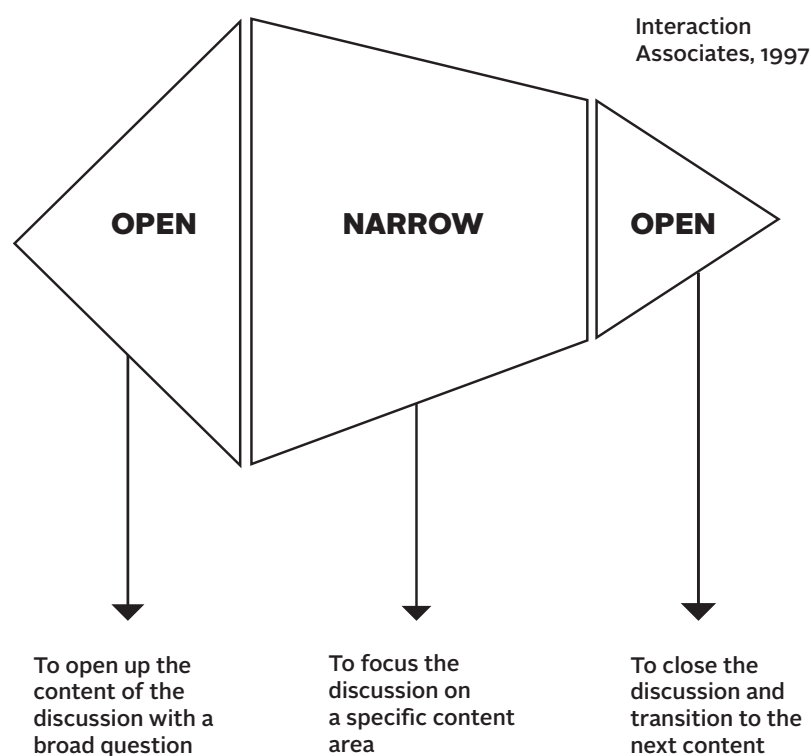
Stages of leading a discussion: Open, Narrow, and Close

One of the biggest challenges trainers face is leading discussions in ways that make the content, process, and interactions satisfactory to the participants. To do so, a good training facilitator makes conscious choices about when to open, narrow, and close a discussion.

An opening question is a broad question designed to involve participants in the content of the training and to draw out several different ideas or points of view. Such questions require more than just a yes-or-no answer. Opening questions start with the words what, why, and how. A couple of examples of opening questions would be “How do you build trust with a peer?” or “What are the ways you can motivate someone to take their ART?” Appropriate times for opening questions are:

- When you want to raise a new topic to generate interest, assess participants’ experience with the topic, or elicit an example from the group to illustrate a point
- When you want to shift energy in the room and encourage greater participation
- When you sense that you have been talking too much and need to get more participants involved

A narrowing question or statement is one that focuses on a specific aspect of the content to make a key point or to make the discussion more understandable to the whole group or relevant to participants’ work. Appropriate times for narrowing questions or statements are:



- Immediately following two to three participant responses to an opening question
- When a participant's comment leads the trainer to a specific aspect of upcoming material
- When a participant's story is wanted to illustrate a specific part of the content

A closing question, statement, or transition is used to summarize key points and move on, transition to new content, or acknowledge a participant's statement without opening up a larger discussion. Appropriate times for closing questions or statements are:

- When the discussion is no longer on the key topic
- When key points have been made
- When participants' statements lead to the next content
- When it is time to take a break
- When you have run out of time

How to set up, conduct, and debrief on exercises

Training exercises are designed to help participants assimilate and then begin to integrate key learning. To optimize the use of exercises, it is important to set up, conduct, and debrief effectively.

Setup: Key steps for giving instructions

Stand in the middle of the room to command undivided attention.

- If you plan to ask participants to work in small groups, give them instructions before the breakout. It is difficult to get participants to listen once they are out of their chairs and moving around.
- Set the context: tell participants what the exercise is about.
- Promote interest in the activity.
- Review the instructions with the group.
- Check frequently for understanding.
- Give timeframes.
- Break up into small groups or pairs.
- Give small groups a location to meet.

Conduct key activities during the exercise:

- Move among the groups to keep them focused. Give time checks as appropriate.
- Listen to be sure the participants are doing the exercise properly.
- Answer questions as needed.
- Reconvene the group for a debriefing.

Types of questions needed to generate a debrief discussion:

- Ask how each group did the exercise.
- Ask what problems were encountered.

- Assess whether or not participants got it.
- Ask how the exercise relates to their work.
- Close the debriefing and transition to the next content.

Other facilitation skills

No list can capture the complexity of the training facilitator role, but there are several core facilitation skills that every training facilitator should have. These include:

Room set-up

The most effective ways to set up the seating in a training room are in a U-shape and at round tables in small groups (for example, four to five seats per tables). A U-shape enables all participants to see the trainer as well as each other, and allows the trainer to move closer to participants to make eye contact and hear what they are saying. Small group tables can reduce formality, relax the setting, and facilitate small group work.

Standing

By standing in the middle of the room, the trainer commands undivided attention. Facilitators can use this technique when reconvening the group after breaks and lunch, giving instructions for an activity, making an important point and summarizing to the discussion to bring it to a close.

Sitting

By sitting in a chair in the middle of the room, the facilitator is leveling the playing field between participants and himself or herself. This technique is used when telling personal stories or relating professional experiences in an informal and conversational style. In this case, the facilitator is not commanding undivided attention but rather is inviting participants to join him or her in a chat.

Fading

Fading is to move or disappear into the background. This is what a facilitator does when he or she wants the group to interact with each other during role plays, when participants are presenting or reporting out on an activity to the larger group, or when it is the co-trainer's turn to facilitate.

Movement

The facilitator should move around the room to demonstrate energy and excitement about the material being presented. This technique also allows the facilitator to move closer to different participants and make eye contact with them, which makes participants feel they are getting individual attention from the facilitator and can lead to higher levels of participation and better rapport between facilitator and participant. A note of caution: when moving around the room it is important not to pace or fidget, because this may make the trainer seem nervous, anxious, or lacking in confidence.

Gauging the group

Gauging the group involves eye contact and scanning to determine whether participants are engaged in the process and understand instructions. It allows the facilitator to assess body language and participation levels. Some participants are shy and may not comment much, but may still indicate a readiness to participate through their eye contact. By gauging the group, the facilitator can encourage quieter participants to speak by nodding or using other nonverbal signals.

Asking open-ended questions

Open-ended questions invite dialogue and do not suggest that there is a single correct response. Closed-ended questions elicit either yes or no responses. Open-ended questions usually begin with the words “what” or “how.”

For example, instead of asking participants “Did you like today’s training?” (which is a closed question), a good facilitator would ask “What did you like about today’s training?” Be aware that “why” questions can sometimes be perceived as judgmental.

Attending

Attending means paying attention to the needs of participants. Some examples of attending behaviors are: providing water or beverages and snacks, minimizing distractions in the room, making the space welcoming and comfortable, greeting everyone kindly, and checking the temperature in the room. Another example is using breaks in the training to check in with quiet participants to see how the training is working for them or to address a misunderstanding between a participant and facilitator or between participants, or anything else the facilitator notices during the training.

Pause time (Managing silence)

Pause time is the silent time in the group interaction. This usually happens when the facilitator or a participant poses a broad, open-ended question to the group or when something happens in the group and people need process what they just experienced. It is important for the facilitator to allow the silence for reflection and assimilation, to sharpen the focus of the discussion, and to integrate emotionally intense material.

Facilitators can manage silence by waiting 10 seconds after asking a question and by asking the question in a different way if participants do not respond during that time.

Bouncing back (Referring to the group)

Bouncing back means that the facilitator poses a question from a participant back to that person or to the entire group to stimulate discussion. For example, someone in the group may ask: “What is the difference between HIV and AIDS?” The facilitator responds: “What have you heard is the difference?” or “What does everyone else think?” This not only gives the facilitator a chance to assess the knowledge level in the room, but also gives participants a chance to demonstrate their knowledge, learn from each other, express alternate points of view, and direct the discussion in a way that meets their needs.

Tact

Tact is defined as having “a keen sense of what to do or say in order to maintain good relations with others, avoid offense, or skill and grace in dealing with others” (Webster’s Dictionary). It is important for facilitators to acknowledge controversial moments, keep calm under pressure, maintain neutrality as emotions flare, and manage with care sarcasm or other undesirable interactions within the group. The opposite of tact is being argumentative, defensive, offensive, rude, or threatening, and facilitators should avoid such behavior, even when a participant is behaving badly. A good facilitator always takes the “high road” and never loses his or her patience in front of the audience. When things get heated, the facilitator should call for a break and deal with participant issues privately.

Blocking

Blocking is intervening to stop counterproductive behavior in the group. This skill is used to protect participants and enhance the flow of the group process. If a participant continues to demonstrate negative behavior after blocking, the facilitator can call for a break while he or she deals with the individual privately.

Active listening

There are four components to active listening: 1) clarification, 2) paraphrasing, 3) reflecting, and 4) summarizing.

Clarification: To check the accuracy of what was said, a facilitator can ask participants questions such as:

- “Did I hear you correctly?”
- “Is what I heard what you meant for me to hear?”
- “What do you mean by that?”
- “Say more about that”

Paraphrasing: To help participants focus on the key content of the message and make sure it is understood correctly, a facilitator can rephrase something a participant has said. For example, if a person is describing some of the challenges he encountered after disclosing his HIV status at work, the facilitator might respond, “So, what I’m hearing you say is that disclosure at work has been difficult for you, is that right?”

Reflecting: Communicating understanding of the feelings being expressed lets participants know they are heard and understood. If someone says: “I hate it when my sister comes to visit, because she says and does things that make my blood boil,” the facilitator might respond: “So, you are feeling angry, is that right?” or “Sounds like you are feeling really angry.” Examples of questions that help reflect feelings include:

- “How do you feel about that?”
- “How does that make you feel?”
- “What feelings or emotions does it bring up for you?”
- “How would you like to express that feeling?”

Summarizing: Once there has been enough discussion about a topic, a facilitator can tie everything together by summarizing what has been said. For example, the facilitator says: “In this part of the training, we talked about the stages of leading a discussion, how to open a discussion, narrow it down, and then close it. We also covered how to set up, conduct, and debrief on exercises. What questions do you have?”

Storytelling

Telling stories from your own experience, giving examples, and drawing analogies helps learners assimilate and integrate learning. The purpose of storytelling should be to help peer navigators understand ways to retain service beneficiaries in care and to support adherence to treatment regimens. Good stories affect participants on three levels:

Emotional: The content and delivery of the story evokes feelings and moves people emotionally.

Sensible: Participants follow the story and understand the content if it is delivered logically, with a clear beginning, middle, and end.

Connection: Participants can connect to the underlying values and beliefs inherent in the story. Storytellers can elicit participant involvement through intermittent questions.

Facilitators should choose stories and examples that are meaningful to them, relevant to the workshop objectives, and interesting to the participants.

NOTE: When telling personal stories, a facilitator should not “steal” the spotlight and monopolize the conversation. Instead, he or she should tell the story quickly, make the point, and move on.

Push, pull, and balance skills

Giving Information: Giving information (a push skill) is an important skill for training facilitators. It involves first knowing the material, and then sharing it clearly and accurately. When giving information, facilitators should:

- Use visual support materials.
- Break information into parts for easier understanding.
- Present information in an order that will make sense to participants.
- Answer questions on specific topics.
- Check to make sure that the information given is clear to participants.

Giving directions: Giving directions is a push skill that facilitators use when they want participants to do something, such as turn to a specified page or break out into small groups to do a specific activity. When giving directions, facilitators should:

- Do so in an inviting or requesting manner. (Giving directions is not the same as giving orders.)
- Use visual aids and repeat as often as needed to make sure the task is understood.
- Check for understanding after giving directions and throughout the activity.
- If breaking out into small groups or doing any other activity involving physical movement, be sure to give directions before everyone starts moving out of their seats.

Eliciting information: Eliciting information from participants (a pull skill) involves using open-ended questions, managing silence, and referring to the group while carefully listening to participants' comments and questions. Pull skills also involve paying attention to participants' nonverbal behavior. When using this skill, a facilitator should:

- Clear his or her head of other thoughts.
- Give full attention to what the other person is saying.
- Avoid predicting what someone means after hearing the first few words or sentences.
- Give verbal and nonverbal reinforcement.
- Check for understanding by asking questions or by rephrasing what participants say.

Balance skills: Balance skills involve giving and receiving feedback, maintaining a nonjudgmental perspective, setting the climate, keeping on topic, and managing time.

- Giving and receiving feedback is a balancing act. Effective facilitators correct misinformation and give an affirming response to a participant at the same time, and they know how to give feedback and how to receive and apply it. For example, if someone provided misinformation, the facilitator could say, "Thank you, John, for sharing that. However, I think the answer is actually X."
- Maintaining a nonjudgmental perspective is another balancing act. To learn, people need to feel safe and willing to participate in a session. Part of this safety is in knowing that their values and beliefs will be respected. By remaining nonjudgmental, effective facilitators balance many skills at once. They apply skills they have learned, such as avoiding labels, and instead use language that describes behavior. They also give affirming feedback to all participants even when their own values differ from those of the participants. An example could be, "Thank you, John, for sharing your thoughts on this issue. It is important to understand that not everyone will hold your or other's beliefs. When we are confronted with thoughts and ideas that

differ from our own, we have to remember to listen and not try to change that person's mind or lifestyle. We strive to provide options but are not directive.”

- Managing time is finding a balance between meeting group needs, taking advantage of teachable moments, and staying on schedule. Managing time includes getting agreement from the group on starting, ending and break times, being responsible for starting and ending sessions on time, making sure that all important agenda items fit into the schedule, and reaching agreement with participants regarding time and content issues.

Handling difficult situations

There will be situations where “talkers” in the group do not listen to others or have their own agendas. Acknowledge their ideas, but if they are not relevant to the discussion at hand, reply with “That is a good point, but we are focusing on this issue now. Perhaps we can address that issue during break or at the end of the session.” You can use the “Parking Lot” technique (e.g. putting remarks/points on a flip chart that need to be addressed before the training/meeting is complete) to acknowledge such remarks and move on to the relevant topic.

Some participants may not want to be in the session. If a person is disruptive, give him or her the choice to leave, because no one is forcing a participant to learn.

If you have a group with widely varied skill levels, it can be difficult to design a training that will meet all participant needs. Through interaction and dialogue, everyone can learn from each other. Start the training by acknowledging the range of skills and knowledge among participants and by establishing ground rules that make clear that all ideas and questions are respected.

At times you may need to step out of the curriculum. An exercise may go wrong or a topic may spur an emotional debate. Try to read your audience and adjust the training to fit the needs of participants.

Facilitating a training of peers

Because training is not just about a peer's work or potential work, but also about his or her life, there may be certain exercises or comments that trigger painful memories (transference). Trainers need to be aware of these possibilities and have the skills to address and connect them to the training topic. Trainers who are peers themselves may have their own memories triggered by stories shared by training participants (counter-transference) and will need to have the skills and experience to manage those feelings while conducting a training.

You will also need to consider the health care needs of participants who are living with HIV. Depending on their health, they may need more breaks, a rest time, a place to keep medications, and a way to adhere to any nutritional or sequencing requirements regarding medication.

Finally, a peer training should be designed to accommodate different literacy levels. If an exercise requires reading, you can ask for volunteers to read the piece aloud. If you are training individuals for whom English is a second language, it is important to avoid slang or colloquialisms that might be hard to understand.

NOTE on PowerPoint presentations

Optional PowerPoint presentations are provided as part of the toolkit, but keep in mind that a constant stream of slides with every session can switch participants off. LINKAGES recommends finding alternative ways to present information whenever possible, including using flipchart paper, notecards, and original activities. Almost all the sessions in this toolkit can be presented without the use of a projector.

BEFORE THE TRAINING

Successful training workshops require extensive preparation. Facilitators should ensure that the following steps are done well in advance:

1. Read the Peer Navigation Implementation Guidance and the supplemental PowerPoint slides, and review all the navigation tools in the toolkit.
2. Go through this training manual thoroughly in preparation for the training.
3. Ensure peer navigators will be participating in the training on the correct days/times.
4. Prepare copies of the Peer Navigator Implementation Guidance and appendices for participants to take home to read.
5. Prepare all materials (for games and exercises) required for the sessions, as well as PowerPoint presentations (PPTs) and other handouts.
6. Link with local resource persons required for the sessions (for example, people living with HIV and clinicians) and ensure they are prepared to participate on the day/time allocated; ask for a volunteer to tell his/her story for **Session 15, Positive Health, Dignity, and Prevention** (*which can be done early in the training*).
7. Review relevant human rights legislation, policies, and laws with respect to sex work, same sexual relations, and drug use.
8. Obtain a directory of services relevant to the program (if possible).
9. Obtain a visual client flow algorithm that shows how beneficiaries move through the service continuum, and where and in what way peer navigators play a role.
10. Pick up treats (candies, chocolates) to use to encourage participants to respond to questions posed in the sessions.

HOW TO USE THE TRAINING MODULES

Each session consists of the following format:

SESSION #. TITLE OF THE SESSION	
Time	Objectives
DURATION IN MINUTES	What the facilitator hopes to achieve by the end of the session

Materials: Materials that are required to carry out the session (for example, flipchart paper, markers, supplemental PowerPoint slides, and handouts); preparatory actions to ensure the session runs smoothly

Process: Step-by-step instructions on how to implement the activities and run the sessions

Notes: Additional information that will help build your knowledge and guide your discussions and exercises

Key things to remember as a facilitator:

Recommended:

- Read the training module completely before the workshop.
- Be flexible. Scheduling may have to change depending on the needs of the participants.
- Use different teaching methods to enhance participation and retain interest.
- Ensure all teaching materials, including handouts and charts, are prepared before each session.
- Solicit and honor participants' local knowledge and experience.
- Encourage peers to participate and make presentations.
- Ensure that at the end of the training, participants develop individual or organizational follow-up action plans.
- Remember that this is a participatory workshop, and your role is to FACILITATE!

Not recommended:

- Letting any one person dominate the discussion
- Speaking more than the participants
- Allowing distractions such as mobile phones and chatting between participants
- Talking to the participants, rather than with them as part of a discussion
- Reading directly from the PowerPoint presentations (It is best if you can prepare well and use the presentation slides as cue cards to elaborate on the relevant points.)

CORE MODULES

INTRODUCTION TO THE CORE MODULES

This training toolkit is divided into **core** and **optional** modules. The core modules on the following pages are those that are essential for effective peer navigation and recommended for all navigators in training. Training on the core models will take two to three days, depending on the experiences and prior training of participants.

There are 27 core modules, including an introduction to the training workshop at the beginning, and a guided practicum and post-training assessment at the end. The modules cover a range of topics that introduce the HIV services cascade and its relevance in peer navigation programming, the roles and responsibilities of peer navigators, pairing and initial and subsequent meetings with beneficiaries, linkage, referral, client flow, and management and supervision. The modules also cover a range of skillsets necessary for effective navigation, including treatment literacy, differentiated service delivery, communication and counseling skills, and partner disclosure.

Country programs may find it necessary to adapt the training materials and modules to the local context. Each country program will need to adapt or develop the following modules for their own context:

- Introduction to the LINKAGES program
- Operationalization and implementation of peer navigation in country
- National guidelines and protocols
- Client flow algorithms

SAMPLE DETAILED TRAINING AGENDA FOR FACILITATORS

Peer Navigation Training Location – MONTH YEAR				
DAY ONE				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
9:00 am	1. Introduction to the workshop	<ul style="list-style-type: none"> • Enable the facilitator and participants to get to know each other. • Explore expectations for the training. • Establish ground rules. • Review the agenda. 	<ul style="list-style-type: none"> • Handout 1. Sample Training Agenda • Notebooks for participants • Name cards • Note cards • Flipchart paper • Markers • Tape 	<ul style="list-style-type: none"> • Small group discussion
9:30 am	2. Pre-training assessment	<ul style="list-style-type: none"> • Evaluate participants' baseline knowledge. • Evaluate the impact of the training. 	<ul style="list-style-type: none"> • Handout 2. Peer Navigation Pre-Training Assessment 	<ul style="list-style-type: none"> • Small group exercise
9:50 am	3. Introduction to the LINKAGES program	<ul style="list-style-type: none"> • * Participants will understand the background, mission, values, and objectives of the relevant organization(s) (as applicable), and the role of peer navigation in the larger programmatic context. 	<ul style="list-style-type: none"> • Optional PPT 3. Introduction to the LINKAGES Program (<i>template needs to be modified for local context</i>) • Optional handouts: brochures, other organizational materials or relevant reports 	<ul style="list-style-type: none"> • Small group discussion
10:10 am Coffee/tea break				
10:30 am	4. Common leaks in the "HIV Cascade"	<ul style="list-style-type: none"> • Participants will understand the HIV Cascade and begin to understand the role of peer navigators in linking and supporting beneficiaries to remain within the continuum of HIV services. 	<ul style="list-style-type: none"> • Optional PPT 4. The HIV Cascade • Handout 4. The HIV Cascade Puzzle – Game Pieces (<i>puzzle pieces should be printed in color, cut to shape, and ideally laminated</i>) • Tape 	<ul style="list-style-type: none"> • Presentation • Group activity
11:40 am	5. Introduction to peer navigation	<ul style="list-style-type: none"> • Participants will understand the terms "peer," "navigator," and "peer navigator." • Participants will begin understanding how peer navigation fits within the service network. 	<ul style="list-style-type: none"> • Optional PPT 5. Introduction to Peer Navigation • Handout 5. Introduction to Peer Navigation 	<ul style="list-style-type: none"> • Small group discussion
12:10 pm	Lunch			

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
1:15 pm	6. Roles and qualities of a peer navigator	<ul style="list-style-type: none"> Participants will understand their basic functions as trained peer navigators and the qualities that will enhance their work. 	<ul style="list-style-type: none"> Flipchart paper Notecards Tape Notebook paper Optional PPT 6. Roles and Qualities of a Peer Navigator Handouts: <ul style="list-style-type: none"> ▶ 6.1 Roles and Qualities of a Peer Navigator ▶ 6.2 Roles and Responsibilities of Roles and Responsibilities of Peer Outreach Workers, Peer Navigators, and Case Managers 	<ul style="list-style-type: none"> Small group activity Small group discussion
2:00 pm	7. Special considerations in working with key populations	<ul style="list-style-type: none"> Participants will understand some of the specific challenges key population members face in accessing services. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 7. Special Considerations in Working with Key Populations 	<ul style="list-style-type: none"> Small group discussion Small group activity
2:45 pm	8. Confidentiality	<ul style="list-style-type: none"> Participants will understand the importance of, and techniques for, maintaining confidentiality. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 8. Confidentiality Handouts: <ul style="list-style-type: none"> ▶ 8.1 Ghislaine's Case Study ▶ 8.2 Sample Confidentiality Agreement 	<ul style="list-style-type: none"> Case study Small group discussion
3:20 pm Coffee/tea Break				
3:40 pm	9. Ethics in providing peer services	<ul style="list-style-type: none"> Participants will be able to describe what ethics are. Participants will be able to identify ethical standards to be used in their work. 	<ul style="list-style-type: none"> Flipchart paper Markers Handouts: <ul style="list-style-type: none"> ▶ 9.1 Ethical Standards for Peer Navigators ▶ 9.2 Code of Ethics and Confidentiality Pledge 	<ul style="list-style-type: none"> Small group activity Small group discussion
4:20 pm	10. The importance of boundaries	<ul style="list-style-type: none"> Participants will understand why professional boundaries are needed and useful. Participants will understand when and how to use professional boundaries with beneficiaries. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 10. The Importance of Boundaries Handouts: <ul style="list-style-type: none"> ▶ 10.1 Creating Boundaries ▶ 10.2 Creating Boundaries Answer Key 	<ul style="list-style-type: none"> Group activity Small group discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
4:40 pm	Wrap-up	<ul style="list-style-type: none"> Answer questions. Conduct daily evaluation. 		<ul style="list-style-type: none"> Small group discussion
DAY TWO				
9:00 am	Warm-up	<ul style="list-style-type: none"> Review key concepts from Day 1. Get energized for the day's activities. 		<ul style="list-style-type: none"> Group Energizer
9:10 am	11. Boundaries and confidentiality scenarios	<ul style="list-style-type: none"> Participants will be able to problem-solve real-life scenarios that they may face in the role of a peer navigator. 	<ul style="list-style-type: none"> Flipchart paper Markers Handout 11. Boundaries and Confidentiality Scenarios (cut papers into individual scenarios) 	<ul style="list-style-type: none"> Small group activity Small group discussion
9:40 am	12. Pairing with a beneficiary and the first meeting	<ul style="list-style-type: none"> Participants will understand how they will be paired with their beneficiaries and the recommended steps for the first meeting. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 12. Pairing and the First Meeting 	<ul style="list-style-type: none"> Small group discussion Role play
10:10 am Coffee/tea break				
10:30 am	13. Subsequent meetings — intake assessment, action planning, referral, and linkage	<ul style="list-style-type: none"> Participants will have an overview of the intake process and the various supportive services they may provide their beneficiaries in subsequent meetings. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 13. Intake – Action Planning – Referral – Linkage Handouts: <ul style="list-style-type: none"> ▶ 13.1 Intake – Action Planning – Referral – Linkage ▶ 13.2 Intake Assessment Tool ▶ 13.3 Action Plan Tool 	<ul style="list-style-type: none"> Small group discussion Small group activities
11:40 am	14. Follow-up meetings — the Minimum Package of Services	<ul style="list-style-type: none"> Participants will understand the specific kinds of services they are likely to provide during regular follow-up visits with their beneficiaries. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 14. The Minimum Package of Services Handout 14. The Minimum Package of Services 	<ul style="list-style-type: none"> Small group discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
12:00 pm	Lunch			
1:00 pm	15. Positive Health, Dignity, and Prevention	<ul style="list-style-type: none"> Participants will understand the importance of prevention among people living with HIV and their partners, risk-reduction counseling for those living with HIV, and respect for all individuals' sexual rights. Participants will understand issues specific to serodiscordant couples and how best to address them. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 15. Positive Health – Dignity –Prevention Handout 15. Positive Health – Dignity –Prevention 	<ul style="list-style-type: none"> Personal story about living with HIV (volunteer) Small group discussion Small group activity
2:00 pm	16. Introduction to antiretroviral therapy	<ul style="list-style-type: none"> Participants will understand the basics of antiretroviral therapy (ART) and will be able to communicate how it works. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 16. Introduction to Antiretroviral Therapy Handouts: Handout 16. Introduction to Antiretroviral Therapy 	<ul style="list-style-type: none"> Small group discussion Role play
2:40 pm	17. Adherence to treatment – the <i>Life Steps</i> approach	<ul style="list-style-type: none"> Participants will understand why it is important to initiate and remain on treatment Participants know how to use the <i>Life Steps</i> approach to support beneficiaries to adhere consistently to their treatment regimens. 	<ul style="list-style-type: none"> Flipchart Markers PPT Presentation 17. Adherence to Treatment – the <i>Life Steps</i> Approach Handout 17. Adherence to Treatment – the <i>Life Steps</i> Approach 	<ul style="list-style-type: none"> Small group discussion Role play
3:30 pm	Coffee/tea break			
3:50 pm	18: Differentiated service delivery	<ul style="list-style-type: none"> Participants will understand the concept of differentiated service delivery. Participants will understand how to use a differentiated service delivery approach to optimize support for their beneficiaries. 	<ul style="list-style-type: none"> Flipchart paper Markers Tape Optional PPT 18. Differentiated Service Delivery Handouts: <ul style="list-style-type: none"> ▶ 18.1 Differentiated Care JUMBLE ▶ 18.2 Differentiated Service Delivery 	<ul style="list-style-type: none"> Group activity Small group discussion
4:50 pm	Day 2 Wrap-up	<ul style="list-style-type: none"> Review key concepts from Day 2. Address any outstanding issues in the Parking Lot. 		<ul style="list-style-type: none"> Group Discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
DAY THREE				
9:00 am	Warm-up	<ul style="list-style-type: none"> Review key concepts from Day 2. Get energized for the day's activities 		<ul style="list-style-type: none"> Group Energizer
9:10 am	19. Communication skills	<ul style="list-style-type: none"> Participants will understand the purpose and benefits of good communication. Participants will be able to describe and use a few skills to enhance communication with their beneficiaries. 	<ul style="list-style-type: none"> Flipchart paper Markers Handouts: <ul style="list-style-type: none"> ▶ 19.1 Optical illusion ▶ 19.2 Cash Register Exercise ▶ 19.3 Communication Skills ▶ 19.4 Types of Communication ▶ 19.5 Definition of Active Listening – Barriers to Effective Communication ▶ 19.6 Effective Communication Strategies ▶ 19.7 Active Listening Strategies ▶ 19.8 Closed – Open-Ended – Focused Questions ▶ 19.9 Paraphrasing 	<ul style="list-style-type: none"> Group activity Small group discussion
10:10 am	Coffee/tea break			
10:30 am	20. Active listening and counseling	<ul style="list-style-type: none"> Participants will be able to demonstrate the importance of communicating clearly with others. Participants will understand how easy it is to miss what others are saying and will discuss what that means for communication. 	<ul style="list-style-type: none"> Flipchart paper Markers Four notecards to be attached to separate sheets of flipchart paper with the following written on them: <ul style="list-style-type: none"> ▶ What is counseling? ▶ What is not counseling? ▶ Objectives of counseling ▶ Client-centered approach (to counseling) Handouts: <ul style="list-style-type: none"> ▶ 20.1 Helpful Communication Techniques ▶ 20.2 Communication Stoppers 	<ul style="list-style-type: none"> Group exercise Small group discussion
11:15 am	21. Practicum – listening to others	<ul style="list-style-type: none"> Participants will have practiced different types of communication skills. 	<ul style="list-style-type: none"> Handout 21. Interview Checklist 	<ul style="list-style-type: none"> Group activity Small group discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
11:45 am	22. Introduction to disclosure	<ul style="list-style-type: none"> Participants will be able to discuss the basics of HIV disclosure 	<ul style="list-style-type: none"> Flipchart and markers Handout 22. Telling 	<ul style="list-style-type: none"> Small group discussion Small group activity
1:30 pm	23. The benefits and risks of disclosure	<ul style="list-style-type: none"> Participants will be able to identify the benefits and risks of disclosure. 	<ul style="list-style-type: none"> Flipchart and markers Handouts: <ul style="list-style-type: none"> ▶ 23.1 HIV and Disclosure ▶ 23.2 Who Needs to Know You Are HIV+ ▶ 23.3 Disclosing to Loved Ones ▶ 23.4 The Benefits and Risks of Disclosure 	<ul style="list-style-type: none"> Small group discussion
2:15 pm	24. Peer navigation implementation – client flow	<ul style="list-style-type: none"> Participants will understand how beneficiaries optimally move through the services continuum. Participants will have a basic understanding of key collaborators within the service network. 	<ul style="list-style-type: none"> Flipchart paper Markers Draft local Directory of Services [if developed/available—copies for all participants preferred] Client flow diagram – large format [each program should have developed a country/program-specific client flow algorithm in advance of the training that includes major service providers and clarifies how beneficiaries move between services at facilities and in the community] 	<ul style="list-style-type: none"> Small group discussion Small group activity
3:15 pm Coffee/tea break				
3:35 pm	25. Peer navigation implementation – management and supervision	<ul style="list-style-type: none"> Participants will understand their specific roles within the network of services available to their beneficiaries, including the role of a navigator within the case management team, and the process for clinical supervision. 	<ul style="list-style-type: none"> ▶ Flipchart paper ▶ Markers ▶ Optional PPT 25. PN Implementation - Management and Supervision [NOTE: INCOMPLETE! To be modified based on local context.] 	<ul style="list-style-type: none"> Small group discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
DAY THREE				
9:00 am	Warm-up	<ul style="list-style-type: none"> Review key concepts from Day 2. Get energized for the day's activities 		<ul style="list-style-type: none"> Group Energizer
9:10 am	19. Communication skills	<ul style="list-style-type: none"> Participants will understand the purpose and benefits of good communication. Participants will be able to describe and use a few skills to enhance communication with their beneficiaries. 	<ul style="list-style-type: none"> Flipchart paper Markers Handouts: <ul style="list-style-type: none"> 19.1 Optical Illusion 19.2 Cash Register Exercise 19.3 Communication Skills 19.4 Types of Communication 19.5 Definition of Active Listening – Barriers to Effective Communication 19.6 Effective Communication Strategies 19.7 Active Listening Strategies 19.8 Closed – Open-Ended – Focused Questions 19.9 Paraphrasing 	<ul style="list-style-type: none"> Group activity Small group discussion
10:10 am Coffee/tea break				
10:30 am	20. Active listening and counseling	<ul style="list-style-type: none"> Participants will be able to demonstrate the importance of communicating clearly with others. Participants will understand how easy it is to miss what others are saying and will discuss what that means for communication. 	<ul style="list-style-type: none"> Flipchart paper Markers Four notecards to be attached to separate sheets of flipchart paper with the following written on them: <ul style="list-style-type: none"> What is counseling? What is not counseling? Objectives of counseling Client-centered approach (to counseling) Handouts: <ul style="list-style-type: none"> 20.1 Helpful Communication Techniques 20.2 Communication Stoppers 	<ul style="list-style-type: none"> Group exercise Small group discussion
11:15 pm	21. Practicum – listening to others	<ul style="list-style-type: none"> Participants will have practiced different types of communication skills. 	<ul style="list-style-type: none"> Handout 21. Interview Checklist 	<ul style="list-style-type: none"> Group activity Small group discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
11:45 pm	22. Introduction to disclosure	<ul style="list-style-type: none"> Participants will be able to discuss the basics of HIV disclosure 	<ul style="list-style-type: none"> Flipchart and markers Handout 22. Telling 	<ul style="list-style-type: none"> Small group discussion Small group activity
12:30 pm Lunch				
1:30 pm	23. The benefits and risks of disclosure	<ul style="list-style-type: none"> Participants will be able to identify the benefits and risks of disclosure. 	<ul style="list-style-type: none"> Flipchart and markers Handouts: <ul style="list-style-type: none"> ▶ 23.1 HIV and Disclosure ▶ 23.2 Who Needs to Know You Are HIV+ ▶ 23.3 Disclosing to Loved Ones ▶ 23.4 Disclosure: Telling Others About Your HIV 	<ul style="list-style-type: none"> Small group discussion
2:15 pm	24. Peer navigation implementation – client flow	<ul style="list-style-type: none"> Participants will understand how beneficiaries optimally move through the services continuum. Participants will have a basic understanding of key collaborators within the service network. 	<ul style="list-style-type: none"> Flipchart paper Markers Draft local Directory of Services [if developed/available –copies for all participants preferred] Client flow diagram – large format [each program should have developed a country/program-specific client flow algorithm in advance of the training that includes major service providers and clarifies how beneficiaries move between services at facilities and in the community] 	<ul style="list-style-type: none"> Small group discussion Small group activity
3:15 pm Coffee/tea break				
3:35 pm	25. Peer navigation implementation – management and supervision	<ul style="list-style-type: none"> Participants will understand their specific roles within the network of services available to their beneficiaries, including the role of a navigator within the case management team, and the process for clinical supervision. 	<ul style="list-style-type: none"> Flipchart paper Markers Optional PPT 25. PN Implementation - Management and Supervision [NOTE: INCOMPLETE! To be modified based on local context.] 	<ul style="list-style-type: none"> Small group discussion

Peer Navigation Training Location – MONTH YEAR				
TIME	TOPIC	OBJECTIVES	MATERIALS	METHOD
4:15 pm	26. Additional peer navigation implementation tools	<ul style="list-style-type: none"> Participants will be introduced to the Peer Navigation Implementation Guide and to some of the tools and resources designed to assist them in their work (that have not already been addressed). 	<ul style="list-style-type: none"> Copies of the LINKAGES Peer Navigation Implementation Guide Local Directory of Services (handed out in Session 24) Copies of appendices from the Implementation Guide: <ul style="list-style-type: none"> ▶ 26.1 Adherence Counseling Checklist – Initial Visit ▶ 26.2 Adherence Counseling Checklist – Follow-up Visit ▶ 26.3 Tool for Transition from Navigation Services 	<ul style="list-style-type: none"> Small group discussion
4:55 pm	Wrap-up	<ul style="list-style-type: none"> Review key content from the training. Address issues in the Parking Lot. Distribute and collect evaluations (in this session or at the end of the option Day Four practicum). Provide certificates. 	<ul style="list-style-type: none"> Handout 27. PN Training Evaluation Form Certificates 	
DAY FOUR (OPTIONAL)				
9:00 AM – 12:00 PM	27. Peer Education Practicum	<ul style="list-style-type: none"> Participants will have practiced various elements of peer navigation based on the skills and tools provided in the training. 	<ul style="list-style-type: none"> Various notecards Pens or markers Optional PowerPoint Presentation: 27. Post-Training Assessment Handout 27. PN Training Evaluation Form 	<ul style="list-style-type: none"> Guided role play

1. INTRODUCTION TO THE WORKSHOP	
Time	Objectives
30 min	<ul style="list-style-type: none"> • Enable the facilitator and participants to get to know each other. • Explore expectations for the training. • Establish ground rules. • Review the agenda.

MATERIALS:

- ☐ **Handout 1. Sample Training Agenda**
- ☐ Notebooks for each participant, pens
- ☐ Name cards
- ☐ Notecards (various colors)
- ☐ Flipchart paper
- ☐ Tape

PROCESS:

1. **Welcome** the participants and thank them for attending. Note that there will be time throughout the training to ask questions, and ask if there are any questions before the training begins.
2. **Familiarize** participants with the venue and review the general schedule for meeting daily, including start and end times and lunch and break times. Note that break times and lunch times may change throughout the day, depending on how long the sessions take and participant interest.
3. Begin the session by sharing the **purpose** of the training program and reviewing the training **agenda** with the group.
4. Facilitate an **icebreaker** for participants to introduce and meet one another. See below for two suggested icebreakers.
5. Facilitate an **expectations session**. Place one or two flipchart papers on the wall marked “Expectations.” Ask the participants to take a few minutes to write down their expectations for the training on yellow notecards, and then tape them on the flipchart sheets on the wall. Once everyone has contributed, take a few minutes to go through the expectations, either by having participants read their own or by reading them from the wall.
6. **Establish ground rules**. Ask the group to brainstorm ground rules for the week. Offer prompts if needed (such as no mobile phone use in the room, computers kept off, and respect start and finish times). Record the rules on a flipchart sheet titled “Ground rules” and make sure the sheet remains visible for the entire week.
7. Set up the **Parking Lot**. Write “Parking Lot” on a sheet of flipchart paper and explain that any issue that requires further discussion will be included in the Parking Lot. Be sure to return to the Parking Lot by the end of the week and address all items listed on the list.

NOTES:**Icebreaker Option 1:**

- Have participants split into pairs with someone they do not know.
- Allow 2 minutes for the participants to talk to their partners and find out five things about them. Information may include name, where they come from, their favorite food, a hobby or expertise, a place they dream to travel to one day, etc.
- At the end of 2 minutes, each pair is asked to come to the front of the room and introduce each other to the group.

Icebreaker Option 2:

- Participants stand in a circle and say their names, where they come from, any experience they have related to the training material, and an interesting fact about themselves. For a more humorous experience, you can ask each person to think of what kind of kitchen appliance or item they feel best represents them that day, and why (for example, a blender, a wooden spoon, or a pot).

2. PRE-TRAINING ASSESSMENT	
Time	Objectives
20 min	<ul style="list-style-type: none"> Evaluate participants' baseline knowledge. Evaluate the impact of the training.

MATERIALS:

- ☐ Handout 2. Peer Navigation Pre-Training Assessment

PROCESS:

- 1. Explain** that you will be giving a pre-training assessment to learn more about what participants know, and to see what knowledge they may have gained from the training.
- 2. Distribute** a copy of **Handout 2, Peer Navigation Pre-Training Assessment**, to each participant. Ask the participants to open their notebooks to a blank sheet of paper and to write down the answers to the questions as best they can. Explain that they will have about 10 to 15 minutes to complete the pretest.
- 3.** When the participants have completed the assessment, **ask** them to hold onto their tests. Time permitting, you can return to these questions at the end of the training.

NOTES:

The pretest allows the participants to gauge what they already know prior to the training. The questions cover the entire training, including core and optional modules. The pretest will prime participants to pay closer attention to areas that may be less familiar. You may need to adjust the contents of the pretest depending on which modules you will be covering in the training. You can collect participants' answers, hand them back at the end of the training, and go over the answers at that time.

3. INTRODUCTION TO THE LINKAGES PROGRAM	
Time	Objectives
20 min	<ul style="list-style-type: none"> Participants will understand the background, mission, values, and objectives of the relevant organization(s) (as applicable), and the role of peer navigation in the larger programmatic context.

MATERIALS:

- ☐ Optional **PowerPoint Presentation 3. Introduction to the LINKAGES Program** (*Template presentation must be filled in for each country context*)
- ☐ Handouts:
 - ▶ Optional organizational materials and other relevant handouts as determined by the organization

PROCESS:

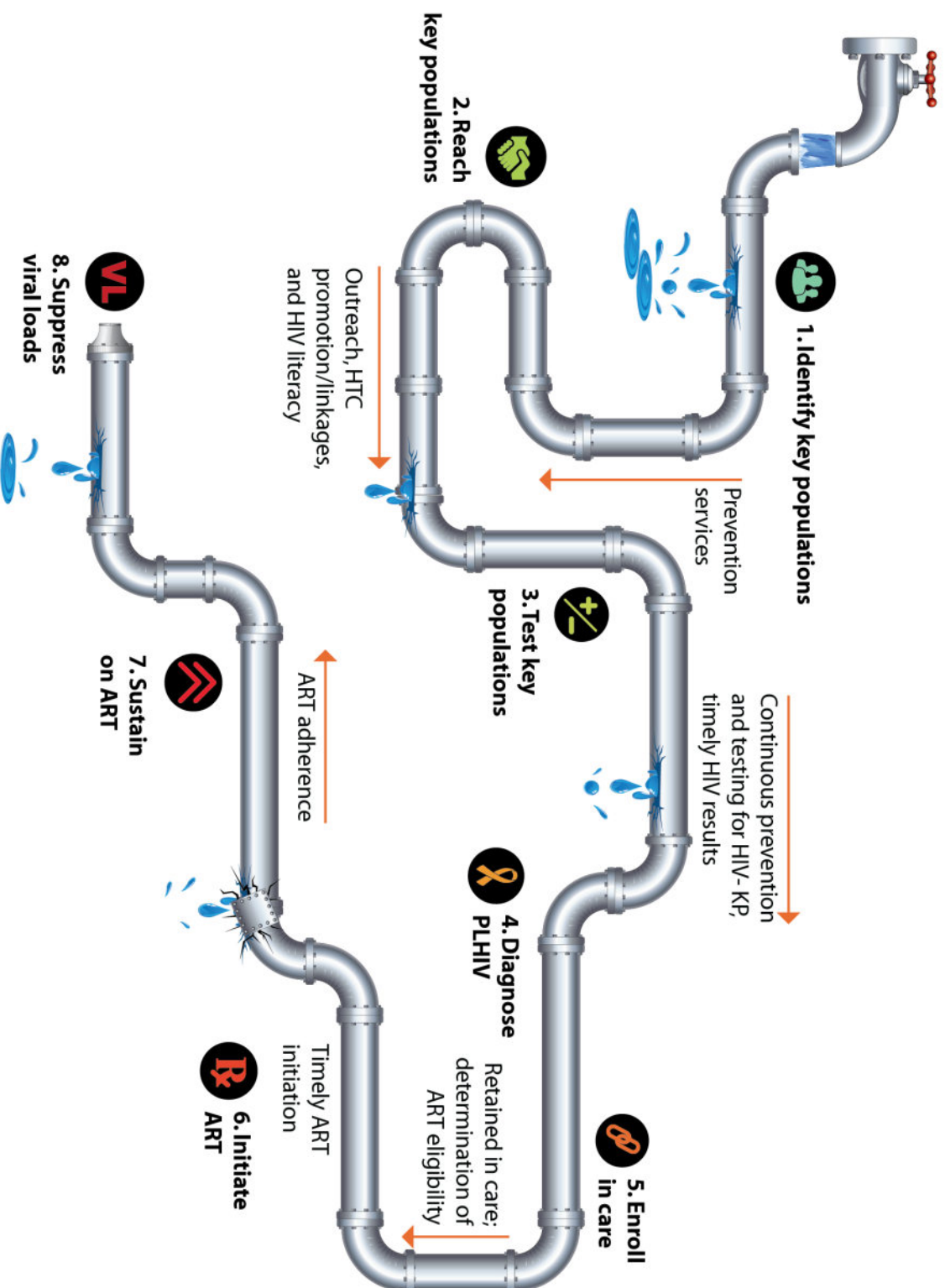
1. **Introduce** the program/organization's background, mission, values, and objectives, using whatever method is appropriate (for example, a PowerPoint presentation, discussion, or organizational chart).
2. **Discuss** briefly the role of peer navigation as part of a comprehensive network of services. (You will go into much greater detail in Sessions 24 and 25.)
3. **Ask** if anyone has any questions and provide answers.

NOTES:

This session is intended as an opportunity for LINKAGES to provide background and a rationale for the role of peer navigation as part of the services network. The content will differ for each organization/training. A sample outline with suggested material to include is provided below. The purpose of this introduction is to ensure that participants understand where they fit within the larger context of the national/local response, and their relationship to the organization(s), agencies and/or government teams with whom they will work.

- I. The LINKAGES Cascade
- II. Local epidemiology and the national response
- III. Brief overview of relevant organization(s) and objectives
- IV. Rationale for peer navigation in the local context
- V. Role of peer navigation as part of the comprehensive services network

NOTE: Facilitators can create additional PowerPoint slides and handouts with relevant information to be included as part of this toolkit.



4. COMMON LEAKS IN THE HIV CASCADE	
Time	Objectives
30 min	<ul style="list-style-type: none"> Participants will understand the terms “peer,” “navigator,” and “peer navigator.” Participants will begin understanding how peer navigation fits within the service network.

MATERIALS:

- ☐ Optional **PowerPoint Presentation 4. The HIV Cascade**
- ☐ **Handout 4. The HIV Cascade Puzzle – Game pieces**

You will need one copy of pre-cut pieces placed in an envelope for each group of five to eight participants. Ideally these pieces are printed from PowerPoint in the form of handouts with two slides per page, and then cut along the lines and laminated for re-use.

- ☐ Tape

PROCESS:

1. **Facilitate** the HIV Cascade Puzzle game (30 minutes).
 - a. Divide the participants into groups of four to five.
 - b. Hand each group one envelope with a complete set of puzzle pieces.
 - c. Explain that the puzzle, when assembled, represents the HIV treatment cascade.
 - d. Instruct the groups to put the puzzle together as best they can (noting that order matters). Ask them also to indicate where beneficiaries may “leak out” of the cascade using the water droplet puzzle pieces.
2. **Ask** one group to present their puzzle.
3. **See** if other groups have constructed their puzzles differently.
4. **Bring** the group back together and use the PowerPoint slide on the HIV Cascade to go through each phase and emphasize the areas where peer navigators might play an important role.
5. **Summarize** the session and answer any questions.

NOTES:

Facilitators can use this session to introduce and emphasize the areas where beneficiaries may fall out of the service cascade. It can also serve as an introduction to the many ways that peer navigators can support their beneficiaries to remain within the network. Participants should have a chance to brainstorm freely. Facilitators can note that roles and skills will be provided throughout the training.

See the puzzle on the following page.

5. INTRODUCTION TO PEER NAVIGATION	
Time	Objectives
70 min	<ul style="list-style-type: none"> Participants will understand the HIV Cascade and will begin to understand the role of peer navigators in linking and supporting beneficiaries to remain within the service continuum.

MATERIALS:

- ☐ Optional **PowerPoint Presentation 5. Introduction to Peer Navigation**
- ☐ **Handout 5. Introduction to Peer Navigation**

PROCESS:

1. **Ask** the participants the meaning of “peer,” “navigator,” and “peer navigator.” Encourage discussion, and use the definitions and suggested questions below to help clarify.
2. **Clarify** the differences between peer educators, peer navigators, and case managers.
3. **Begin discussing** peer navigation in the context of the region, country, and/or program where you are providing the training.
4. **Emphasize** that peer navigators work more like counselors than instructors or teachers, and that in some cases, they may take on numerous roles to help manage the care of their service beneficiaries. Note that you will be covering specific roles and responsibilities in the next session and that you will be referring again to **Handout 5, Introduction to Peer Navigation**.

NOTES:

Peer definition:

- A person who shares similar characteristics with another, such as HIV-positive status, age, social status, ability, profession, or sexual preference. For example:
 - ▶ In a school – students can be peers
 - ▶ In an industry/company – employees can be peers
 - ▶ In a hospital – nurses can be peers
- Similarly, men who have sex with men are peers of each other (though not all men who have sex with men may identify as gay). People who provide sexual services in exchange for money or other support are also peers of each other.

Ask: *In what other ways can two people be peers?*

- Critical: a peer is likely to understand many experiences of his or her peers better than someone who does not share those experiences or similar characteristics

Ask: *How might peer navigators work within the service network here in X program/country?*

- Critical: Participants should begin thinking about their roles.

² Adapted from Building blocks to peer success: A toolkit for training HIV-positive peers. Boston: Boston University School of Public Health; 2009.

Navigator definition:

- “A person who directs the route or course of a ship, aircraft, or other form of transportation, especially by using instruments and maps.”— Google definition

Peer navigator definition: A peer who performs the role of navigator

- In the context of an HIV/AIDS program, peer navigators are often **HIV-positive, medication-adherent role models who understand and can convey clearly how to access and utilize key services for people living with HIV and their partners, loved ones, and children.**

Emphasize that the responsibility is first to listen, then to assist; to help with problems, but not to tell peers what to do. It is important to bridge the gap between persons living with HIV and the medical and social service systems. This is where peer navigators play an important role, as the bridge.

Say: *You may wonder what a peer navigator is supposed to do. The answer is based on the individual needs of each peer with whom you may come in contact. Because peer navigators are generally living with HIV, sometimes their most important role is in sharing their HIV status with the peers whom they meet. This lets the peers know that they are not alone. Peer navigators must be able to listen carefully to others and to help them solve their problems. They do so by drawing on their own experiences and learning from others' experiences.*

Explain how a peer serves as a bridge between beneficiaries and services.²

Say: *As peer navigators, we are the people who may be able to answer questions for others concerning health care, medications, symptoms, and services and sometimes just listen to what others have to say about these issues. Peer navigators may also be asked to explain who is on the health care team and who will have information about their HIV status. Peer navigators are not doctors and should never give medical advice. They can inform peers of places and resources to go to get medical assistance and treatment. As you can see, peer navigators are a very important part of health care delivery.*

A basic principle for peer navigation is that people are capable of solving their own problems if given a chance.

A basic philosophy: Most of the time, people are served best by a relationship that supports their own empowerment and decision-making.

The goal: To help your peers find their own solutions to their problems, not to solve their problems for them.

Your tools: Tools to use in this process are active listening skills, problem solving skills, and your own experience with personal and cultural issues.

Say: *It is important for peer navigators to be trusted, especially when peers may need to disclose confidential information to you. We are going to discuss ways to be a good peer navigator and learn how to communicate with each other to provide the best service we can. Remember that listening is the beginning of effective communication. We talk and communicate with others every day. What we say to them depends on our relationship with them.*

Ask: *What do you think makes a good peer navigator?*

Responses may include the following:

²New York State Department of Health AIDS Institute. Case management definition. 2013 November – [cited 8 May 2017]. Available from: <https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/definitions.htm>

- Serves as someone to talk to
- Listens
- Provides encouragement and support
- Makes no false promises
- Works together to solve problems and learn about issues
- Asks questions on behalf of peers
- Is trusting
- Knows how to build rapport
- Knows how to listen and to be compassionate
- Has a desire to help
- Gives no advice, judges not

In an *ideal setting*, peer navigators work as part of a multidisciplinary team that addresses the variety of potential needs an individual living with HIV may have throughout his or her life. Individual needs will vary, but could include clinical, psychosocial, diagnostic, mental health, substance use, gender-based violence-related, legal, and other needs. Through the case management approach, a team of individuals works collaboratively to discuss and prioritize beneficiary needs, sharing the responsibility of ensuring that they are met.

Team composition will vary in each country/program based on available resources and capacities. The team might consist of a trained case manager, a clinician (nurse/doctor), a social worker, and a psychosocial counselor, in addition to a peer navigator. In settings where resources are limited, the team may include only a peer navigator, a clinician, and the navigation team supervisor. Recommended practice is that the case management team meets weekly to discuss individual cases, consider problems, and develop solutions to ensure optimal outcomes for each beneficiary.

In some cases, navigators may take on some of the duties of facility-based staff as part of a task-shifting agreement developed between a community-based or nongovernmental organization and a public-sector service site. Each program will need to consider all available human resources within the service network, and agree with the various providers where navigation can enhance service access, uptake, and retention. Clearly defining the roles and responsibilities of each team player will be critical to the success of case management and peer navigation.

Case managers generally undergo professional training and have substantial experience supporting individuals' use of services within a network. Case management is a multi-step process to ensure timely access to, and coordination of, medical and psychosocial services for a person living with HIV and (in some models) his or her family/close support system. It may involve all or some of the following activities: service planning, service plan implementation, coordination, clinical guidance, monitoring and follow-up, case conferencing, crisis intervention, advocacy for services, consultation with providers, psychosocial support, supportive counseling, and beneficiary education.³

Peer navigators collaborate with providers in the care network to support beneficiaries to enroll in care and to access and navigate the services they need to maintain healthy lives and achieve their health-related goals. Their duties might include referral to clinical, psychosocial, and other care and support services, accompaniment to appointments (including support with transportation), adherence support, routine appointment reminders, follow-up for missed appointments, and tracking of those lost to follow-up. They generally handle a caseload of 20 to 40 individuals living with HIV, depending on the stage of the epidemic in the area, the quality of health services, and the number of high-need individuals to whom they are providing support.

6. ROLES AND QUALITIES OF A PEER NAVIGATOR

Time	Objectives
45 min	<ul style="list-style-type: none"> Participants will understand their basic functions as trained peer navigators and the qualities that will enhance their work.

MATERIALS:

- ☐ Flipchart paper
- ☐ Notecards
- ☐ Tape
- ☐ Notebook paper
- ☐ Optional **PowerPoint Presentation 6. Roles and Qualities of a Peer Navigator**
- ☐ Handouts:
 - ▶ **6.1 Roles and Qualities of a Peer Navigator**
 - ▶ **6.2 Roles and Responsibilities of Peer Outreach Workers, Peer Navigators, and Case Managers**

PROCESS:

1. **Place** a flipchart paper on the wall titled “**Roles**” and another titled “**Qualities**.”
2. **Break** the participants into pairs and ask them to think about the key **roles** and **qualities** of a peer navigator. As they brainstorm, ask them to record the **roles** on pink cards and the **qualities** on green cards, and to place the cards on the flipchart papers on the wall.
3. Using the cards placed on the wall by the participants, **facilitate** a group discussion on the roles of a peer navigator:
 - a. What roles does a peer navigator perform? What are not the roles of a navigator?
 - b. What are the qualities that make a good peer navigator?
 - c. Which of the roles come most naturally to you? Which might be more challenging?
 - d. Who in the group is a new peer navigator, and who has experience as a navigator?
4. If necessary, use **PowerPoint 6.1, The Role and Qualities of a Peer Navigator**, to review the roles and qualities of peer navigators and the minimum package of services, or work with what the group provided on the flipchart paper and note additional items that did not come up in the exercise.
5. **Pass** around pieces of notebook paper, and ask each participant to write down which qualities they have and which they do not have or need to work on.
6. **Ask** if somebody wants to present what she or he wrote down.
7. **Ask** all participants to put their sheets into their personal folders.
8. Review these points:
 - a. Peer navigators have a number of roles and responsibilities that they need to undertake to bring about positive change in their beneficiaries’ lives.
 - b. A peer navigator is like a friend who knows how to give good guidance across several areas and who knows where to find additional help.

- c. Peer navigators should have some basic qualities that will help them in their work. They should also strive to improve the qualities on which they feel they need to work.

9. Distribute handouts **6.1, The Roles and Qualities of a Peer Navigator**, and **6.2, The Roles and Responsibilities of Peer Outreach Workers, Peer Navigators, and Case Managers**.

10. Summarize the session.

NOTES:

A peer navigator **is** a:

- Friend
- Sounding board
- Health educator
- Facilitator for health care
- Guide
- Coach
- Advocate
- Community resource

A peer navigator **is not** a:

- Case manager
- Medical expert
- Drug abuse counselor
- Mental health specialist
- Permanent resource or long-term solution

Qualities that make a good peer navigator:

- Makes him or herself available
- Is committed to the goals and objectives of the project
- Is sensitive to the values of the community
- Is accountable to the community
- Is tolerant and respectful of others' ideas and behaviors
- Is a good listener
- Has good communication and interpersonal skills
- Is self-confident
- Has leadership qualities
- Is willing to learn and experiment in the field
- Is committed to being accessible to community members at times of crisis
- Has the ability to create a new cadre of peers and to delegate/hand over responsibilities
- Shares responsibilities
- Knows how to set boundaries and prevent burnout

7. SPECIAL CONSIDERATIONS IN WORKING WITH KEY POPULATIONS

Time	Objectives
45 min	<ul style="list-style-type: none"> Participants will understand some of the specific challenges key population members face in accessing services.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 7. Special Considerations in Working with Key Populations**

PROCESS:

1. **Write** the following headings on four different sheets of flipchart paper:
 - a. Legal barriers and enablers
 - b. Stigma, discrimination, violence, and safety
 - c. Language
 - d. Mobility
2. **Begin** by asking the group why it is important to provide specific HIV and related services for key populations. Possible answers include: heightened risks associated with transmission and acquisition of HIV, the increasing incidence of HIV among key populations/the concentration of new infections among key populations, and greater levels of stigma and discrimination and their effect on access to services
3. **Facilitate** a brief discussion about the epidemiology of HIV among key populations in the local context. Where possible, obtain recent local prevalence and/or incidence data disaggregated by KP group. If local data are not available, obtain regional data. Ideally, you will be able to present a table or graph that shows the estimated number of new infections by key population out of the total number of new infections, emphasizing that key populations are disproportionately affected by HIV. Some sample slides are provided in the optional PowerPoint presentation for this session.
4. **Ask** the participants to split into four groups, and provide each with one of the four flipchart sheets with the terms written on them. Ask each group to spend about 10 minutes discussing what should be considered in providing services and support for members of key populations based on the terms/themes written on their sheets.
5. **Bring** the groups back to the plenary and have a reporter from each group briefly discuss what the group came up with. See if others have anything to add, and repeat the process for the remainder of the groups. Use the notes below to fill in anything that may have been missed.

NOTES:

KP members face different challenges in accessing HIV and related services compared to other service beneficiaries. It is important to keep the following issues in mind when working with key populations.

Legal barriers and enablers

Laws, regulations, and policies can be barriers to effective service access and uptake. In providing support for key populations, it is important to be aware of potential legal barriers and local policies, such as anti-sodomy

laws, laws against sex work, penalties for carrying drug paraphernalia (i.e., needles and syringes), and other criminalized acts. Policies might also be highly localized (for example, some facilities have dress codes that can be used to deny KP members access to services). Conversely, many individuals — including KP members — may not be aware of their individual rights under local law. Navigators will be able to better serve their beneficiaries if they have a basic understanding of local human rights protections and policies. As part of their work, navigators should know how to link beneficiaries to free or low cost legal assistance.

Stigma, discrimination, violence, and security

Stigma and discrimination (S&D) against key populations are common. Evidence also shows that stigma in health facilities and by law enforcement services is particularly common, creating significant barriers to accessing services and redress for abuse. Global evidence suggests that key populations have an elevated risk of violence and abuse and that these experiences are common. Abuse can take various forms, including physical, sexual, psychological, and economic abuse. Key populations may experience violence, harassment, and/or blackmail from their sexual or domestic partners, sex work clients, law enforcement officials, community members, and even family members.

When providing navigation services, and especially when conducting home visits, it is essential to ensure beneficiary safety and security. Navigators and program leads should consult with and sensitize law enforcement and related officials before proceeding with community engagement activities. The program should also have an emergency response system in place that includes leadership from the uniformed services, local leadership, community-based organizations, and multilateral and bilateral stakeholders.

Language and terms

Many terms commonly used to describe key populations are derogatory or outdated. Key population members may prefer specific terms. It is also important to note that peer navigators may encounter language barriers while working with some key populations, especially sex workers who have migrated from other locales or countries. When speaking with and about key populations, navigators should adopt the terms that key population members prefer, and should avoid any terms that may be judgmental.

Mobility and hidden populations

Some key populations, particularly sex workers, are highly mobile. Others, due to high perceived or actual stigma, remain hidden and are averse to being associated with a KP-focused program or drop-in center. This may be the case, for example, with some men who have sex with men who are on the “down low” (not out as gay or bisexual). Navigators need to be adaptive, responsive, and consider ways that service beneficiaries who change locations can be followed up effectively, if that is their wish.

8. CONFIDENTIALITY	
Time	Objectives
35 min	<ul style="list-style-type: none"> Participants will understand the importance of, and techniques for, maintaining confidentiality.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 8. Confidentiality**
- ☐ Handouts:
 - ▶ **8.1 Ghislaine's Case Study**
 - ▶ **8.2 Sample Confidentiality Agreement**

PROCESS:

1. **Explain** that you will be talking about building a trusting relationship with beneficiaries, the importance of maintaining confidentiality, and behaving ethically. In the following session, you will conduct an exercise to explore setting boundaries.
2. **Ask** the participants to read **Handout 8.1, Ghislaine's Case Study**.
3. **Elicit** responses to the questions on confidentiality below.
4. **Affirm** responses, and follow the **Facilitator Notes**.
5. **Distribute** and review **Handout 8.2, Sample Confidentiality Agreement**, per the facilitator notes below.
6. **Summarize** the session.

NOTES:⁴

Ask: *What is confidentiality?*

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

⁴Adapted from Building blocks to peer success: A toolkit for training HIV-positive peers. Boston: Boston University School of Public Health; 2009.

Most governments have established laws to maintain and protect the rights and interests of customers. There may be standards for data exchange that protect the confidentiality and security of health care records. Privacy or confidentiality rules regulate how information is shared. When a beneficiary engages with a health service, pharmacy, or social service, she or he should usually be informed of his or her right to confidentiality and the policy and procedures regarding the release of his or her personal information. Often a beneficiary signs a form stating that she or he has reviewed and understands his or her rights.

[Facilitators should have a basic understanding of these laws and should work a basic overview of them into this section]

Ask: *Why is confidentiality important?* (Elicit three to five responses.)

Ask: *What kinds of things might a beneficiary want to keep confidential?* (Elicit three to five responses.)

Remind the participants of Ghislaine's Case Study.

Ask: *What were concerns for Ana about confidentiality, and how did Ghislaine address them? What could she have done differently?*

Ask: *What are some potential confidentiality issues that may arise in your work?*

- A beneficiary's HIV status is revealed by a hospital employee to someone who knows him or her.
- A beneficiary reveals information about himself or herself that puts the beneficiary at great physical risk of harm.
- A staff member of the program discusses the name and status of a beneficiary in front of other staff.
- A beneficiary refuses to initiate ART, and his or her sexual partner is a friend of yours.
- A beneficiary living with HIV may intentionally be infecting others.
- You know well the person assigned to you as a beneficiary.

Peer navigators will need to be aware of the various ways that beneficiary confidentiality can be compromised, including in person, on the phone, through email and text messaging, and in the handling of hard copy documents. It is important to understand the agreements on confidentiality established with network facilities and providers. Navigators may at times work offsite and interact on service beneficiaries' behalf with a range of individuals, which can increase the risk of breach of confidentiality of beneficiary information.

Peer navigators may also have access to data, including paper and potentially electronic records. Facilitators for this training will need to check with the local program so they can discuss in detail the policies and procedures for protecting the confidentiality of their beneficiaries when accessing paper and electronic beneficiary files.

Ask: *What might be the consequences of breaking confidentiality?*

- The employee may be reprimanded, given a warning, or be dismissed from the agency.
- The beneficiary may be embarrassed.
- The beneficiary will lose trust in the peer navigator and the agency.
- The beneficiary may file charges against the peer navigator and the agency.
- An organization/agency could be fined or criminally penalized.

Summarize the discussion by briefly reviewing the key points, and then tell participants that usually each organization has a document that is signed by the beneficiary and the peer navigator. This form is an agreement between the beneficiary and the peer that their discussions will be confidential. Such agreements help build trust and make confidentiality formal.

Hand out the **Sample Confidentiality Agreement**. Point out that organizations generally have beneficiaries sign an agreement at their first meeting, when they explain the roles of a peer navigator. This step should be done in the first meeting with the beneficiary. If you cannot get something signed the first time you meet with your beneficiary, you should get a verbal agreement.

Note that every organization that works with beneficiaries has a confidentiality policy or agreement that employees should follow.

Ask: *When is it OK to break confidentiality? What are the steps to follow?*

Briefly review the three times when confidentiality may be broken and the steps to follow. It is a good idea to review these policies with your supervisor before beginning your work as a peer navigator.

1. If a beneficiary is suicidal:

There is a technique called QPR – question, persuade, refer. If you feel comfortable doing so, you can ask the beneficiary the following questions:

- Are you suicidal, or have you thought about hurting yourself?
- Do you have a plan for how you would do it?
- How would you do it?

If you think a beneficiary is suicidal, immediately seek assistance from your supervisor at the agency you are working with.

Call an emergency response team if the beneficiary needs immediate assistance, even if you have doubts.

2. If the beneficiary threatens homicide or plans to seriously hurt someone:

Immediately seek assistance from your supervisor at the agency you are working with.

3. If a beneficiary shares that he or she is physically abusing a child or dependent adult:

Immediately seek assistance from your supervisor at the agency you are working with.

Summary

Close with these key points:

- Confidentiality is an important part of a peer navigator-beneficiary relationship
- There are many reasons why a navigator must do all she or he can to maintain a beneficiary's confidentiality, including building trust and to provide support.
- A beneficiary may have several things she or he wants kept confidential (for example, HIV status, experience of domestic violence, where she or he lives, sexual history) and peer navigators should be mindful of them.
- There are times when a beneficiary's confidentiality may have to be broken for his or her own safety or the safety of others, such as when the beneficiary is seriously threatening suicide, homicide, or abuse.

NOTES:

Beneficiaries will be given the option of choosing to receive text messages, voicemails, and/or emails. Peer navigators should never remove materials with beneficiary identifying information from program sites. When peer navigators meet service beneficiaries offsite, they should not carry anything that has their beneficiaries' contact information, including names, numbers, or addresses. If a beneficiary provides change of contact information while meeting with a peer navigator in the field, the navigator should ask the beneficiary to come to a service site (or call the navigator later at the site) to update the site's official contact register.

Because peer navigators often interact with facility staff, the program should have agreements with service sites on the sharing of beneficiary information. (If they have been established, reference them here. If not, note that the agreements will be developed as part of their work.) Beneficiaries should always be asked for consent for each level of sharing between providers and service sites.

Peer navigators may be members of the same community as their service beneficiaries, and therefore may encounter service beneficiaries in social settings. They should take care in approaching service beneficiaries during these situations and should be careful not to reveal a beneficiary's participation in the program to anyone without the express consent of the beneficiary. Service beneficiaries and navigators may have a preexisting relationship or may share acquaintances. Every effort should be made to ensure that the navigator and beneficiary are comfortable in their working relationship. Where necessary, it may make sense to reassign navigators if relationship boundaries are unclear or stressed.

Check with the local program to discuss exactly what the consequences are for a breach in confidentiality. Based on the severity of the breach, actions may include a warning, reprimand, dismissal, legal action, or other measures based on local policies and laws. The program may also have support systems in place to respond if someone's safety is at risk.

9. ETHICS IN PROVIDING PEER SERVICES

Time	Objectives
40 min	<ul style="list-style-type: none">• Participants will be able to describe what ethics are.• Participants will be able to identify ethical standards to be used in their work.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Handouts:
 - ▶ 9.1 Ethical Standards for Peer Navigators
 - ▶ 9.2 Code of Ethics and Confidentiality Pledge

PROCESS:

1. **Write** the following questions on three pieces of newsprint (one for each group):
 - a. What are ethics?
 - b. Why are they important?
 - c. What are some ethical standards peers should follow in working with beneficiaries?
2. **Introduce** the activity by explaining that participants will be assigned to small groups to brainstorm a list of ethics and standards for peer navigators to follow.
3. **Assign** participants to three groups by counting off one to three until all participants are assigned to a group. Assign a space in the room for each group. Ask participants to go to their assigned groups in the respective spaces.
4. **Give** each small group a piece of paper that has the three questions written on it. Ask each group to appoint a reporter and a recorder.
5. **Instruct** the groups to use the paper to brainstorm answers to the question. Tell the groups they will have about 10 minutes to do this activity.
6. **Bring** the entire group back together and ask each reporter to go over his or her group's work. Ask open-ended questions to draw out their thoughts on the ethical standards that peer educators should follow.
7. **Potential answer to brainstorm:** Ethics are principles that govern right and wrong practices and moral conduct.
8. **Distribute two copies each of Handout 9.1, Ethical Standards for Peer Navigators, and Handout 9.2, Confidentiality Pledge.** Review both sheets with the participants. Ask if there are any questions, and request that they sign a copy of each document for themselves and a copy to be kept by the program. Collect the program copies in a folder.
9. **Summarize the session.** Explain to the participants that ethical standards help new peer educators in the management of peer-beneficiary relationships.

10. THE IMPORTANCE OF BOUNDARIES	
Time	Objectives
20 min	<ul style="list-style-type: none"> Participants will understand why professional boundaries are needed and useful. Participants will understand when and how to use professional boundaries with beneficiaries.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 10. The Importance of Boundaries**
- ☐ Handouts:
 - ▶ **10.1 Creating Boundaries**
 - ▶ **10.2 Creating Boundaries Answer Key**

PROCESS:

1. Have the participants **form two lines** 10 feet apart and face each other. Designate one line as A's, and the other as B's. Pairs will be created by having each person pair with the person directly in front of them.
2. **Tell** the A's that they are going to walk slowly towards the B's. Tell the B's that they will stand still and, when they start to feel uncomfortable with how close the A's are coming to them, should put their hands up with their palms facing their "A" partners.
3. **Emphasize** that there is no "right" or "wrong" distance: it is a matter of personal comfort. There will be some giggling, but encourage the group to do this silently and to pay close attention to their feelings.
4. **Repeat** the activity but mix up the pairs so the B's get to walk toward a different person in the A line.
5. After the second group of pairs have done the exercise, **ask** everyone to return to their seats and process what has happened by asking such questions as:
 - How did it feel to be B and to have the power to stop the other person?
 - How did it feel to be A and not have that power?
 - What does this have to do with being a peer navigator?
 - Who has the power to set boundaries in the navigator-beneficiary relationship?
 - We've been looking at physical boundaries, but what other kinds of boundaries are important for us to set?
 - How might you feel if a beneficiary sets boundaries that are farther away than you'd like?
 - How might you feel if her boundaries are closer than yours? What are some safe ways to let others know our boundaries?
6. Through our discussion today, we have seen that peer navigators face many challenges. To avoid burnout, we need to create boundaries and limitations for ourselves.

Ask: *What is a boundary and what does it mean to set boundaries?*

- A boundary is a dividing line between you and anyone else that represents both physical and emotional limits.
- Boundaries ensure that others do not cross the line.
- Boundaries make you feel safe and healthy.
- Boundaries make others feel safe around you.
- Boundaries set relationship guidelines so people know how to behave around you.

7. **Give** participants the **Creating Boundaries** handout and tell them they can take notes on it if they choose. Review the **Creating Boundaries** handout and ask participants what they would do. Use the answer key if necessary.

Ask: *What are some ways we can set boundaries with beneficiaries?*

Tips for setting boundaries:

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

Ask: *What can you do when someone crosses your boundaries?*

- **Inform** – Let the person know what they are doing while using “I statements.”
- **Request** – Let them know what you want.
- **Take a stand** – Let them know that their behavior in crossing that boundary is not appreciated or is disrespectful.
- **Time Out** – Step out of the situation briefly for your safety.
- **Extended Time Out** – Stop the relationship until the person changes the unwanted behavior.

8. **Summarize: Wrap up by** reminding the participants that the responsibility of peer navigators is not to convince people to change behaviors that they believe are wrong or not a part of their own values, even if they are risky. Our responsibility is to make sure that people have the information they need, have the chance to develop the skills they need, and have the support to explore their own beliefs and values so they can make healthy decisions. The more we let our personal values into our work, the more likely it is that we will close the door with someone. Beneficiaries are more likely to trust us and to learn from us if they see us as nonjudgmental.

⁵ Adapted from Building blocks to peer success: A toolkit for training HIV-positive peers. Boston: Boston University School of Public Health; 2009.

Acknowledge that avoiding judgment is — and will continue to be — a tough challenge. We are here because we care about our beneficiaries' health, and it is hard to watch someone do things that are not healthy. But we will have a much better chance of helping our beneficiaries if we keep that door open rather than trying to change them.

NOTES:⁵

Service beneficiaries can be vulnerable and form emotional, financial, and other type of dependencies. They may also express sexual attraction toward their navigators, and/or a navigator may discover she or he has an emotional or sexual interest in one or more beneficiaries. Program staff, including navigators, should be prepared for this, and should understand that sexual relationships with beneficiaries are strictly prohibited.

Each navigator should designate clear office hours with his or her service beneficiaries. Some navigators may wish to be available to service beneficiaries by phone at any time, day or night. Such an approach should be discussed and decided upon by the navigator and supervisor(s) together, considering issues such as office hours, acceptable meeting locations, burnout, availability of clinical supervision, and personal safety. Some navigators may find that limiting their availability to established office hours at a fixed site during specific days of the week is easier to manage than being available every day. Peer navigators should minimize travel time and costs as much as possible.

11. BOUNDARIES AND CONFIDENTIALITY SCENARIOS

Time	Objectives
30 min	<ul style="list-style-type: none"> Participants will be able to problem-solve real-life scenarios that they may face in the role of a peer navigator.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ **Handout 11. Boundaries and Confidentiality Scenarios** (*cut papers into individual scenarios*)

PROCESS:

1. **Introduce** the activity by explaining that participants will be assigned to small groups to brainstorm scenarios where confidentiality or boundaries may have been broken.
2. **Pass** out the **Confidentiality and Boundaries Scenarios** (you will need to cut them into separate strips).
3. **Assign** participants to groups of three to four, and assign a space in the room for each group.
4. **Give** each group a piece of paper with their scenario number and the corresponding questions written on it (the questions are in the Boundaries and Confidentiality Scenarios handout).
5. **Ask** each group to appoint a reporter and a recorder, and tell the group they will have about 10 minutes to do this activity.
6. **Bring** the entire group back together and ask each reporter to go over his or her group's work.
7. **Ask** open-ended questions to draw out thoughts on the questions and the discussions that arise from the group responses.
8. **Summarize** the session and answer any questions the participants have.

12. PAIRING WITH A BENEFICIARY AND THE FIRST MEETING	
Time	Objectives
30 min	<ul style="list-style-type: none"> Participants will understand how they will be paired with their beneficiaries and the recommended steps for the first meeting.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 12. Pairing and the First Meeting** (see note in Step 2 below)

PROCESS:

1. **Explain** the country or program-specific procedures for linking beneficiaries to a navigator. As these will vary by country, facilitators should consult with program managers or supervisors before this session to ensure that they understand how the matching will take place. Elicit questions and provide answers as needed before moving on. It may help to have a program representative in the room for this session in case there are specific questions about pairing.
2. **Introduce** the process for the first meeting with a beneficiary using the notes provided below. Facilitate a discussion about the process, and answer questions as needed. [NOTE: **PowerPoint 12, Pairing and the First Meeting**, has a placeholder slide for the local program's procedures/steps for pairing navigators and beneficiaries. This slide should be filled in before the presentation, if it will be used to guide the discussion.]
3. **Remind** the participants that it is important to build trust in this phase, not to overwhelm beneficiaries, and to treat them with respect. Note that there will be modules on active listening and counseling skills later in the training, and that these skills will be essential in the first and subsequent meetings.
4. **Facilitate** a role play by having the participants split into pairs, where one serves as the peer navigator and the other as a new beneficiary. Ask the pairs to practice going through the basic steps for the first meeting, allowing about 10 minutes for the role play, and then switch (20 minutes for both).
5. **Summarize** the session.

NOTES:

Pairing

Each program can determine how best to match beneficiaries with navigators based on beneficiary preferences, team composition, local regulations, and available resources. Some beneficiaries may need time after a positive diagnosis to adjust to their health status before meeting with a navigator. Others may wish to have prompt support from a navigator who can answer questions and help them understand better what a positive diagnosis entails.

Ideally, programs should have someone such as a case manager or coordinator who can work with beneficiaries shortly after diagnosis to assess their needs, discuss available options, and jointly determine who might be an appropriate navigator (taking into consideration skills, strengths, and caseloads). Before matching someone with a navigator, it is important to obtain consent from each beneficiary to ensure she or he is aware that his or her positive diagnosis and some personal details will be shared as part of the process. Where navigators are based at drop-in centers or in the same facilities that provide testing, individuals may be connected directly to a navigator on the same day, or on a later day, depending on their preference.

The first meeting

The **first navigation meeting** should be focused on building a relationship with the beneficiary. Navigators should be cautious about moving too fast or trying to cover everything. Beneficiaries will often indicate either through verbal or nonverbal communication how comfortable they are and how much they would like to discuss in the first session. If necessary, navigators may need to plan a day and time for a second meeting to begin discussing beneficiary needs, priorities, and support.

At minimum, navigators may wish to accomplish the following in the first meeting:

1. Introduce themselves.
2. Explain their role.
3. Provide emotional support and encouragement as needed.
4. Discuss treatment initiation and reiterate the treatment literacy messages addressed in the post-test counseling session.
5. Provide contact information.

13. SUBSEQUENT MEETINGS — INTAKE ASSESSMENT, ACTION PLANNING, REFERRAL, AND LINKAGE	
Time	Objectives
70 min	<ul style="list-style-type: none"> Participants will have an overview of the intake process and the various supportive services they may provide their beneficiaries in subsequent meetings

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 13. Intake – Action Planning – Referral – Linkage**
- ☐ Handouts:
 - ▶ **13.1 Intake - Action Planning – Referral – Linkage**
 - ▶ **13.2 Intake Assessment Tool**
 - ▶ **13.3 Action Plan Tool**

NOTE: You may wish to break this session into multiple sessions, or take small breaks between exercises.

PROCESS:

1. **Explain** that by the second or third meeting, navigators may wish to begin exploring the specific needs of their beneficiaries and developing plans to address those needs. Note that some beneficiaries may take time to come to this stage, and that navigators should be patient and move at a pace that is comfortable for their beneficiaries.
2. **Facilitate** a discussion about individual beneficiary needs and the importance of being able to prioritize them. You can use the hierarchy of needs pyramid (Maslow's Hierarchy of Needs) provided in **Handout 13.1, Intake – Action Planning – Referral – Linkage**, as an example. Explain that immediate physical needs, such as housing or safety, usually take precedence over emotional needs.
3. **Ask** the participants to break into small groups of five to six people each. Using the sample hierarchy of needs, ask each group to brainstorm the kinds of needs that they think their beneficiaries may have, and to place them along a hierarchy pyramid drawn on flipchart paper. Allow 10 to 15 minutes for this exercise. Bring the groups back to plenary and ask a rapporteur from one group to present. Ask if the other groups came up with different needs or categorizations, and allow for comments/questions.
4. **Ask** the participants to look at **13.2, the Intake Assessment Tool**. Explain that the intake assessment is a job aid that can help guide a discussion with a beneficiary on what his/her specific needs may be, and how best to prioritize them. Use **Handout 13.1, Intake – Action Planning – Referral – Linkage**, to discuss the key elements of the assessment and guidelines for asking questions.
5. **Ask** the participants to break into groups of three. Note that each group will be conducting a role play, where one participant serves as a navigator, another as a beneficiary, and the third as an observer. Explain that the beneficiary will be meeting with the navigator for the second time, and that she or he should take a few moments to come up with his or her own life scenario, including circumstances that might require assistance from a navigator to ensure his or her HIV and related service needs are met. While the beneficiary is taking a few moments to think of a scenario, the navigator and observer should review the **Intake Assessment Tool**. Allow the groups 5 minutes to prepare, and answer any questions before beginning. Instruct the groups that they will have 20 minutes to conduct the role play. As they conduct the role play, move about and observe from a distance, allowing space for the groups to practice.

6. **Bring** the groups back to the plenary, and begin by asking the “beneficiaries” to provide insights on the process. Ask how they felt, and what about the process worked well for them. Invite the “navigators” to do the same, followed by the observers. Record on flipchart paper observations about what worked well. Allow for a quick break, if needed, before proceeding.

7. **Ask** the participants to look at **Handout 13.3, the Action Plan Tool**. Explain that the action plan provides a structure for noting the issues that a beneficiary may be facing, based on the needs assessment, and developing actionable steps to address those needs. Explain that there are also spaces to record immediate referrals and priority goals.

On the second page of the tool, there is a table that serves as an action plan both for the beneficiary and the navigator. Together, the beneficiary and navigator can set realistic, actionable steps, and agree on when those might be completed. It may also help to note potential challenges the beneficiary may face and ways of overcoming those challenges. **NOTE:** a similar but more extensive process will be used to develop a treatment adherence plan.

8. **Ask** the participants to break out into their three-person groups again. Explain that they will continue with their role play, now using the Action Plan Tool as a guide. Based on the scenarios from the previous exercise, navigators should work with their beneficiaries to agree on key issues that need to be addressed, immediate referrals (to whom/where/when), priority goals moving forward, and specific actions (page 2 of the plan). Note that, at a minimum, navigators will need to ensure that beneficiaries:

- Have scheduled necessary diagnostic and medical appointments
- Are aware of the location of their appointments, whom they will meet, and what will be done
- Have the means to attend to their appointments on time, including transportation, time off work if needed, daycare, etc.
- Are reminded of their appointments 24 hours before they take place
- Have attended their appointments at the appropriate times
- Are contacted in the event they did not show for an appointment (within 24 hours)

Allow 10 to 15 minutes for this part of the role play.

9. Once the groups are finished, **bring them back** to plenary and facilitate a discussion like the one described in step 6 above. Record the main observations on what worked and answer any questions before moving to the next session.

10. **Summarize** the session.

14. FOLLOW-UP MEETINGS — THE MINIMUM PACKAGE OF SERVICES	
Time	Objectives
20 min	<ul style="list-style-type: none"> Participants will understand the specific kinds of services they are likely to provide during regular follow-up visits with their beneficiaries.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 14. The Minimum Package of Services**
- ☐ **Handout 14. The Minimum Package of Services**

PROCESS:

1. **Begin** by noting that each beneficiary will have different needs, but most beneficiaries will require more frequent visits in the early stages of support.
2. **Distribute Handout 14, The Minimum Package of Services**, and facilitate a discussion about the package. Introduce each service shown in bold, and ask the participants what they think the service entails. Using the notes below, fill in anything that may have been missed in the discussion.
3. **Use** the optional PowerPoint presentation, or flipchart paper and markers, to guide the discussion as appropriate.
4. **Answer** questions as needed and **summarize** the session.

NOTES:

In the first session, beneficiaries and navigators can decide together when their next session will be, and the frequency and times of the sessions thereafter. Initially, meetings with beneficiaries are likely to be more frequent (i.e., once a week) to help them adjust to an HIV diagnosis, attend appointments, obtain prescriptions, and address immediate needs and challenges. The first few visits also tend to be the most intensive, particularly for beneficiaries with multiple or complex needs. During these sessions, navigators should encourage, support, and help build the skills of their beneficiaries to address those needs, provide referrals and linkage to available services, and follow up to ensure beneficiaries access those services. They can review and update beneficiaries' **action plans** as appropriate.

Over time, meetings may become less frequent (i.e., once a month). In subsequent meetings, navigators and beneficiaries may review action plans, address any adherence issues, and ensure medical and related appointments are maintained. After beneficiaries begin ART, navigators can check if their beneficiaries have adjusted well to taking routine medication and are adhering to their regimens. **[NOTE: Adherence counseling will be covered in a separate session.]** Navigators should continue to follow up with service beneficiaries who identify few or no goals at the initial assessment, to assist with emerging needs.

15. POSITIVE HEALTH, DIGNITY AND PREVENTION	
Time	Objectives
60 min	<ul style="list-style-type: none"> Participants will understand the importance of prevention among people living with HIV and their partners, risk-reduction counseling for those living with HIV, and respect for all individuals' sexual rights. Participants will understand issues specific to serodiscordant couples and how best to address them.

Prep! You will need to prepare ahead by finding a volunteer who is willing and interested in sharing his or her experiences with his or her HIV diagnosis. If no participant is interested, you may need to hire or request an HIV-positive volunteer from the community to join the session. See Step 2 below.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 15. Positive Health – Dignity -Prevention**
- ☐ **Handout 15. Positive Health – Dignity – Prevention**

PROCESS:

1. **Explain** that you will be talking about people's experiences living with HIV and how to help them move from their immediate response to receiving an HIV diagnosis toward prevention of onward transmission, initiating ART, ART adherence, and living a healthy life.
2. **Participant story:** Ask the participants earlier in the training if there is anyone who would like to volunteer to share his or her experience learning of his or her HIV diagnosis and what happened afterwards. You can suggest that anyone interested come and see you during a break to discuss what this will entail, to ensure the volunteer feels comfortable. During the session, ask the volunteer to share his or her story, with a focus on his or her experiences related to responses from friends, family members, and partner(s) and on navigating the service network. You can use the following probes:
 - What was it like when you first learned your HIV-positive status?
 - What experiences have you gone through during that period?
 - How have you handled the challenges you have faced?
 - Where or from whom have you received support?
 - How are you doing today in comparison to the time when you were diagnosed?

Ask: What has this person told you about his/her experience living with HIV?

3. **Introduce** the main concepts of Positive Health, Dignity, and Prevention. (You can use the optional PowerPoint presentation or **Handout 15, Positive Health – Dignity – Prevention**, to guide your discussion, but wait until the end of the session to give the handout to the group.)

Say: *Positive Health, Dignity, and Prevention approaches aim to increase the self-esteem, confidence, and ability of HIV positive people to care for themselves and to avoid passing HIV on to others. People's perceptions of risk may change when their health improves; reinforcement of prevention messages is an important part of working with people living with HIV beneficiaries. Peer navigators should provide their beneficiaries with accurate information on:*

- a. **Risk of sexual transmission**
 - b. **Appropriate methods of protection and provision of supplies**, including:
 - Condoms and lubricants
 - Clean needles and syringes
 - c. **Available services, including:**
 - Antiretroviral treatment
 - Psychosocial support from trained staff
 - Referral to other relevant services in the community (support for violence prevention and response, drug/alcohol rehabilitation, diagnosis and treatment of sexually transmitted infections, mental health)
4. **Ask** the participants to break into three groups and ask each group to discuss and record their thoughts on one of the following questions.
- a. What should people living with HIV know about prevention of HIV transmission?
 - b. What are some key messages for prevention from people living with HIV to HIV-negative individuals?
 - c. What are some of the issues serodiscordant couples need to consider?
 - d. What are some of the essential services that people living with HIV need to maintain healthy lives and ensure prevention of onward transmission?

After a few minutes, ask the groups to come back together and ask one member of the group to report on the issues they raised. Make sure all points are addressed, based on the information in the handout.*

5. **Distribute Handout 15, Positive Health – Dignity – Prevention**, and recommend that the participants review the principles of the approach on their own time.
6. **Summarize** the session. Peer navigators have an important role in supporting their beneficiaries to live positively and with dignity, to help prevent onward transmission to their sexual partners and (for people who inject drugs) peers, and to access relevant prevention and referral services in their communities.

NOTE: Even though it is likely that most, if not all the people in the room will be living with HIV, use caution in asking people to identify themselves as living with HIV. If a participant has disclosed his or her status earlier in the training, then facilitators may ask him or her privately if he or she would like to share some of his or her

16. INTRODUCTION TO ANTIRETROVIRAL THERAPY	
Time	Objectives
40 min	<ul style="list-style-type: none"> Participants will understand the basics of antiretroviral therapy (ART) and will know how to communicate how it works.

Prep! *Review Handout 16, Introduction to Antiretroviral Therapy, and make sure you are comfortable with the information and concepts within. The handout serves as the detailed notes for this session.*

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 16. Introduction to Antiretroviral Therapy**
- ☐ **Handout 16. Introduction to Antiretroviral Therapy**

PROCESS:

1. **Provide** copies of **Handout 16, Introduction to Antiretroviral Therapy**, to each participant and explain that you will be going over the main points in the handout during this session.
2. Use flipchart paper or the optional PowerPoint presentation, **Introduction to Antiretroviral Therapy**, to introduce and discuss the basics of ART and associated diagnostics. To prepare for this session, you may wish to review the information in **Handout 16, Introduction to Antiretroviral Therapy**. You can also use the handout to guide the discussion.
3. **Ask** the participants what remaining questions they may have and do your best to provide answers. Be sure to put questions in the Parking Lot if you are not able to provide answers during the discussion.
4. **Role play:** Ask the participants to split into groups of three. Ask each group to select one person to explain to the other two what ARVs are and how they work, as if explaining the subject to a beneficiary. Encourage the individuals playing the beneficiaries to ask common questions, even if the answers are challenging.
5. **Plenary discussion:** Ask the groups how the sessions went. What was easy? What was challenging? Where do they need more support or practice? What answers do they need to obtain to address common questions?

NOTES:

This session is an overview of ART and is not intended to be clinically exhaustive. Peer navigators should know the basics, but beneficiaries will still need to refer to their clinical providers for details. Facilitators should gauge to what degree peer navigator trainees are interested in learning more in-depth about ART, and then adjust this session accordingly. Facilitators may also find it necessary to review the basics of HIV before delving into a discussion about ART.

17. ADHERENCE TO TREATMENT – THE <i>LIFE STEPS</i> APPROACH	
Time	Objectives
50 min	<ul style="list-style-type: none"> Participants will understand why it is important to initiate and remain on treatment. Participants will know how to use the <i>Life Steps</i> approach to support beneficiaries to adhere consistently to their treatment regimens.

MATERIALS:

- ☐ Flipchart
- ☐ Markers
- ☐ PowerPoint Presentation 17. Adherence to Treatment – the Life Steps Approach
- ☐ Handout 17. Adherence to Treatment – the Life Steps Approach

PROCESS:

- 1. Begin by reviewing** why it is critical for beneficiaries to remain adherent to their treatment regimens. Ask if anyone would like to share his or her experience providing adherence support or counseling to someone living with HIV or managing another chronic illness.
- 2. Present PowerPoint Presentation 17, Adherence to Treatment – Life Steps Approach,** and facilitate a discussion on the model and the various steps.
- 3. Role play:** Split the participants into groups of two. Ask one member in each group to choose two steps in which she or he has faced or still faces challenges in adhering to his or her regimen. Have the other member role-play a counseling session with his or her “beneficiary” using the *Life Steps* approach and ask them to come up with strategies to overcome those barriers.
- 4. Plenary:** Facilitate a discussion on observations and reactions to this approach, and how participants envision using the approach to support their beneficiaries.

NOTES:

This session covers one of the most important roles of the peer navigator, and one that may have the strongest effect on beneficiary outcomes. The approach places beneficiaries in the driver’s seat and empowers them with the skills to identify and address barriers on their own. The entire *Life Steps* tool is provided with the LINKAGES Peer Navigation Toolkit. If there is sufficient time, it may be more effective to role-play through the entire tool, which will ensure that peer navigators leave the training with more experience in counseling through the steps.

Treatment adherence

“Treatment adherence” means taking your HIV drugs when and how you are supposed to. Treatment adherence is important because it affects how well one’s HIV medications decrease one’s viral load. The lower one’s viral load, the healthier one is likely to be. Near perfect adherence is needed to fight HIV successfully.

Near perfect adherence means taking the prescribed dose of medication at the same time every day at least 95% of the time.

Adherence also helps to prevent drug resistance. If you skip a dose of your medication, the virus may begin producing more of itself. When you skip many doses, you may develop strains of HIV that are resistant to the medications you are currently taking — and possibly even to medications you haven't taken yet. If this happens, it could leave you with fewer treatment options.

- Once a patient develops resistance to his or her first line of treatment, she or he may be switched to a second-line ART regimen. Generally, there are no further regimens available after second-line therapy.

Things that beneficiaries can do to help with adherence:

- Develop a treatment plan.
- Understand why adherence is important.
- Learn possible side effects and how to manage them.
- Discuss barriers to taking the medications with his or her peer navigator so that they can work out a solution together.
- Schedule taking medications around daily routines, which can make it easier to remember and stick to the regimen. For example, take the medication at the same time each day and keep it in the same place. Use mobile app reminders.
- At the beginning of each week, put the week's worth of medication in an organized box. Use the organizer to help plan for the week and adjust for possible changes in routine, such as holidays or vacations.

Watch your supply of medication and get enough to last between trips to the clinic.

18. DIFFERENTIATED SERVICE DELIVERY	
Time	Objectives
60 min	<ul style="list-style-type: none"> Participants will understand the concept of differentiated service delivery. Participants will understand how to use a differentiated service delivery approach to optimize support for their beneficiaries.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Tape
- ☐ Optional **PowerPoint Presentation 18. Differentiated Service Delivery**
- ☐ Handouts:
 - ▶ **18.1 Differentiated Care JUMBLE**
 - ▶ **18.2 Differentiated Service Delivery**

PROCESS:

1. Begin the session by asking the participants a few questions about beneficiary needs.

Ask: *Do you think that beneficiary needs are likely to change over time? Is it possible for someone to begin the navigation process needing minimal support, and over time potentially needing much more? In what situation might this happen? Should navigators provide equal time and support to each beneficiary? Why? Why not?*
2. **Explain** the concepts of differentiated service delivery using the talking points below. Use the PowerPoint presentation or a flipchart and markers to facilitate a discussion. Do not discuss the differentiated care tables, because they will be the basis for the following exercise.
3. **Differentiated care JUMBLE:** Ask the participants to split into two teams. Hand each team a set of the **Differentiated care JUMBLE** blank tables and pre-cut rows (page 2 of **Handout 18.1**). The tables will serve as models for how the teams should develop their own tables using large flipchart paper (see below).
4. **Explain** that the teams will have 20 minutes to design their own tables on flipchart paper (in large format) and to determine how to fill in the tables using the pre-printed options. Note that some jumble cards are duplicated because they show up in more than one table. Let the participants know that it's okay if they aren't sure where the cards go, and that you will have a chance to discuss the outcomes as a group at the end of the exercise. Ask if there are any questions, provide answers, and begin the exercise.
5. **Plenary:** Bring the groups back together and ask one of the groups to present their table. Ask the other group if there was anything different in their table, and give them a chance to explain. Facilitate a discussion about the tables using the standard SOPs modified for the local context, and address any questions or concerns. Use the completed tables in **Handout 18.2, Differentiated Service Delivery**, to guide the discussion and ensure the tables are filled in appropriately.
6. **Distribute** a copy of **Handout 18.2, Differentiated Service Delivery**, to each participant and ask if there are any questions.
7. **Summarize** the session.

NOTES:

The notes in **Handout 18.2, Differentiated Service Delivery**, serve as the detailed notes for this section.

WHO Clinical Staging of HIV/AIDS and Case Definition

The clinical staging and case definition of HIV for resource-constrained settings were developed by the World Health Organization in 1990 and were revised in 2007. Staging is based on clinical findings that guide the diagnosis, evaluation, and management of HIV, and it does not require a CD4 cell count or a viral load measurement. Clinical stages are categorized as 1 through 4, progressing from primary HIV infection to advanced AIDS. These stages are defined by specific clinical conditions or symptoms. For a complete list of Stage 3 and 4 conditions and symptoms, refer to the following website:

<https://aidsctc.org/guide/hiv-classification-cdc-and-who-staging-systems>

19. COMMUNICATION SKILLS	
Time	Objectives
60 min	<ul style="list-style-type: none"> Participants will understand the purpose and benefits of good communication Participants will be able to describe and use a few skills to enhance communication with their beneficiaries.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Handouts:
 - ▶ 19.1 Optical Illusion
 - ▶ 19.2 Cash Register Exercise
 - ▶ 19.3 Communication Skills
 - ▶ 19.4 Types of Communication
 - ▶ 19.5 Definition of Active Listening – Barriers to Effective Communication
 - ▶ 19.6 Effective Communication Strategies
 - ▶ 19.7 Active Listening Strategies
 - ▶ 19.8 Closed – Open-Ended – Focused Questions
 - ▶ 19.9 Paraphrasing

PROCESS:

1. **Icebreaker #1:** Pass out **Handout 19.1, Optical illusion**, to each participant and ask the participants what they see. Responses might vary from a young girl looking sideways to an old woman looking toward the foreground. The point of this activity is that everyone does not see the same thing, and in this case, there can be more than one reasonable interpretation. Communication is key to understanding one another.
2. **Icebreaker #2: Distribute Handout 19.2, The Cash Register Exercise**, to each participant. Ask them to read the instructions, and then give them 5 minutes to complete the exercise in pairs. After everyone has completed the exercise, ask the participants to tell you for how many questions the answer was “?” (meaning not enough information).

Tell them that the answer for #3 is false and for #6 true, and that the rest of the answers are “Not enough information.” Discuss with the group why this is the case.

Say: *As human beings, we sometimes prefer to fill in the blanks, instead of asking questions to get a clear understanding of what is going on. This exercise helps demonstrate the importance of using our communication skills to get more information and the potential risks of making assumptions.*

3. Continue the session by explaining that communication involves sharing information by listening and giving feedback.

Say: *For good communication, you need to use your:*

- *Eyes – see other’s facial expressions, make eye contact*
- *Ears – be attentive by concentrating on what is being said; be impartial and don’t form an opinion, just listen*
- *Mouth – reflect back, acknowledge the speaker’s reaction, and summarize what has been said.*
- *Mind – to soak it all in*
- *Heart – Listen with sensitivity and compassion*

4. Distribute **Handout 19.3, Communication Skills**, to each participant.

5. **Say:** *We’re going to look at six specific communication skills that we can use in any situation, with anyone. As we go along, you may wish to complete your Communication Skills worksheet. The first communication skill is **Affirming**.*

Ask: *What does “affirming” mean? Allow one or two responses.*

Affirming is a positive confirmation. When you affirm something that someone has done or said, you are providing them with support and encouragement. This is simple, yet many of us forget to do it.

Ask: *What are some examples of affirming statements? Allow three to four responses and write them on a flipchart. Examples might include:*

- “That’s good.”
- “I’m glad you asked that.”
- “You’ve come to the right place.”
- “That’s a great question.”
- “You’re on the right track.”
- “You really seem to have given this a lot of thought.”

6. The second skill is **Open-ended Questions**.

Ask: *What’s an open-ended question?*

Open-ended questions are questions that can’t be answered by “yes” or “no.” Why are they useful? We get much more information from people; participants “own” the information they’re learning; and open-ended questions are a powerful teaching tool.

Ask: *What are some examples of open-ended questions that you would use when getting to know someone and where they come from?*

As participants come up with questions, if they ask a closed question, simply answer “yes” or “no” and move on. When they come up with open-ended questions, write the first word of the question on the flipchart, until you have the following list:

- When
- Where
- How
- Who
- Why

- Tell me more ... also counts, even though it's not really a question, because it still elicits more information.

Tell participants that these are all words that open-ended questions usually begin with. We want our peers to feel comfortable talking and clarifying when needed, so we use open-ended questions as much as possible, such as:

- *What would you like to share?*
- *Tell me a little about how you've been feeling?*
- *Tell me how I can help you.*
- *I'm not sure if I fully understand what you mean. Could you tell me a little more?*

Ask: What about “why” questions? What are the possible negative connotations of why questions?

Even though they can be open-ended, “why” questions may sound like a judgment.

Example: “Why does that scare you?”

Ask: How else could you ask this question?

(Example: “What about that scares you?”)

Explain: Let's practice changing some “why” questions.

Ask participants to listen to each question and think of a different way to ask it. Ask if anyone has some thoughts on how they might reword the question with a different format. Use the “Better” examples below each “why” question if necessary to help participants think about alternatives. The “why” questions can be listed on flipchart paper with alternatives written next to or below them.

- “Why are you feeling frustrated?”
Better: What is it that is making you feel frustrated?
- “Why don't you want to do that?”
Better: What are your reasons for not wanting to do that?
- “Why are you here?”
Better: What brought you here today?
- “Why don't you want to go to the hospital?”
Better: What are your reasons for not wanting to go the hospital?
- “Why don't you want to go back to your family in the village?”
Better: What are your reasons for not wanting to return to your village?

Ask: What are some terms we should stay away from because they will give us yes or no responses and very little information?

- Could you
- Would you
- Should I
- Can you
- Do you
- Are you

7. The next skill is **Active Listening**.

Ask: *What do you think it means to listen actively?*

Using your eyes, ears, mouth, heart, and body language to listen. This is especially important if someone is showing some strong feelings, including feelings of sadness, shock, anger, frustration, or grief.

Ask: *If a beneficiary is having one (or more) of these feelings, how easy will it be for him or her to take on new information, problem-solve, or set goals?*

Not so easy. So, what can we do to help him or her to let go of these feelings, so that she or he can be more open? One simple and effective way to help someone let go is to name the feeling, by saying something like, “you seem _____ (upset/frustrated/sad,” etc.).

Ask: *Why does this work?*

We let the person know it's okay to have feelings; we give him or her permission to express those feelings and to let them go if needed.

Ask: *So, why can it be hard to listen actively?*

We tend to want to “fix” the situation when someone is having uncomfortable feelings. But sometimes what is most helpful is just letting the person speak and guiding them through the process.

8. The next skill is **Nonverbal Messages**.

Ask: *what are nonverbal messages?*

- Posture: let your body show that you are interested by sitting up and leaning toward the speaker.
- Equal positioning: if the speaker is standing, you stand. If the speaker is sitting, you sit as well.
- Facial expression: remember that feelings are reflected in facial expressions.
- Gestures: your body language reveals a lot about how you interpret a message, so be aware of when you send signals that might cause the speaker to believe that you are angry, in a hurry, or bored, etc.

It is also important to remember that different cultures have different styles of body language. For example, in many cultures it is considered rude to make eye contact with someone who is older than you.

9. The next skill is **Express Thoughts and Feelings**.

Ask: *How do we express thoughts and feelings in a way that supports our beneficiaries?*

- Be open and honest: this will help build trust.
- Speak clearly: don't mumble and don't talk too quietly. If you don't know the word for something, describe what you mean so that you and the beneficiary can have a shared understanding of your concern or question.
- Make the distinction between facts, beliefs, and feelings. For example, which of the following statements are which? “The best medical regimen for all beneficiaries is ...” (belief) “I'm so pleased

^aAdapted from Building blocks to peer success: A toolkit for training HIV-positive peers. Boston: Boston University School of Public Health; 2009.

you've been taking your meds." (feeling) "Most people living with HIV experience ..." (fact)

10. The last skill is to **Communicate Without Making the Person Feel "Wrong."**

Ask: *How do we do this?*

- Express concerns nonjudgmentally: talk about your questions or concerns without blaming other people. For example, you might be angry that your beneficiary stood you up three times in a row. Rather than talk about her being irresponsible, you can ask her what stopped her from showing up.
- Use "I" statements. Rather than saying, "You didn't explain that very well," say, "I didn't understand what you just said. Please explain it again."

11. Time permitting, go through each of the remaining handouts for this session with the participants. You may wish to give them time to read each, and then fill in the exercises in handouts 19.8 and 19.9 together. (depending on the interest/capacity of the group). If possible, reconvene and go over each of the additional skill sets and answer any questions. Review of these skills will be necessary for the practical exercise in the following session.

12. Summarize the session: Using these skills may feel artificial and awkward at first, but with practice, they come more easily. Practice is critical! Practicing with children is a great way to try the skills out, since you're less likely to be self-conscious. We will have a chance to practice these in another session.

20. ACTIVE LISTENING AND COUNSELING

Time	Objectives
45 min	<ul style="list-style-type: none"> Participants will be able to demonstrate the importance of communicating clearly with others. Participants will understand how easy it is to miss what others are saying and will discuss what that means for communication.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Four notecards to be attached to separate sheets of flipchart paper with the following written on them:
 - ▶ What is counseling?
 - ▶ What is not counseling?
 - ▶ Objectives of counseling
 - ▶ Client-centered approach (to counseling)
- ☐ Handouts:
 - ▶ **20.1 Helpful Communication Techniques**
 - ▶ **20.2 Communication Stoppers**

PROCESS:

1. **Introduce** the session by noting that peer navigators need strong active listening and counseling skills to meet the needs of their beneficiaries.
2. **Tape** the four notecards on four different flipchart papers, and facilitate a group brainstorm on each, recording the group's inputs. Refer to the notes on counseling below to ensure that the critical elements of counseling are addressed.
3. **Facilitate** the Telephone Game.

THE TELEPHONE GAME ⁶

- **Think** of a statement to use in the game, or use the following: "Yolanda's aunt shared her secret sweet potato pie recipe with me."

Say: We are going to do an activity called the Telephone Game. Some of you may have heard about or played this game before. I have a statement that I am going to whisper into (NAME OF FIRST PERSON)'s ear. S/he is going to whisper the statement into (NAME OF SECOND PERSON)'s ear, and so on. **[NOTE: Designate either a clockwise or counter-clockwise direction.]** The trick is that a person can say the statement only once. No repeating is allowed! Whatever you hear, pass along the statement the best you can to the next person. The last person will be (name of last person). When the statement comes around to that person, s/he will say aloud what s/he heard.

- **Begin** the game. Whisper: "***Yolanda's aunt shared her secret sweet potato pie recipe with me***" (or another statement) in the first person's ear. The first person whispers what she or he has heard in the second person's ear. This continues around the circle until the last person has heard the statement.

- **Ask** the last person say aloud what he or she has heard. Then state the original phrase. Compare what the last person heard to the original statement.

4. Discuss the activity.

- *How is it that (last person) heard “..” when the original statement was “..”?*
- *How often do messages change like this in everyday life?*
- *What rules of the game were responsible for the changes in the statement?* (possible answers: whispering, no repeating)
- *When people are really paying attention to you, how do you know?*
- *What are some ways they sit?*
- *What are some ways they talk? What are some ways they look at you?*
- *What does it feel like?*

5. Facilitate a discussion on communication skills. (20 minutes) For effective communication to take place, both the speaker AND the listener must actively participate. **Ask:** *What are some reasons you might not always give your full attention to a speaker?* **[NOTE: Record participants’ ideas on flipchart paper.]**

Possible responses include:

- No time to listen to everything a person says
- Multitasking — doing more than one thing at a time
- Other tasks seem more important
- Judgments interfere —you don’t agree with what the person has done or is talking about
- Personal agenda — you want to push your solution

Say: *Now, what risks do these “communication stoppers” pose to the peers you are trying to educate?*

Possible responses include:

- Listeners feel alienated.
- They don’t feel supported.
- Trust could be compromised.

Say: *Let’s take a few minutes and talk about what makes an effective communicator. Think of someone who you think is a “good” communicator.*

[Give participants 30 to 60 seconds to think of an example, 60 seconds to discuss each of the following questions.]

Ask: *What are some things this person did well? How did this person make you feel when she or he listened to you?*

Ask: *How willing were you to share things about yourself or your problems with this person?*

Ask: *What are some communication skills you valued in this person?* **[Write responses on flipchart.]**

Possible responses include:

- Attentive to feelings
- Nonjudgmental
- Available
- Fair
- Interested

Say: *We have discussed the importance of good communication skills. We will spend more time practicing listening and attending, and paying attention to what helps and what blocks communication with others.*

6. Distribute the 20.1 Helpful Communication Techniques and 20.2 Roadblocks to Communication Skills handouts and discuss them if there is time.

Say: *It is important for peer educators to develop good listening skills. Mistakes in clear communication are easy to make.*

7. Summarize the session.

NOTES:

Counseling is:

- The process that occurs when a beneficiary and counselor set aside time to explore difficulties, which may include the stressful or emotional feelings of the beneficiary.
- The act of helping the beneficiary to see things more clearly, possibly from a different viewpoint. This can enable the beneficiary to focus on feelings, experiences, or behavior, with a goal of facilitating positive change.
- A relationship of trust. Confidentiality is paramount to successful counseling. Professional counselors will usually explain their policy on confidentiality and professional ethics. They may, however, be required by law to disclose information if they believe that there is a risk to life.

Counseling is not:

- ⊗ Giving advice
- ⊗ Judgmental
- ⊗ Attempting to sort out the problems of the beneficiary
- ⊗ Expecting or encouraging a beneficiary to behave in a way in which you may have behaved when confronted with a similar problem in your own life
- ⊗ Getting emotionally involved with the beneficiary
- ⊗ Looking at a beneficiary's problems from your own perspective, based on your own value system

Effective counseling reduces confusion and allows beneficiaries to make decisions leading to positive changes in their attitudes and/or behaviors. It is not giving advice, or acting on someone else's behalf. The ultimate aim of counseling is to enable the beneficiary to make his or her own choices, reach his or her own decisions, and act upon them accordingly.

21. PRACTICUM - LISTENING TO OTHERS	
Time	Objectives
30 min	<ul style="list-style-type: none"> Participants will have practiced different types of communication skills.

MATERIALS:

- ☐ Handout 21. Interview Checklist

PROCESS:

- Ask** the participants to break up into groups of three. Tell them that they will now practice interviewing each other, integrating many of the communication techniques that were discussed in the previous exercises. Remind participants that these are difficult skills and this is a safe space in which to practice them a little.
- Distribute** copies of **Handout 21, Interview Checklist**, to all participants. Explain that each person will have a chance to be the interviewer, the interviewee, and the observer. Groups need to decide for the first go-round who will play each role.
- Explain** the following:
 - Only the observer needs to use the handout.
 - The role of the interviewer is to discover information about the interviewee's life. The interviewer can ask about his or her history, passions, inspirations, challenges that he or she has overcome, etc. The interviewer should try to use the active listening techniques that have been discussed and can look to the interview checklist for a review. (Acknowledge that they may use all or only some of the techniques you have discussed today.)
 - The role of the interviewer is to respond to the interviewee's questions. Whenever the interviewer asks a closed-ended question, she or he should respond with "yes" or "no."
 - The role of the observer is to watch the interview and note on the Interview Checklist whether or not the interviewer is using active listening techniques and to list examples of the use of such techniques.
 - Interviewers will spend 3 minutes conducting the interview. Afterwards, both the observer and interviewee will have 1 minute to give feedback to the interviewer. Participants should rotate roles until everyone has been the interviewee, interviewer, and observer.
- Bring** the participants back to the larger group and get feedback on how the exercise went.

For the interviewers: How difficult was it to use those active listening techniques?

For the interviewees: How well did you feel that they were being heard by your interviewers?

For the observers: What were some of the ways the interviewer was successful in making the interviewee feel comfortable and encouraging him or her to talk?

For all: What active listening strategies do you feel comfortable using with beneficiaries? Which ones do you think you still need to work on?

Summarize the session.

22. INTRODUCTION TO DISCLOSURE

Time	Objectives
45 min	<ul style="list-style-type: none"> Participants will be able to discuss the basics of HIV disclosure.

MATERIALS:

- ☐ Flipchart and markers
- ☐ **Handout 22. Telling**

PROCESS:

1. **Prepare** ahead by writing the following on four separate flipchart sheets and placing them on the wall in such a way that all participants will be able to see them (each of the following letters corresponds to what should be written on a single sheet of paper):
 - a. Who, What, Where, When, How
 - b. **Role of Peer Navigator:** a) Listen; b) Support; c) Encourage; d) Suggest; e) Provide; f) Share your own experience
 - c. **Unsafe disclosure:** a) Pressured by a friend or loved one; b) Under the influence of drugs or alcohol; c) Not honest with self about the situation; d) Needed something; e) Violent situation
 - d. **Safe Disclosure:** a) You make the choice: the place, the time...; b) You are sober, calm; c) You have information/phone number to give if there are any questions and you are ready to answer and/or discuss HIV; d) You have someone to talk with who can support you; e) You thought it through carefully; f) You take your time; g) You have a trusting relationship with the other person; h) You know why you wanted/needed to disclose your status to this person
2. **Lead** a brief discussion on the importance of thoughtful disclosure.

Say: "Disclosure" means telling someone about one's HIV status. Conversations about HIV disclosure are important, and as peer navigators, you should be prepared and mindful of how you can help your beneficiaries with this process. Whom to tell, and how to tell can be a complex and personal decision, with which your beneficiary will likely need help. There is no best way to tell someone, just as there is no sure way to know what their reaction to the news will be. You cannot tell your beneficiaries what to say or whom to say it to, but you can provide them with support and resources that may help them in the process. You can provide your beneficiaries with some questions they should ask themselves before disclosing. (Move to Step 3 for the questions, as marked on the flipchart paper.)
3. **Acknowledge** the question words that you have written on the flipchart, and note that these are all specific questions to consider when disclosing one's status. Then review the supportive roles of the peer navigator.
4. **Facilitate** a discussion about safe versus unsafe disclosure using the pre-written flipchart papers.

5. **Distribute** a copy of **Handout 22, Telling**, to each participant. Ask the participants to write their answers to the first two questions only on the worksheet. Ask the group to break into pairs and ask one person in each pair to tell his or her partner about a safe disclosure experience and the other person to tell his or her partner about an unsafe disclosure experience.

Say that each person has about 2 minutes to share a story. While one person talks, the other person should practice listening without interruptions. Remind the participants of the importance of safety and say that each person should share only what they are comfortable sharing.

Begin the exercise, and after 5 minutes, ask the pairs to switch and repeat. After another 5 minutes, ask them to stop.

6. **Reconvene** the group and lead a discussion by asking the following questions:

- How easy or difficult was it to share the good experience you had? Why?
- How easy or difficult was it to share the not-so-good experience you had? Why?

Emphasize that what you are not concerned about what happened, but how it happened. That is, you're not asking them to share their stories with the group, but to think about what they did that helped make this a good experience for the person telling the story.

Emphasize that safe disclosure requires more time and work from a person than unsafe disclosure.

Acknowledge that we have all made choices we felt were right, and those we would have done differently, in disclosing something at one point in our lives. This applies to other kinds of personal information, not just HIV.

7. **Ask** the group to look at their "Telling" handouts, and to write their answers to the last two questions on the worksheet.
8. **Wrap up** by reminding the group that making decisions about disclosure is a lot like making other decisions in our lives. We have excellent tools for making sound decisions, and their beneficiaries do, too. Note that you will be discussing the benefits and risks of disclosure in the next session.

23. THE BENEFITS AND RISKS OF DISCLOSURE

Time	Objectives
45 min	<ul style="list-style-type: none"> Participants will be able to identify the benefits and risks of disclosure.

MATERIALS:

- ☐ Flipchart and markers
- ☐ Handouts:
 - ▶ 23.1 HIV and Disclosure
 - ▶ 23.2 Who Needs to Know You Are HIV+
 - ▶ 23.3 Disclosing to Loved Ones
 - ▶ 23.4 The Benefits and Risks of Telling Others About Your HIV

PROCESS:

1. **Ask:** the participants what some of the benefits of disclosure are. Allow responses.
 - Telling others about one's status may take pressure off and relieve stress. This can help one stay healthy.
 - Emotional support
 - Relief from the burden of secrecy
 - Connecting with others who are living with HIV
 - Controlling one's own disclosure on one's own terms
2. **Ask:** participants what some of the risks of disclosure are, especially for key populations. Allow responses and ensure that the following points are covered.
 - Potential of stigma, violence, and abandonment, often at the hands of the people closest to them
 - Rejection, discrimination, and loss of privacy and confidentiality
 - For members of key populations in particular, confidentiality of medical information, including HIV status, is essential to the protection of their human rights, because they often face elevated risks if their domestic partners, families, or communities discover that they are HIV-positive.
 - People living with HIV may also face significant guilt if they believe they may have transmitted HIV to a sexual partner.
3. **Ask:** *What are the roles of a peer navigator when supporting a beneficiary through disclosure?*

Responses can include:

- Listen to concerns and fears.
- Reaffirm that is okay not to disclose.
- Help the beneficiary process why she or he should disclose and what she or he wants to come out of it.
- Offer non-directive suggestions instead of telling the beneficiary what to do and how to do it.

- Avoid using legal issues and scare tactics to persuade the beneficiary to disclose.
- Encourage the beneficiary to reduce his or her risk of harm.

Ask: *What is the best thing to do when a person tells you that she or he wants to disclose to someone?* [Possible answers include: ask if the person has a private place where the disclosure can take place, ask the person if she or he feels safe disclosing, and prepare the person for possible reactions.]

Say: *Peer navigators should encourage their beneficiaries to consider several things before disclosing to someone.* These include:

- What do you need most from the person you are telling? Have the beneficiary think about how this person knowing can help the situation or make it worse.
 - Whom are you most comfortable telling? Have the beneficiary think of someone who can support them in a nonjudgmental way while coping with his or her own feelings.
 - How important is privacy to you? Have the beneficiary consider how the person she or he is considering disclosing to regularly deals with others' confidential information.
 - Prepare for reactions. Have the beneficiary consider if the person might get upset. The beneficiary might also provide written information on HIV to the person.
 - Where will you tell? Have the beneficiary choose a place that is comfortable and provides enough privacy.
 - What are some of the risks? Have the beneficiary think about the risks associated with disclosing, such as telling someone who might become violent.
4. **Briefly review** the handouts provided with this session and answer any questions. Note that the last handout is a brochure that can be provided to beneficiaries to help them with making decisions on disclosure.
 5. **Summarize.** Disclosure is a personal choice, and everyone has unique experiences in disclosing. Peer navigators need to respect the decisions that their beneficiaries make about disclosure.

24. PEER NAVIGATION IMPLEMENTATION – CLIENT FLOW

Time	Objectives
60 min	<ul style="list-style-type: none"> Participants will understand how beneficiaries optimally move through the service continuum. Participants will have a basic understanding of key collaborators within the service network.

Prep! *It is critical to have a clear understanding of client flow for the program before facilitating this session. LINKAGES recommends that all programs develop a diagram that outlines clearly how beneficiaries move through the service continuum. It will help to have such a diagram in advance of this session to help clarify client flow during the discussions.*

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Draft local **Directory of Services** [if developed/available — copies for all participants preferred]
- ☐ **Client flow diagram – large format** (*Each program should have developed a country/program-specific client flow algorithm in advance of the training that includes major service providers and clarifies how beneficiaries move between services at facilities and in the community.*)

PROCESS:

1. **Ask** the participants to break into three to four groups, and provide each group with flipchart paper and markers.
2. **Instruct** each group to come up with a list of key service providers and facilities that a beneficiary might need to access at any point in time, depending on clinical, diagnostic, psychosocial, legal, violence prevention and response, and other needs.
3. **Explain** that once the groups have come up with a list, they should create a visual client flow diagram that shows how a service beneficiary, once diagnosed with HIV, might move through the network. Allow about 20 to 30 minutes for this part of the session and provide support as needed to guide each group.
4. Once the groups have come up with draft diagrams, ask one group to volunteer to present their client flow example. Thank the group for presenting, and ask if anyone has any questions for the group. Continue with the questions below.
 - a. Are there any services that other groups came up with that we might want to include on this client flow diagram? If so, what would you suggest?
 - b. Did any groups have a different way of diagramming client flow? If so, what was different in your example? [Use the **Directory of Services** and the country/program-specific client flow diagram to fill in any key services that may not have been included.]
 - c. With which service providers in our model do we need to have formal agreements to help facilitate referral and linkage to services?
 - d. What are some of the key roles we discussed that peer navigators play in ensuring beneficiaries effectively navigate these services?

5. **Use** the program's client flow diagram if needed to help clarify any potential missing elements, or to clarify navigation of beneficiaries as they move through the service network.
6. **Summarize** the session.

NOTES:

Effective implementation of peer navigation requires several elements to be in place prior to initiation. One of these elements is a clear understanding of how beneficiaries will flow through the care continuum from the point at which they are diagnosed through ongoing maintenance for treatment adherence and viral suppression. Facilitators should have a clear visual schematic of this client flow to guide the discussions.

Facilitators should also be aware of formal agreements that will need to be established, or are already established, with referral sites, including clinical, psychosocial, and others, to ensure that peer navigator roles within the process are clearly understood and to determine to what degree navigators will have access to beneficiary information. Facilitators should emphasize that confidentiality is critical along the entire continuum, from messaging, to record keeping, to discussing cases in case management meetings.

In some cases, navigators may be based at drop-in centers or community-based organization offices. Others may be based at public-sector facilities. Facilitators should know in advance where navigators will be based and should incorporate that information in this session.

25. PEER NAVIGATION IMPLEMENTATION – MANAGEMENT AND SUPERVISION

Time	Objectives
40 min	<ul style="list-style-type: none"> Participants will understand their specific roles within the network of services available to their beneficiaries, including the role of a navigator within the case management team, and the process for clinical supervision.

Prep! Facilitators will need to work with the program to modify the PowerPoint presentation for this session with up-to-date local information. While the presentation has a structure and many sections filled in, it is incomplete.

It may also help to provide a calendar of regular meetings that are likely to take place, including who will lead, where they will take place, for how long, and what will be covered.

MATERIALS:

- ☐ Flipchart paper
- ☐ Markers
- ☐ Optional **PowerPoint Presentation 25. Peer Navigation Implementation – Management and Supervision** [**NOTE: INCOMPLETE!** To be modified based on local context.]

PROCESS:

1. Begin by re-emphasizing that peer navigation is a set of supportive services that fit within the continuum of care and treatment for people living with HIV. The services are intended to help beneficiaries link to and remain within the network, adhere to their treatment, and ultimately obtain viral suppression.
2. **Review** the concept of case management and discuss the composition of the case management team in the local program context [**NOTE:** This varies by country/program and will need to be determined and clarified in advance of this session.]
3. **Explain** that the peer navigator is a member of the case management team, linked with a community-based organization (and in some cases a facility). Use a visual diagram if possible to show how peer navigators fit within the team. Note that navigators work somewhat independently compared to clinical and nonclinical facility staff. They may meet or talk with service beneficiaries on their own schedules, outside the operating hours of the facilities that the program is collaborating with or supporting.
4. **Explain** that, as with any position on a team, it is important for each team member to know what is expected on a daily, weekly, and monthly basis. Note that the group has already covered peer navigator roles and responsibilities and recommended operating procedures for ensuring beneficiaries receive the support they need based on differentiated care models and individual needs.
5. **Introduce** the concept of supportive supervision and explain that it involves both clinical and operational oversight. Facilitate a discussion for a few minutes on the differences between clinical and operational oversight.

- 6. Facilitate** a discussion about how peer navigation will be operationalized in the local context in terms of supportive supervision, weekly and monthly meetings, reporting, and other key issues. **[NOTE:** The contents of this discussion will depend on the specific operating procedures for operational and clinical supervision of peer navigators in the local context. Facilitators will need to review the local standard operating procedures and projected schedules for meetings with supervisors and case management teams and among peer navigators, in addition to reporting]. Use the notes below to guide adaptation of discussion notes for this section.

NOTES:

Each program should have SOPs for navigation in place prior to this training, or developed shortly after, to ensure that each member of the case management team (including the navigator) understands his or her roles in the context of counseling, referral, linkage, enrollment, retention in care, and provision of professional services such as mental health and drug rehabilitation. The SOPs should explain clearly the process for determining how and when service beneficiaries are assigned to a navigator, rules of engagement, expectations in terms of privacy and confidentiality, focal point collaboration at referral sites, and standards for meeting, referral, support, follow-up actions, and timing. Facilitators should review these SOPs prior to conducting this training session. The SOPs can be introduced by supervisors after navigators have gone through this initial training in small group sessions at sites where the navigators will be based.

Oversight

Each program should have a system for supervision of navigators that includes both clinical and operational oversight. Performance should be monitored using established quality assurance standards and procedures based on the minimum package of services and should be reviewed regularly.

It is up to individual programs to determine scheduling for regular case management, supervisory, and check-in meetings. Programs should also determine a plan for emergency clinical supervision in the case of a crisis (see **3.3.a of the *Peer Navigation Implementation Guide*** for more information). SOPs should outline how navigators can manage their hours, appropriate locations for meetings, and how schedules will be tracked. Ideally, clinical supervision will be available during weekdays and normal hours when navigators meet with their service beneficiaries, though this will depend on each local context. The priority for meeting locations and times should be the safety and security of both navigators and their service beneficiaries.

Operational supervision

Navigators will benefit from having a home base where they can meet with service beneficiaries, other navigators, and supervisors, pick up supplies, register information, and coordinate events. This base can be a community-based organization office, drop-in center, or a government treatment facility. Each site or group of sites should have a designated coordinator who supervises the overall implementation of navigation. The coordinator can be responsible for the following (if a case manager is not assigned these duties):

- Matching navigators with eligible service beneficiaries
- Ensuring that all services are provided in accordance with SOPs
- Supporting navigators to liaise with referral service providers
- Ensuring that program data are collected, recorded, and reported appropriately
- Establishing regular supervision meetings

The coordinator should be familiar with all the services available in the community, focal points from each site, and the SOPs on navigation. She or he should be ready to help navigators address issues related to the operational details of their work, such as scheduling, reimbursement for travel to meetings, management of referral information, and liaison with focal points. Coordinators should keep a daily calendar to track all navigator-beneficiary meetings, whether they are on or off site.

Case management and clinical supervision

Each program should have its own case management/clinical supervision procedures and structure, and agreements with public health facilities and their leaders based on available human resources and services. Nurses or other designated providers can serve as immediate clinical supervisors for navigators. They should help navigators set boundaries with their service beneficiaries and develop methods for dealing with crisis situations. They can also help ensure that clinical support is available for navigators in situations when a licensed mental health worker's assistance is needed.

The case manager, or another individual assigned (such as a supervisor or peer navigator lead), can be responsible for organizing **weekly case management meetings** to review cases, discuss challenges, and brainstorm solutions. Weekly case management meetings can be conducted in groups. During the meetings, navigators can provide rapid overviews of each case they are managing, with the intention of reviewing all cases. Programs may choose to conduct more in-depth discussions of challenging or successful cases once a month, or more often if desired.

Programs may also wish to conduct **weekly or biweekly one-on-one sessions** between supervisors and navigators. These sessions can be an opportunity for supervisors to check in on their navigators, provide encouragement and support, and help them deal with personal issues, including stress, burnout, and any concerns that arise from the job.

26. ADDITIONAL PEER NAVIGATION IMPLEMENTATION TOOLS	
Time	Objectives
40 min	<ul style="list-style-type: none"> Participants will be introduced to the Peer Navigation Implementation Guide and to some of the tools and resources designed to assist them in their work (that have not already been addressed).

Prep! *If local SOPs have been developed for peer navigation implementation, it is critical to include them in this session, if not already addressed. If the SOPs (standard operation procedures) have not yet developed, facilitators should discuss with the program leads when they will be developed and should refer to their development in the training.*

MATERIALS:

- ☐ Copies of the **LINKAGES Peer Navigation Implementation Guide**
- ☐ Local **Directory of Services** (handed out in Session 24)
- ☐ Handouts (copies of appendices from the Implementation Guide):
 - ▶ **26.1 Adherence Counseling Checklist – Initial Visit**
 - ▶ **26.2 Adherence Counseling Checklist – Follow-up Visit**
 - ▶ **26.3 Tool for Transition from Navigation Services**

PROCESS:

1. **Begin** the session by giving a brief overview of the **Peer Navigation Implementation Guide**. Explain that in conjunction with the handouts provided in this training, which offer information and guidance on the various skill sets peer navigators must have, the Implementation Guide serves as a roadmap for implementing the routine tasks that navigators will undertake to support their beneficiaries and function as part of a case management team. More information is provided in the notes below.

NOTE: *The guide and associated SOPs will vary for different countries and programs. Each program should develop its own SOPs, and peer navigators should know them well as part of their job. Facilitators must be sure to obtain and train on the updated local guide and SOPs to ensure their participant trainees learn what will be implemented in their local context.*

2. **Explain** that peer navigators will be responsible for providing support for 20 to 40 people living with HIV. The process for engaging with beneficiaries will usually begin right after or shortly after the beneficiary is diagnosed with HIV. In some programs, peer navigators may also serve as outreach workers and/or lay counselors and testers and may know the beneficiary prior to his or her diagnosis. The specific process should be clarified based on the local context.
3. **Remind** the participants that the primary role of the peer navigator is to identify the needs of the beneficiary for health care and/or other services and to help the beneficiary acquire those services.
4. **Review** what the first and subsequent peer navigation encounters will look like. Refer the participants directly to **Section 3.2 in the Peer Navigation Implementation Guide**, which provides an overview of each of the steps necessary for the first few visits.
 - a. The first meeting is an opportunity to get to know your beneficiary and is usually conducted at a facility

or drop-in center (DIC). Subsequent meetings can be scheduled independently and as needed, and can take place outside of the facility or DIC.

- b.** Peer navigators will work with their beneficiaries in the first meeting to complete an **Intake Assessment** and develop an **Action Plan**.
 - c.** In subsequent visits, peer navigators may work with beneficiaries to conduct **adherence counseling** using the **Life Steps** approach and the adherence counseling checklists, address other issues that require navigator support, provide necessary referrals, or accompany their beneficiaries to a service site.
- 5. Present and discuss the Directory of Services.** Note that it will be the job of the navigator, in collaboration with program staff, to help ensure that the directory is up-to-date.
- 6. Present and describe the adherence counseling checklists.** Explain that the checklists are to be used as guides in conjunction with the *Life Steps* adherence tool to ensure that all adherence-related needs are met. There is one checklist for the initial meeting and one to be used for subsequent meetings. Peer navigators may conduct the *Life Steps* approach with their beneficiaries on the first, second, or third visit, or may stretch it out over a few visits if needed.
- 7. Present and discuss the Tool for Transition from Navigation Services.** This form is particularly relevant for programs whose funding may end soon. All peer navigators should be aware that at some point, they may be conducting a final official visit with their beneficiaries, and there are important steps that need to be taken to ensure their beneficiaries are effectively prepared.
- 8. Allow time** for the participants to go through the forms and ask questions as needed. Explain that they will have a chance to practice using the forms in a mock exercise in the next session, if the time has been allotted for the optional Peer Navigation Practicum.

27. PEER NAVIGATION PRACTICUM – OPTIONAL (CAN BE CONDUCTED THE MORNING OF A FOURTH DAY)	
Time	Objectives
90-180 min	<ul style="list-style-type: none"> Participants will have practiced various elements of peer navigation based on the skills and tools provided in the training.

MATERIALS:

- ☐ Various notecards
- ☐ Pens or markers
- ☐ Optional **PowerPoint Presentation. 27. Post-Training Assessment**
- ☐ **Handout 27. PN Training Evaluation Form**

PROCESS:

1. **Ask** each participant to take 5 minutes to write a sample scenario on a card, based on anything addressed during the training (an initial visit with a peer navigator, adherence support, substance use, violence, discrimination, etc.). Collect the cards.
2. **Split the participants into groups** of two to three, and hand each group a scenario card. Ask the groups to read the scenario, choose roles, and implement a role play where a peer navigator meets with a beneficiary to conduct whatever action or activity is required of the situation. Remind the participants that they have learned various skill sets throughout the week and have various tools at their disposal to guide the process. Note that you will be happy to provide guidance and support as needed in preparation for and during the role plays.
3. Time permitting, **hand each group** a new card and ask them to switch roles and repeat the process.
4. **Switch** cards among groups if there is time remaining.
5. **Walk around** during the role plays to answer any questions.
6. **Bring** the groups back into plenary and discuss how the practice sessions went.
7. Based on the group and the nature of the workshop:
 - a. Summarize the week.
 - b. Optional: Review the Pre-Training Assessment questions using the optional **PowerPoint presentation: 27, Post-training assessment.**
 - c. Provide your contact information.
 - d. Ensure that participants fill out evaluations.
 - e. Conduct a certification ceremony.
 - f. Thank the participants and hosts as appropriate.

NOTES:

This session is important for participants to begin to feel comfortable in counseling sessions and to practice what they have learned. The session will challenge participants to think of realistic situations for their peers and then address them using as many of the techniques presented in the past few days as they can. You may wish to limit the time for scenarios or allow them to stick to one scenario for the duration if the role plays are going well.

APPENDIX 1. CORE MODULE HANDOUTS

HANDOUT 1. SAMPLE TRAINING AGENDA

LINKAGES PEER NAVIGATION TRAINING AGENDA CITY, COUNTRY

Day 1, Month Day, Year	
8:30 AM	Registration
9:00	Introduction to the workshop
9:30	Pre-training assessment
9:50	Introduction to the LINKAGES program
10:10	Break
10:30	Common leaks in the HIV Cascade
11:40	Introduction to Peer Navigation
12:10 PM	Lunch
1:15	Roles and qualities of a peer navigator
2:00	Special considerations in working with key populations
2:45	Confidentiality
3:20	Break
3:40	Ethics in providing peer services
4:20	The importance of boundaries
4:40	Wrap-up
Day 2, Month Day, Year	
9:00 AM	Warm-up and recap of previous day
9:10	Boundaries and confidentiality scenarios
9:40	Pairing with a beneficiary and the first meeting
10:10	Break
10:30	Subsequent meetings – intake assessment, action planning, referral, linkage
11:40	Follow-up meetings – the Minimum Package of Services
12:00 PM	Lunch
1:00	Positive Health, Dignity and Prevention
2:00	Introduction to Antiretroviral Therapy
2:40	Adherence to treatment – the Life Steps approach
3:30	Break
3:50	Differentiated service delivery
4:50	Day 2 Wrap-up
Day 3, Month Day, Year	
9:00 AM	Warm-up and recap of previous day Introduction to the workshop
9:10	Communication skills
10:10	Break
10:30	Active listening and counseling
11:15	Practicum – Listening to others
11:45	Introduction to disclosure
12:30 PM	Lunch
1:30	The benefits and risks of disclosure
2:15	Peer navigation implementation – client flow
3:15	Break
3:35	Peer navigation implementation – management and supervision
4:15	Additional peer navigation implementation tools
4:55	Wrap-up

HANDOUT 2. PEER NAVIGATION PRE-TRAINING ASSESSMENT

Name: _____ Date: _____

Please circle the correct answer, or fill in the blanks per the instructions.

1. TRUE or FALSE: Peer navigators must come from the key population community that they serve.
2. TRUE or FALSE: Peer navigators do not need to be living with HIV.
3. TRUE or FALSE: A peer navigator is the same thing as a case manager.
4. Circle which of the following represents the kind of relationships men who have sex with men can have:
 - a. Long-term monogamous relationships with a primary partner
 - b. Open relationships with a primary partner
 - c. Dating or casual relationships
 - d. Situational same-sex relations: men who live/work in the military, boarding schools, prisons, etc.

5. Please provide definitions for the following:

Sexual orientation

Gender identity

6. Which bodily fluids can transmit HIV?
 - a. Blood
 - b. Semen/pre-cum
 - c. Vaginal fluids
 - d. Breast milk
7. Name the three most common symptoms of sexually transmitted infections:
 - a.
 - b.
 - c.
8. What are three things clients should be provided information on for “Positive prevention”?
 - a.
 - b.
 - c.
9. Which of the following are essential services peer navigators should ensure that people living with HIV (PLHIV) have?
 - a. Antiretroviral treatment (ART)
 - b. Psychosocial support from trained staff
 - c. Adherence counseling
 - d. Referral to relevant services

- 10.** TRUE or FALSE: PrEP is primarily for gay men.
- 11.** TRUE or FALSE: All male condoms can be used with any lubricant made for human consumption, either water- or oil-based.
- 12.** What are two classifications of lubricants?
- a.
 - b.
- 13.** Name the five different classes of antiretroviral (ARV) drugs approved for use in HIV treatment:
- a.
 - b.
 - c.
 - d.
 - e.
- 14.** TRUE or FALSE: A “normal” viral load is under 40 to 75 copies.
- 15.** TRUE or FALSE: Short-term side effects of ART can include anemia, diarrhea, dizziness, fatigue, headaches, nausea and vomiting, pain and nerve problems, and rash.
- 16.** TRUE or FALSE: Treatment adherence means taking your drugs when and how you are supposed to.
- 17.** TRUE or FALSE: Counseling is the same thing as giving advice.
- 18.** TRUE or FALSE: One purpose of “reflecting” is to encourage your beneficiary to continue talking.
- 19.** Name three types of gender-based violence:
- a.
 - b.
 - c.
- 20.** Which types of mental health issues might your clients face? (Circle all that apply.)
- a. Anxiety
 - b. Depression
 - c. Sexual problems
 - d. Eating disorders
 - e. Suicidal tendencies
- 21.** Which of the following is a basic human right? (Circle all that apply.)
- a. Right to work
 - b. Right to privacy
 - c. Right to education
 - d. Right to revenge

HANDOUT 5.1 INTRODUCTION TO PEER NAVIGATION

A **PEER** is a person who shares similar characteristics with another, such as age, social status, ability, profession, or sexual preference.

A **NAVIGATOR** supports someone to know how and where to access and utilize services and to act to ensure positive outcomes for his or her health and wellbeing.

In an HIV program, peer navigators are usually **HIV-positive, medication-adherent role models who understand and can convey clearly how to access and utilize key services for people living with HIV and their partners, loved ones, and children.**

Programs may employ both peer navigators and peer educators. Although they may sound similar, these positions have distinct roles:

- Both peer navigators and peer educators can conduct outreach in the community and can identify, assess, and refer clients based on their health and social needs.
- Peer navigators undergo additional training to ensure that they can help their clients effectively navigate and remain within the service network to ensure positive and healthy outcomes. The additional training provides PNs expert knowledge on facility- and community-based services, counseling skills, and an understanding of the potential needs of their clients.

HANDOUT 6.1

ROLES AND QUALITIES OF A PEER NAVIGATOR

Roles of a peer navigator

While specific services may vary based on the needs of a given program, it is essential that all peer navigators build the trust of their clients without judgment or prejudice. The roles and responsibilities of peer navigators may include the following:

1. Refer and link beneficiaries to clinical, psychosocial, and other support services.
2. Link with health and other social service providers as needed.
3. Support beneficiaries to adhere to their treatment regimens and to attend appointments.
4. Provide counseling and emotional support.
5. Give feedback and support to team members.
6. Maintain the confidentiality of information about the beneficiary, including sexual orientation and medical status.

In general, peer navigators should work with each person to help identify areas of greatest need, develop an action plan to meet those needs, and build the necessary skills so the client can continue to address his or her own needs in the future.

Qualities that make a good peer navigator

- Makes him or herself available
- Is committed to the goals and objectives of the project
- Is sensitive to the values of community
- Is accountable towards the community
- Is tolerant and respectful of others' ideas and behaviors
- Is a good listener
- Has good communication and interpersonal skills
- Is self-confident
- Has leadership qualities
- Is willing to learn and experiment in the field
- Is committed to being accessible to community members at times of crisis
- Shares responsibilities
- Knows how to set boundaries and prevent burnout

HANDOUT 6.2 ROLES AND RESPONSIBILITIES OF PEER OUTREACH WORKERS, NAVIGATORS, AND CASE MANAGERS

	Function	Peer Outreach Worker	Navigator	Case Manager
Community-based	Represents one or more key population(s)	✓	Optional	
	Conducts community outreach	✓		
	Provides commodities, including condoms, lubricants, and/or safe injection equipment	✓	✓	
	Serves as HIV+, treatment-adherent role model	Optional	Preferred	
	Conducts motivational interviewing	✓	✓	✓
	Identifies and assesses health and social support needs of service beneficiaries	✓	✓	
	Links service beneficiaries to HIV testing services	✓	[For partners/families]	
	Links service beneficiaries to other clinical and social support services	✓	✓	✓
	Monitors progress service beneficiaries are making toward goals		✓	✓
	Provides post-test guidance on available diagnostic and clinical services	Optional	✓	✓
Facility-based	Conducts detailed client intake assessment		Optional	✓
	Supports HIV-positive service beneficiaries to complete referrals to clinical services		✓	✓
	Provides routine follow-up for service beneficiaries		✓	✓
	Supports service beneficiaries to maintain treatment adherence		✓	✓
	Supports service beneficiaries to make medical appointments		✓	✓
	Provides guidance and experience on positive living and prevention for sexual partners		✓	✓
	Reviews caseload to identify and track down service beneficiaries lost to follow-up, in coordination with clinical staff		✓	✓
	Provides psychosocial support, supportive counseling, and beneficiary education		✓	✓
	Provides clinical guidance, monitoring, and follow-up			✓
	Conducts case conferencing and crisis intervention			✓
	Advocates for services and conducts consultations with providers			✓

HANDOUT 8.1 GHISLAINE'S CASE STUDY

Ghislaine is a peer navigator living with HIV.

Ana, a female sex worker, has recently tested positive for HIV and was referred to Ghislaine by a social worker named **Carrine** at a local medical clinic.

Carrine refers her clients to Ghislaine when they need a peer navigator, and the two of them sometimes coordinate care for their mutual clients. Carrine is Ana's social worker. Carrine is also Ghislaine's personal social worker—and helps Ghislaine from time to time. Ghislaine and Carrine are, therefore, in two different kinds of relationships. Carrine is Ghislaine's social worker, and the two of them are also colleagues.

Carrine referred Ana to Ghislaine when Ana was a few months pregnant. Ana had recently tested positive for HIV. Ghislaine and Ana met for the first time after Ana's initial HIV clinic appointment. While they were meeting privately, Ghislaine explained peer advocacy to Ana, and disclosed her own HIV status. As soon as Ana found out Ghislaine was also living with HIV, she burst out crying. Ghislaine empathized with Ana's feelings, because she had been there herself. She also reassured her that she wasn't alone, and that many women were living full lives after receiving this diagnosis.

During the first meeting, Ghislaine learned that Ana needed: 1) emotional support; 2) education and information; and 3) support attending appointments. Ghislaine shared with Ana what she could provide. Ana said she would like to get this help from Ghislaine. Ghislaine suggested that they talk and/or meet at least once per week. Ana agreed. Ghislaine filled out an intake and consent form with Ana. Ana agreed in writing that Ghislaine could speak with Carrine and Ana's doctor to help coordinate care for her. They set a follow-up meeting for a week later. The two of them decided that Ana would visit Ghislaine at the drop-in center before a medical appointment to talk. Then, Ghislaine would accompany Ana to her medical appointment for moral support and to help ask questions of the doctor.

After meeting with Ana, Ghislaine touched base with Carrine the social worker to let her know that the meeting went well and she would be helping Ana with emotional support, information, and medical appointments. Carrine thanked her and asked if Ana had also mentioned her unstable living situation. Ghislaine said no. Carrine told Ghislaine that Ana might require help finding a safe place to stay if she was kicked out of the house where she stays with her mother, grandmother, and siblings. Carrine explained that Ana and her mother fight, and the mother had threatened to make Ana leave. Carrine said she was thinking of having a meeting with Ana and her mother, hoping to mediate the conflict and encourage the mother to allow Ana to stay until the birth of the baby. At that point Carrine could find another housing situation for Ana and her baby. Ghislaine, suddenly wondering about the father of the baby, asked Carrine about the father. Carrine replied that Ana told her the father was “out of the picture.” Ghislaine felt overwhelmed about everything she needs to do to help her new client.

In their next meeting, Ghislaine and Ana talked more about HIV, pregnancy, and Ana's fears. Ghislaine mentioned to Ana that Carrine let her know that her living situation was problematic. “She told you that?” Ana said. “She wanted me to know, in case you needed me to help you find a safe place to stay,” Ghislaine replied. Ana seemed to relax, and said, “Oh, okay.” Then Ana asked Ghislaine if she “tells Carrine everything.” “I don't tell her everything, and she doesn't tell me everything either,” Ghislaine said. “What you and I talk about is confidential.” “Honest?” asked Ana. “Honest,” Ghislaine replied.

Then Ana began to tell Ghislaine about her on-and-off boyfriend (the father of the child she is expecting) who is very possessive and sometimes “beats her up.” She said that her mother “hates” him and has banned him from the house. Ana fights with her mother, who disapproves because she often hears Ana talking to her boyfriend on the phone. A few times, Ana has “snuck” him over. Ghislaine feels her emotions rising but remains calm with Ana. She always gets protective toward her client when a client mentions domestic violence, because she had a lot of trouble leaving a husband who was abusive. She makes a mental note to talk to Carrine, her close colleague, supervisor, and therapist, for her own emotional support.

HANDOUT 8.2 SAMPLE CONFIDENTIALITY AGREEMENT

As a beneficiary of _____ and a participant in the _____ Peer Navigation Program, you can expect to receive peer support that is professional, respectful, and trustworthy.

Professional peer support means that you can expect your peer navigator to maintain a confidential relationship with you. She will not share information about you with anyone outside of _____ without your consent. There is, however, an exception to this rule. Confidentiality may be waived if your safety or the safety of someone close to you is in question. If questions of safety arise, she will contact either your case manager or another professional for assistance. In most cases, the peer navigator will let you know if she plans to speak with your case manager.

Respectful peer support means that you can expect your peer navigator to honor your privacy. You may choose to share many personal topics with your peer navigator; however, you need only to share personal information if, and when, you feel comfortable.

At times, she or he may offer advice or suggestions, but your peer navigator will keep in mind that you know what is best for you.

Trustworthy peer support means that you can expect your peer navigator to follow through with the support that she offers to you. He or she will be on time and will listen to you during your time together. Time spent together may include peer counseling, accompaniment to doctor visits, visits to your home, phone check-ins, and other activities as decided upon by you and your peer navigator.

As a client of our organization, you are encouraged to speak with your peer navigator if you have questions, concerns, or complaints about the program.

By signing below, you and your peer navigator are agreeing to the above guidelines. You are also indicating your understanding of the standards inherent in the peer navigator-beneficiary relationship.

Beneficiary:

Print Name _____

Signature _____ Date _____

Peer Navigator:

Print Name _____

Signature _____ Date _____

HANDOUT 9.1 ETHICAL STANDARDS FOR PEER NAVIGATORS

These principles may include but are not limited to:

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

HANDOUT 9.2 PEER NAVIGATOR CODE OF ETHICS AND CONFIDENTIALITY PLEDGE

I value my role as a peer navigator, and to fulfill that role, I will:

1. Respect individual differences, including choices people make that may not be my own.
2. Act as a role model, making healthy choices and being true to myself.
3. Honor diversity in all its forms.
4. Maintain confidentiality.
5. Not allow my peer navigator duties to put my emotional or physical well-being at risk.
6. Not enter into a relationship or become sexually active with a beneficiary.
7. Not coerce or blackmail a beneficiary.
8. Learn as much as possible about the issues that affect my peers.
9. Offer only information that I am qualified to offer, with the greatest accuracy possible.
10. Follow through on my word and promises.
11. Meet clients where they are at in their journey toward healing and positive change.
12. Accept supervision and support from others.

I value and know who I am...

I am an individual, a caring helper, a navigator, and a role model.

I am a peer navigator.

FIRST NAME – LAST NAME (PRINT)

SIGNATURE

DATE

HANDOUT 10.1 CREATING BOUNDARIES

HOW TO CREATE BOUNDARIES	HOW WILL I DO THIS?
Communicate openly with clients.	
Follow through with your promises in a timely manner.	
Address your limitations.	
Seek support from your supervisor.	
Refer, refer, refer.	
It is OK to not know.	
Don't feel pressured to share your story every time.	
Be professional.	
Put aside your personal values.	

HANDOUT 10.2 CREATING BOUNDARIES – ANSWER KEY

HOW TO CREATE BOUNDARIES	HOW WILL I DO THIS?
Open communication with beneficiaries.	Let beneficiaries know what they can expect from you and what you expect from them from the beginning and be straightforward.
Follow through with your promises in a timely manner.	Limit rescheduling or canceling appointments made with your beneficiaries.
Address your limitations.	Let beneficiaries know what you are able to do and what you can't do. Share your roles of peer educator with them at the first meeting. Tell them your hours and how they can reach you.
Seek support from your supervisor.	If you don't know what to do or what is appropriate, make sure to contact other coworkers and peers. Always have supervisor's number on hand for emergencies.
Refer, refer, refer.	You can't do everything, so make sure you have a good, updated list of referrals. Make sure you are personally familiar with the referrals before sending beneficiaries to them. Take the time to visit organizations and find contacts at those referrals. Follow through with the referrals.
It is OK to not know.	Tell the beneficiary you don't know and that you will look into the information. Remember, it is a learning process.
Don't feel pressured to share your story each and every time.	Share what is appropriate, needed, and within your comfort zone.
Be professional.	Be organized, timely, and efficient, and follow-through.
Put your personal values aside.	(Based on discussions)

HANDOUT 11. BOUNDARIES AND CONFIDENTIALITY SCENARIOS

Scenario #1

Read the following scenario and answer the questions that follow.

Anson attends the FPATT clinic for services where you, the peer educator, frequently visit for work. You have seen him in the clinic hallways and have acknowledged him as someone who is likely receiving HIV care, but you have not spoken to him before. You, the peer educator, attend a going away party for a friend, and when you walk in to the restaurant, your eyes connect with Anson's.

- What do you do?
- What do you say and when?
- Is this a confidentiality or boundary issue?

Scenario #2

Read the following scenario and answer the questions that follow.

You have just finished an educational session with your client, Sarah. As you are walking her out she asks, "Can I borrow \$30 to buy some food for my kids to eat? I promise I'll give it to you next week when I get my check."

- How would you handle this situation?
- What else comes up?
- Is this a confidentiality or boundary issue?

Scenario #3

Read the following scenario and answer the questions that follow.

FPATT gets a referral from a polyclinic for a client named Frances Leon who would like to be assigned to a peer navigator. You are assigned to Frances. The name is familiar, but you are not sure that you know the person. You meet with Frances and begin the peer working relationship. Unknown to your supervisor is the fact that Frances is a member of your church and that your partner contracted with Frances to clean your house.

- What issues arise for you?
- What are the steps you should take with this client?
- Is this a confidentiality or boundary issue?

Scenario #4

Read the following scenario and answer the questions that follow.

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

- What issues arise for you?
- What do you do?
- Is this a confidentiality or boundary issue?

HANDOUT 13.1 INTAKE – ACTION PLANNING – REFERRAL - LINKAGE

By the second meeting, you will begin to explore your beneficiaries' specific situation and needs. You will likely be asked to conduct an intake assessment for newly diagnosed beneficiaries, if there is not someone else responsible for this. The tool is designed to collect information about your beneficiary that will help you identify and prioritize actions using a hierarchy of needs (see Figure 1). For example, immediate physical needs, such as personal safety, usually take precedence over emotional needs.

An intake tool is provided with Handout 13.2, Intake Assessment. The form is intended to guide a conversation, rather than to serve as a data collection tool. The assessment includes information about:

- Basic health needs
- Transportation
- Housing
- Employment
- Nutrition
- Current health status
- Access and utilization of health care (including HIV treatment and care)
- HIV risk behaviors and current partners
- Current or recent psychosocial challenges
- Current and recent substance abuse issues

Each beneficiary comes with his or her unique set of strengths, resources, needs, and challenges. When prompted with probing questions, beneficiaries are often capable of identifying what may prevent them from accessing HIV and related services. In the second meeting, you can work with your beneficiary to identify key barriers to access for clinical and non-clinical services and facilitators that may help in overcoming those barriers. You should keep the following questions in mind:

- What does the beneficiary already know?
- What are the beneficiary's attitudes and beliefs?
- How ready is the beneficiary to address his or her challenges/needs?



Figure 1. Maslow's Hierarchy of Needs

You can use the following guidelines to guide your conversation:

1. Ask open-ended questions about the beneficiary's perspective on his or her infection and treatment and what needs she or he may have.
2. Gauge the amount of information the beneficiary can/wants to receive. (Beneficiaries who are newly diagnosed have just received a potentially life-altering diagnosis and are likely to be processing a substantial amount of new information; they may be overwhelmed by too much information.)
3. Provide information in response to the goals, concerns, and problems discussed.
4. Ensure that the beneficiary understands the meaning of the information provided.
5. Conduct the intake assessment (if not already conducted).
6. Work with the beneficiary to establish HIV treatment and care priorities and to schedule medical and diagnostic appointments as needed.
7. Assess whether the beneficiary has adequate social support.
8. Discuss other referral needs and options.
9. Agree on a plan of action for the immediate future (if not already determined with the case manager). See below for more guidance on action planning.
10. 10. Deal with the beneficiary's emotional reactions (and your own).

Modified from: *Quality Assurance Measures for Voluntary Counseling and Testing Services*, IMPACT/AIDS MARK. June 2001

Action plan development

Assessing beneficiary needs may take time, and some beneficiaries may feel more comfortable discussing these after the first couple of sessions. By the **second or third meeting**, you can work with your beneficiaries to develop strategies to ensure they can effectively access the services they need. Information gathered during the assessment can feed directly into the development of an action plan. **Handout 13.3, Action Plan Tool**, provides a structure for identifying all the possible needs a beneficiary may have. Together, you and your beneficiary can prioritize which needs must be addressed immediately and which can be addressed later. If you are developing an action plan during a second, third, or fourth visit, you should begin by reviewing your beneficiary's **intake assessment**.

In developing the Action Plan, you should support your beneficiaries to identify their own needs. You can make suggestions, but prioritization and goals must be based on what the beneficiary identifies and decides. In some cases, beneficiary needs and barriers may have little to do with an HIV diagnosis; navigators should respect their service beneficiaries' choices and do their best to support them. They should assist each beneficiary to develop realistic short- and long-term goals and objectives and to determine appropriate steps and timelines for achieving them. Together, the navigator and beneficiary brainstorm potential challenges and obstacles to these goals and objectives and strategize ways to overcome them.

Linkage to care and treatment

One of your principal roles is to help ensure that your beneficiaries are effectively linked to care and treatment services. Linkage to services should follow the standard operating procedures (SOPs) for your program. At minimum, you will need to ensure that your beneficiaries:

- Have scheduled necessary diagnostic and medical appointments
- Are aware of the location of their appointments, whom they will meet, and what will be done
- Have the means to attend to their appointments on time, including transportation, time off work if needed, and daycare
- Are reminded of their appointments 24 hours before they take place
- Have attended their appointments at the appropriate times
- Are contacted (within 24 hours) about missed appointments

The action plan that you develop with your beneficiary can address potential obstacles for these initial appointments. Adherence counseling and addressing complex issues such as gender-based violence and mental health will be discussed in other sessions.

HANDOUT 13.2 INTAKE ASSESSMENT TOOL

This tool can be used to guide a conversation between you and your beneficiary. It should be completed by the second or third session. The goal is to identify areas where your beneficiary may need assistance in prioritizing and accessing services, and reducing HIV and other STI-related risk behaviors. Remind your beneficiary that all information is confidential.

*Each area is prefaced with a **goal** (in **bold**) and includes probes to assist you in obtaining the information you may need to understand your beneficiary's profile and issues that may affect his/her ability to maintain his/her health. While it is recommended that you cover all sections below, it is not necessary to go through all probes; your discussion with your beneficiary should not feel like an interrogation. Feel free to use your own appropriate language to ask questions and probe for answers. There is a space for you to write notes, and after the discussion you can determine low- or high-need classifications for each area based on your notes. LINKAGES recommends that you review this form periodically with your beneficiary to identify areas that may have changed.*

Begin by explaining the purpose of the discussion, the topics that will be covered, and about how long it should take.

Goal/Probes	Notes	Low need	High need
Goal: Understand how the beneficiary identifies him/herself <ul style="list-style-type: none"> Gay, bisexual, straight, trans, other 			
Goal: Understand the beneficiary's living situation <ul style="list-style-type: none"> Can you tell me a little bit about your current living situation? <ul style="list-style-type: none"> Rent, own, live at workplace (brothel), homeless currently or in last six months, live alone, live with someone If with someone, how is that relationship? <ul style="list-style-type: none"> Stable/unstable, how long in current situation? 			
Goal: Understand sexual relations/partnerships over the last 6 months <ul style="list-style-type: none"> Tell me about your current partner(s)/client load <ul style="list-style-type: none"> Male, male and female, trans HIV status of regular sexual partner Number of partners/clients in the last 6 months Condom use with regular partner (sometimes, always, never) Condom use with clients (sometimes, always, never) 			
Goal: Understand employment/financial situation and effect on health/risk <ul style="list-style-type: none"> Employment/earning status and stability of employment/earning Other means of support/income Effect of financial situation on lifestyle and health <ul style="list-style-type: none"> Ability to obtain/maintain medical care Survival sex/exchange of sex for drugs, money, place to stay 			

Goal/Probes	Notes	Low need	High need
<p>Goal: Understand beneficiary's general health status and needs</p> <ul style="list-style-type: none"> • Rating of own health? <ul style="list-style-type: none"> ▶ Excellent, good, fair, poor • Any chronic medical conditions? <ul style="list-style-type: none"> ▶ Diabetes, asthma, heart disease, others... • Current use of health care <ul style="list-style-type: none"> ▶ Regular doctor/health care provider ▶ Where does he/she usually go when ill? ▶ Private insurance, out-of-pocket, or rely on national health system? • Additional health care needs <ul style="list-style-type: none"> ▶ Dental care ▶ Vision care ▶ Food/nutrition ▶ Fitness 			
<p>Goal: Understand if beneficiary may benefit from help with substance use issues</p> <p><i>[Note: Begin by talking with the beneficiary about whether s/he uses alcohol or drugs. If in that conversation, s/he denies ever using both, skip to the mental health section. If drug or alcohol use comes up later, you can return to these questions.]</i></p> <ul style="list-style-type: none"> • Have you ever felt you ought to cut down on your drinking or use of drugs? • Have you ever tried to cut down on your drinking or use of drugs, but couldn't? • Have people annoyed you by criticizing your drinking or use of drugs? • Have you ever felt bad or guilty about your drinking or use of drugs? • Are you currently in substance abuse treatment or recovery? • Have you ever used a needle to inject drugs? If yes: Last 6 months? • Have you ever shared needles? If yes: Last 6 months? 			
<p>Goal: Understand if the beneficiary may benefit from a referral for mental health</p> <ul style="list-style-type: none"> • Have you ever been diagnosed with a serious mental illness? • Have you received mental health treatment in the last 6 months? • Have you taken prescribed medications to help improve your mental health in the last 6 months? • During the last four weeks, how much of the time has your physical health or emotional problems (being down or anxious) interfered with social activities, like visiting with friends, relatives, etc.? 			
<p>Goal: Understand additional needs</p> <ul style="list-style-type: none"> • The beneficiary may have needs that don't fit into the categories above, or that may reveal themselves as the encounter progresses. These might include the need to address: <ul style="list-style-type: none"> • gender-based violence and/or abuse • food/nutrition deficiency • transportation • family issues (e.g., stigma) • legal support 			

HANDOUT 13.3 ACTION PLAN TOOL¹

What issues has the beneficiary identified that may need to be addressed to ensure he/she can effectively adhere to his/her treatment regimen and maintain positive living?

- ☐ Health care and/or medical aid (including general health, dental, vision...etc.) _____
- ☐ Food/nutrition
- ☐ Violence prevention and/or response
- ☐ Mental health counseling
- ☐ Adherence (take HIV medications properly) and/or CD4/viral load monitoring
- ☐ HIV care and treatment
- ☐ Transportation
- ☐ Substance abuse services
- ☐ Financial assistance
- ☐ Housing
- ☐ Employment/income
- ☐ Fitness
- ☐ Education
- ☐ Clothing
- ☐ Legal services
- ☐ Complementary health options (traditional healing, acupuncture, massage, herbal therapy, etc.)
- ☐ Other Services _____

Immediate referrals:

Priority Goals/Needs:

¹Should be completed in conjunction with the Life Steps for ART Adherence tool

Beneficiary will...	Date Complete	Navigator will...	Date Complete
1.		1.	
2.		2.	
3.		3.	

Things that could make it difficult to achieve my goals include:

My plan for overcoming these difficulties includes:

My confidence that I can achieve my goal:

1

2

3

4

5

Not confidentNeutralVery Confident

HANDOUT 14. THE MINIMUM PACKAGE OF SERVICES

The following is the minimum package of services that may occur during a navigation session:

- **Relationship building:** Spend extra time building rapport with the beneficiary. Rapport building is critical for success of the relationship, particularly during the first few visits.
- **General health education:** Help improve the beneficiary's knowledge of the factors associated with his or her own health. For example, if a beneficiary identifies that he or she has a chronic ailment, such as diabetes or asthma, you can share information about that condition.
- **HIV education and counseling:** Provide education about HIV, such as how the virus is transmitted, medication management, and dealing with psychosocial issues of living with HIV.
- **Coaching on communication with medical or service providers:** Provide information on how and where to seek an appointment. Assist individuals to become self-reliant, empowered, and proactive in seeking care and meeting their needs and to communicate clearly and assertively with their service providers.
- **Support for service beneficiaries to adhere to their treatment regimens:** Support the beneficiary to obtain treatment adherence self-efficacy using the Life Steps approach. You can employ a combination of counseling, goal setting, tips, and strategies, including review and revision of the treatment adherence plan, and/or delivery of medication. He or she may assist the beneficiary to link to a peer support group. Navigators can provide practical advice about medication-taking cues, reminders, and organizational tools that have worked for themselves or others.
- **Appointment reminder:** Contact service beneficiaries to remind them of an upcoming scheduled meeting or an upcoming appointment for other services. Use the beneficiary's preferred method of contact.
- **Accompany beneficiary to appointments:** Accompaniment might include appointments for HIV care, substance abuse treatment, mental health, medical check-ups, diagnostics, or social support services for gender-based violence, legal, or other issues.
- **Support for positive health, dignity, and prevention:** Help increase the self-esteem, confidence, and ability of service beneficiaries to care for themselves and to avoid passing HIV to others.
- **Commodity provision:** Provide condoms, lubricants, and sterile injecting equipment, as needed. Where possible, navigators should link with donor-supported interventions to forecast condom, lubricant, needle, and syringe needs and ensure a regular supply is available either through free distribution, social marketing, or other means in common outlets, service provision sites, and venues.
- **Assistance with social grants:** Assist service beneficiaries in understanding and applying for applicable social grants, welfare opportunities, and other potential support.
- **Assistance with legal services:** Assist service beneficiaries to identify and contact appropriate legal service agencies and individuals as needed.
- **Crisis response:** Help beneficiaries obtain immediate services (medical, housing, or mental health). Note: navigators are not intended or trained to be crisis managers or "hotlines" for beneficiaries, and should discourage beneficiaries from seeing them in this way. (Boundaries should be clarified early on.) However, there may be situations in which a beneficiary contacts a navigator for emergency assistance and the navigator can assist in connecting him or her to appropriate help.

HANDOUT 15.

POSITIVE HEALTH, DIGNITY AND PREVENTION

Positive Health, Dignity and Prevention approaches aim to increase the self-esteem, confidence, and ability of people living with HIV to care for themselves and to avoid passing HIV on to others.

People's perceptions of risk may change when their health situation improves; reinforcement of prevention messages is an important part of working with HIV-positive beneficiaries. Peer navigators should provide their beneficiaries with accurate information on:

- Risk of sexual transmission
- Appropriate methods of protection and provision of supplies, including:
 - ▶ Condoms and lubricants
 - ▶ Clean needles and syringes
- Available services, including:
 - ▶ **Antiretroviral treatment** - The World Health Organization now recommends that anyone who has HIV should start treatment as soon as possible.
 - ▶ **Psychosocial support** from trained staff
 - ▶ **Referral** to other relevant services in the community (prevention and support for violence prevention and response, drug/alcohol rehabilitation, diagnosis and treatment of sexually transmitted infections, mental health)

Serodiscordant couples

A serodiscordant couple is one in which one person is infected, and the other is not. Serodiscordant couples need to know about their risk-reduction options, and peer navigators can serve an important role in helping couples avoid onward infection. Navigators should be aware that some individuals may be reluctant to attend counseling with a partner, and it may take time and additional support to engage partners. They should also be aware that many couples face challenges in maintaining consistent condom use during periods when viral load is still detectable in the infected individual. *For more information on HIV prevention for serodiscordant couples, see the link in footnote 1.*¹

For partnerships with people who inject drugs, it is important to develop a plan for safe injection (including injection equipment for diabetics and for transgender women who are injecting hormones). People who inject drugs also need to develop risk-reduction plans for sexual transmission with their partners. *For more information on HIV prevention for drug users and their partners, see the link in footnote 2.*²

¹<http://www.catie.ca/en/pif/spring-2015/hiv-prevention-within-serodiscordant-couples-changing-paradigm>

²<https://www.cdc.gov/globalaids/resources/prevention/docs/toolkit-for-implementing-programs-for-people-who-use-drugs.pdf>

The importance of an undetectable viral load

It is important for navigators to promote the individual and community-level benefits of their beneficiaries' achieving and maintaining an undetectable viral load. Navigators might want to consider the following messages of encouragement and caution:³

- [You can live a healthier and longer life.](#) Using ART to reach an undetectable viral load means that there is less HIV in your body. Less HIV means less damage to your immune system, allowing you to stay healthier and [live longer.](#)
- [You can reduce HIV transmission risk.](#) Studies have shown that people who live with HIV who use ART can reduce the likelihood of transmitting the virus to their HIV-negative partners by as much as [92 percent to 96 percent.](#) More people on effective treatment and with the virus in check means more new HIV infections are prevented.
- **“Undetectable” does not mean “cured.”** An undetectable viral load means that so few copies of the virus are present in the blood that today's monitoring tests are unable to detect them. Even with an undetectable viral load, however, an HIV-positive person still has the virus.
- **It's not impossible to transmit HIV.** Your viral load can fluctuate between monitoring tests. This can happen for no known reason, or when you have a sexually transmitted infection such as chlamydia or gonorrhea, or when ART doses are missed. During these viral load “blips,” the chance of transmitting the virus may be higher. Also, viral load tests monitor only the amount of HIV in the blood, not the amount in semen or vaginal fluid. It is not yet known how much virus needs to be present in body fluids for transmission to be possible.

Additional services

In addition to clinical care, ART, and psychosocial support, navigators should help beneficiaries access other relevant services in the community, including violence prevention and support for victims of domestic and gender-based violence, drug/alcohol rehabilitation, STI diagnosis and treatment, legal aid, and support for orphans and vulnerable children.

PrEP and PEP

Navigators should be familiar with both PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis). Both are methods of preventing HIV that involve taking antiretroviral medications before one is diagnosed with HIV. These treatments may not be available in all areas.

PrEP is increasingly recommended for anyone who is at high-risk of HIV acquisition. It involves a daily pill consisting of two antiretroviral drugs that will prevent the person taking it from contracting HIV.

PEP is used for people who have experienced a high-risk exposure. It involves taking a combination of three drugs as soon as possible after exposure (preferably within two hours and before 72 hours). Regimens and guidance may vary by country, state, or facility. It is important that the navigator understand what the guidance is for the area/facility where they are working.

³<http://betablog.org/fact-sheet-undetectable-viral-load/>

HANDOUT 16.

INTRODUCTION TO ANTIRETROVIRAL TREATMENT

Overview of treatment

ART stands for “antiretroviral therapy.” It involves taking a combination of HIV medicines (called an HIV regimen) every day. While it can’t cure HIV, ART can help you live a longer, healthier life and reduce your risk of HIV transmission nearly to zero if effective.

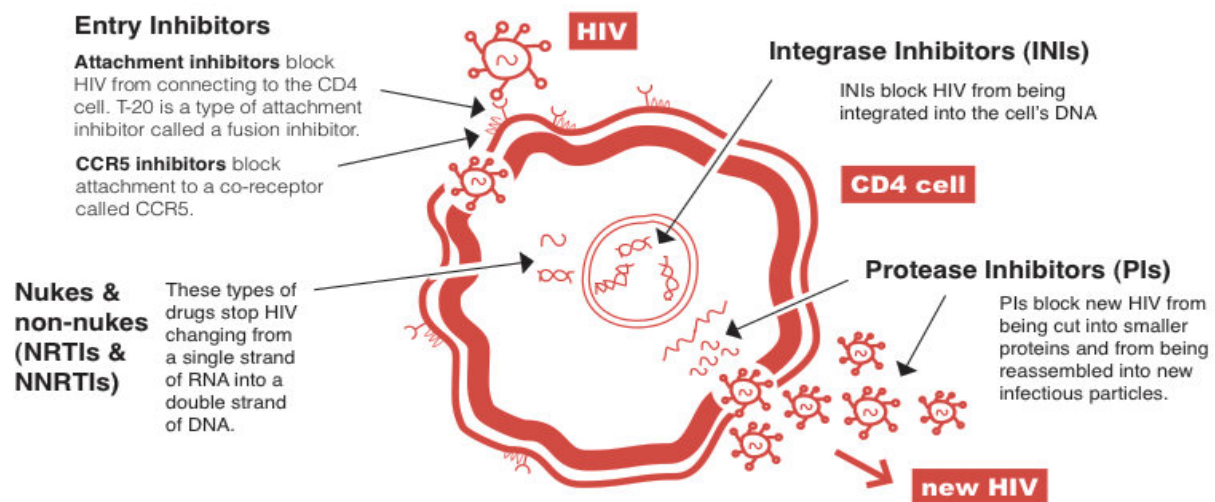
There are currently five different approved classes of HIV drugs. Each one attacks the virus at different points in its life cycle. People are usually prescribed three different drugs from two different classes. A regimen of three drugs is critical for effective treatment of HIV; taking only one drug will do little to stop HIV from harming you.

Taking more than one drug also protects you against HIV drug resistance. When HIV reproduces, it can make copies of itself that are imperfect — and these mutations may not respond to the drugs you take to control your HIV. When you take three different types of drugs, the HIV in your body will be less likely to make new mutated copies that resist your HIV medicines. Today, most clinics can offer three drugs in a single pill.

How HIV drugs work: main types of drugs

Like every living thing, HIV needs to reproduce to survive. HIV reproduces inside the body's CD4 cells, —a process that involves many different stages. HIV drugs work by interfering with some of these stages.

Classes of approved drugs



Different drugs work at different stages of the HIV life cycle. HIV uses CD4 cells as factories to make hundreds of copies of itself.

- Entry inhibitors work by stopping HIV from getting into the CD4 cell.
- Nukes and non-nukes work by stopping one of the main ways HIV reproduces inside the CD4 cell.
- Integrase inhibitors work by stopping HIV from being integrated into the CD4 cell's DNA (genetic material).
- Protease inhibitors work by stopping any new HIV from being cut into smaller, manageable proteins.
- Budding and maturation inhibitors work by stopping any new HIV from being able to go on to infect other CD4 cells. None are currently approved.

Local country guidelines for starting treatment

Consult with your program officers or local clinicians for an overview of the specific drug regimens used in the country context where you are training and to find out whether the program uses the previous WHO staging or the most recent WHO guidance on immediate initiation of treatment for all who are diagnosed.

ART diagnostics

The following diagnostic tests may be available/prescribed for your beneficiaries once they have tested positive. This information will help you know what kinds of tests will be used.

- **CD4 test** – Involves taking a blood sample and counting the number of specific immune cells to see how the body's immune system is functioning after it has been infected with HIV. In certain countries that are not yet implementing test and start (whereby everyone who tests positive is initiated on treatment as soon as possible), this test may be used to determine when clients should be initiated on treatment.
- **Viral load test** – Uses a blood sample to measure the amount of HIV in a person's blood to see whether ART is working. In general, viral load will be declared “undetectable” if it is under 40 to 75 copies in a sample of blood. Even if the viral load test determines that the virus is “undetectable,” or too low to count, a client diagnosed with HIV will have HIV for life, and there is always a chance of passing it on to others. Programs vary in terms of the frequency and points in time when viral loads are tested. Consult with your program supervisor to learn more about how often your beneficiaries will be required to have viral load tests.
- **Creatinine test** - The creatinine test assesses kidney function prior to ART initiation.
- **Other tests may need to be done before and after a client has started ART.** The local country guidelines and health facilities will have more information about this.

The importance of an undetectable viral load

It is important for you to promote the individual and community-level benefits of your beneficiaries' achieving and maintaining an undetectable viral load. You might want to consider the following messages of encouragement and caution:¹

- You can live a healthier and longer life. Using ART to reach an undetectable viral load means that there is less HIV in your body. Less HIV means less damage to your immune system, allowing you to stay healthier and live longer.

¹ <http://betablog.org/fact-sheet-undetectable-viral-load/>

- You can reduce HIV transmission risk. Studies have shown that HIV-positive people who use ART can reduce the likelihood of transmitting the virus to their HIV-negative partners by as much as 92 percent to 96 percent. More people on effective treatment and with their virus in check means more new HIV infections are prevented.
- “Undetectable” does not mean “cured.” An undetectable viral load means that so few copies of the virus are present in the blood that today’s monitoring tests are unable to detect them. Even with an undetectable viral load, however, an HIV-positive person still has the virus.
- It is still possible to transmit HIV. Your viral load can fluctuate between monitoring tests. This can happen for no known reason, or when you have a sexually transmitted infection such as chlamydia or gonorrhea, or when ART doses are missed. During these viral load “blips,” the chance of transmitting the virus may be higher. Also, viral load tests monitor only the amount of HIV in the blood, and not the amount in semen or vaginal fluid. It is not yet known how much virus needs to be present in body fluids for transmission to be possible.

Medication side effects

After initiating ART, some people get headaches, an upset stomach, fatigue, or aches and pains. These side effects usually go away within a few days to a month. Unusual or severe reactions that appear after starting or changing a drug should be reported to a provider immediately.

Short-term side effects may include: anemia (abnormality in red blood cells), diarrhea, dizziness, fatigue, headaches, nausea and vomiting, pain and nerve problems, and rash.

Long-term side effects may include: lipodystrophy (a problem in the way the body stores and redistributes fat), insulin resistance (can lead to abnormalities in blood sugar levels and possibly diabetes), lipid abnormalities (increases in cholesterol or triglycerides), a decrease in bone density, and lactic acidosis (a buildup of lactate, a cellular waste product, in the body which can cause problems ranging from muscle aches to liver failure).

HANDOUT 17.

ADHERENCE TO TREATMENT – THE LIFE STEPS APPROACH

Treatment adherence means taking your HIV drugs when and how you are supposed to. Adherence is important because it affects how well your HIV medications decrease your viral load. The lower your viral load, the healthier you are likely to be. Near perfect adherence is needed to fight HIV successfully. **This means taking the prescribed dose of medication at the same time every day at least 95% of the time.**

Adherence counseling and support is **one of the most important roles** of peer navigators.

Adherence also helps prevent drug resistance. If you skip a dose of your medication, the virus can begin producing more of itself. When you skip many doses, you may develop strains of HIV that are resistant to the meds you are currently taking — and possibly even to meds you haven't taken yet. If this happens, it could leave you with fewer treatment options. Once a person develops resistance to their first line of treatment, they may be switched to a second-line ART regimen; however, switching to a third-line treatment may not be effective.

Life Steps for Adherence

The Life Steps approach provides a systematic way to support your beneficiary to identify barriers to adherence and develop a plan and backup plan to address barriers should they arise. There are 13 steps, each focusing on addressing common barriers to adherence. You may address these in one long counseling session (one to three hours) or over several sessions. Please refer to the **Life Steps** manual for full instructions on the development and maintenance of plans for your beneficiaries.

	LIFE STEPS
1	Educate about adherence.
2	Plan for transportation to the clinic.
3	Plan for keeping appointment dates and obtaining medication.
4	Formulate a daily medication schedule.
5	Plan for storing medications.
6	Plan for obtaining medications when away from home.
7	Identify social supports.
8	Identify motivation for adherence and create association with reminders.
9	Plan for coping with medication side effects.
10	Plan for communicating with treatment team.
11	Prepare for taking medication when using substances (e.g., drugs, alcohol).
12	Prepare to cope with slips in adherence.
13	Review all plans.

Each **Step** follows a typical format, referred to as A-B-C:

- A. Identify the adherence goal.
- B. Identify the barriers to reaching the goal.
- C. Make a plan and a backup plan for overcoming the barrier.

HANDOUT 18.1

DIFFERENTIATED CARE JUMBLE

Differentiated care for beneficiaries living with HIV but not on ART		
New and existing service beneficiaries	Low-need	High-need

Differentiated care for beneficiaries living with HIV but not on ART		
New and existing service beneficiaries	Low-need	High-need
Existing service beneficiaries	Stable ART/Low-need	Unstable ART/High-need

After Month 3: Follow up by phone or in person 1x every 3 months.

Refer service beneficiaries with side effects to clinical provider; reassess health status shortly after referral.



Every 6 months: Follow up by phone or in person.

Months 1-2 (or 3 if needed): Follow up by phone or in person every 1-2 weeks.



Until initiation of ART: Follow up by phone or in person at least 1x per month after initial meetings, and if client classification is defined as low-need.

Until initiation of ART: Follow up as often as necessary to ensure basic needs are met and beneficiary is not lost to follow-up (i.e., weekly).



Call beneficiary 1 day before each appointment; call within 24 hours of a missed appointment to reschedule/provide support.

Call beneficiary 1 day before each appointment (accompany if necessary); call within 24 hours of a missed appointment to reschedule/provide support.



Follow up on viral load/CD4 diagnostics.

Refer service beneficiaries with side effects to clinical provider; reassess health status shortly after referral.



Call the beneficiary the day before each appointment date; call within 24 hours of a missed appointment.

After month 3: Follow up by phone or in person 1x every 2-3 months

Call the beneficiary the day before each appointment date; call within 24 hours of a missed appointment.



Call the beneficiary the day before each appointment date.

After month 2 or 3: Follow up by phone or in person 1x every 2-3 months until beneficiary has 2 consecutive undetectable viral load measures.



Follow up on viral load / CD4 diagnostics.

Goal: 2 consecutive undetectable viral measures

After month 2 or 3: Follow up by phone or in person 1x every 2-3 months until beneficiary has 2 consecutive undetectable viral load measures.

Follow up on viral load/CD4 diagnostics.



Months 1-3: Follow up by phone or in person 1x per month after initial meetings.

Months 1-3: Follow up by phone or in person every 1-2 weeks; provide accompaniment to appointments as needed.

HANDOUT 18.2 DIFFERENTIATED SERVICE DELIVERY

Differentiated service delivery is a client-centered approach that simplifies and adapts services to reflect the preferences and expectations of each beneficiary, while reducing unnecessary burdens on the health system. By providing differentiated services, programs can focus resources on beneficiaries most in need and provide all beneficiaries with individualized care.

Depending on the local policy and resources, some beneficiaries may be on treatment, while others may not yet be. Beneficiaries will also vary in terms of the support they need. Some will require minimal support, if any, and can be classified as low-need. Others may require more intense and/or frequent support and could be classified as high-need. Determination of low- versus high-need classification may be made during the intake assessment, based on the development of individual action plans. Need may increase or decrease over time, depending on emerging issues, or changes in circumstances.

Beneficiaries not yet on ART

Beneficiaries who are not yet on antiretroviral therapy (ART) may have several issues that must be addressed to help them manage an HIV diagnosis, health, and related circumstances. For example, a beneficiary not yet on ART may be classified as high-need if she or he is dependent on a substance, homeless, experiencing violence, malnourished, unemployed, or struggling to make appointments. High-need beneficiaries may need to meet with peer navigators more often and may require multiple referrals and accompaniment or frequent checking in.

Beneficiaries on ART

Similarly, beneficiaries on ART may have diverse needs depending on their circumstances. The World Health Organization (WHO) has developed a classification system for individuals on treatment that determines whether their treatment is stable (low-need) or unstable (high-need).

WHO defines individuals on ART as stable if they have ALL the following characteristics:

- On ART for at least one year, AND
- No adverse drug reactions requiring regular monitoring, AND
- No current illnesses or pregnancy, AND
- Good understanding of lifelong adherence, AND
- Evidence of treatment success: Two consecutive undetectable viral load measures (or, in the absence of viral load monitoring, rising CD4 counts or CD4 counts above 200 cells/mm³ and objective measures of adherence)

WHO defines individuals on ART as unstable if they have the following characteristics:

- CD4 count < 200 CD4 cells/mm³ OR WHO Stage 3 & 4 defining illness

You may have a mix of new beneficiaries and those already engaged in the service network. Among these individuals, some will not yet be on treatment, and some will have initiated treatment. The tables below provide recommended guidance on the frequency and kinds of support new and existing beneficiaries may require, based on high- versus low-need, and stable versus unstable treatment outcomes. Facilitators should refer to national guidelines to adapt these tables to the local context.

TABLE 1. DIFFERENTIATED CARE APPROACH FOR NEW AND EXISTING SERVICE BENEFICIARIES NOT YET ON ART

Differentiated care approach for beneficiaries living with HIV but <u>not</u> yet on ART		
New and existing service beneficiaries	Low-need	High-need
	Until initiation of ART: Follow up by phone or in person at least 1x per month after initial meetings; and client classification as low-need.	Until initiation of ART: Follow up as often as necessary to ensure basic needs are met and beneficiary is not lost to follow-up (i.e., weekly).
	Call beneficiary 1 day before each appointment; call within 24 hours of a missed appointment to reschedule/provide support.	Call beneficiary 1 day before each appointment (accompany if necessary); call within 24 hours of a missed appointment to reschedule/provide support.

TABLE 2. DIFFERENTIATED CARE FOR NEW AND EXISTING SERVICE BENEFICIARIES ON ART

Differentiated care for beneficiaries on ART		
New and existing service beneficiaries	Stable ART / Low-need	Unstable ART / High-need
	Months 1-3: Follow up by phone or in person 1x per month after initial meetings.	Months 1-3: Follow up by phone or in person every 1-2 weeks; provide accompaniment to appointments as needed.
	After Month 3: Follow up by phone or in person 1x every 3 months.	Refer service beneficiaries with side effects to clinical provider; reassess health status shortly after referral.
	Call the beneficiary the day before each appointment date; call within 24 hours of a missed appointment.	After month 3: Follow up by phone or in person 1x every 2-3 months.
	Follow up on viral load/CD4 diagnostics.	Call the beneficiary the day before each appointment date; call within 24 hours of a missed appointment
Existing service beneficiaries	Stable ART / Low-need	Unstable ART / High-need
	Every 6 months: Follow up by phone or in person.	Months 1-2 (or 3 if needed): Follow up by phone or in person every 1-2 weeks.
	Call the beneficiary the day before each appointment date.	After month 2 or 3: Follow up by phone or in person 1x every 2-3 months until beneficiary has 2 consecutive undetectable viral load measures.
	Follow up on viral load/CD4 diagnostics.	Refer service beneficiaries with side effects to clinical provider; reassess health status shortly after referral.

HANDOUT 19.1 OPTICAL ILLUSION



HANDOUT 19.2 CASH REGISTER WORKSHEET

THE STORY

A businessman had just turned off the lights in a store when a man appeared and demanded money. The owner opened a cash register. The contents of the cash register were scooped up, and the man sped away. A member of the police force was notified promptly.

Statement	True (T)	False (F)	Not enough information (?)
1. A man appeared after the owner turned off his store lights.	T	F	?
2. The robber was a man.	T	F	?
3. The man did not demand money.	T	F	?
4. The man who opened the cash register was the owner.	T	F	?
5. The storeowner scooped up the contents of the cash register and sped away.	T	F	?
6. Someone opened a cash register.	T	F	?
7. After the man who demanded the money scooped up the contents of the cash register, he ran away.	T	F	?
8. While the cash register contained money, the story does not state how much.	T	F	?
9. The robber demanded money of the owner.	T	F	?
10. The story concerns a series of events in which only three persons are referred to: the owner of the store, a man who demanded money, and a member of the police force.	T	F	?

HANDOUT 19.3 COMMUNICATION SKILLS

SKILL	WHAT IS IT?	EXAMPLE
Affirming		
Open-ended questions		
Active listening		
Nonverbal		
Express thoughts and feelings		
Communicate without making others feel “wrong”		

HANDOUT 19.4 TYPES OF COMMUNICATION

- **Verbal** – Communication through language
- **Nonverbal** – Communication other than through spoken language. More powerful messages are often conveyed through nonverbal cues rather than through words themselves. Seventy percent to 90 percent of our communication is nonverbal. Examples of nonverbal communication include:
 - ▶ Body language (e.g., folded arms)
 - ▶ Eye contact
 - ▶ Muscle tension (Are neck or jaw muscles taut, fists clenched?)
 - ▶ Posture
 - ▶ Mannerisms (e.g., fiddling with hair, biting nails)
 - ▶ Proxemics (how close we stand when talking. In the USA, people stand from 18 inches to 2 feet from each other; we get uncomfortable if that boundary is violated. Proxemics vary from culture to culture.)
- **Paraverbal** – Communicating not by what you say, but how you say it. Examples of paraverbal communication include:
 - ▶ Voice qualities/voice tone (Is voice flat or monotone?)
 - ▶ Rate of speech (how fast or slow one talks)
 - ▶ Cadence/rhythm of voice
 - ▶ Volume
 - ▶ Inflection

HANDOUT 19.5 DEFINITION OF ACTIVE LISTENING AND BARRIERS TO EFFECTIVE COMMUNICATION

Active listening

Active listening is a way of listening that focuses entirely on what the other person is saying. It confirms understanding of both the content of the message and the emotions and feelings underlying the message to ensure that understanding is accurate.

Active listening is not:

- Quickly agreeing with a beneficiary before she or he finishes speaking
- Passing judgment
- Asking follow-up questions that are for your own information
- Reassuring the beneficiary that the situation is “not that bad”
- Giving advice either from your personal experience or from professionals

Barriers to good communication

- Hearing only part of the message
- Failure to listen
- Listening with a particular mindset or prejudice
- Reacting emotionally
- Making assumptions
- Accents
- Physical barriers
- Cultural barriers
- Religious barriers
- Time pressures
- Distractions/interruptions
- Failure to wait for feedback/response
- Lack of sensitivity to emotions
- Poor volume, tone, or emphasis
- Finishing a person's sentence for him or her
- Not acknowledging a person's experience, emotions, feelings, or desires
- Jumping from topic to topic
- Acting phony

HANDOUT 19.6

EFFECTIVE COMMUNICATION STRATEGIES

- Make eye contact (Like many nonverbal cues, this is culturally specific. In some cultures, direct eye contact is considered a sign of disrespect.)
- Use attentive body language: sit slightly forward with a relaxed, easy posture.
- Be aware of your gestures.
- Stay on the topic.
- Don't be phony; be yourself.
- Be culturally sensitive.
- Focus on the other person.
- Determine what the other person already knows, and then fill in the gaps.
- Smile or nod.
- Don't monopolize the conversation.
- Establish rapport.
- Arrange for privacy.
- Create an atmosphere free of distractions and interruptions.
- Be warm and enthusiastic.
- Show interest.
- Look bright and alert.
- Ask open-ended questions.
- Use active listening skills and approaches.

HANDOUT 19.7

ACTIVE LISTENING STRATEGIES

- Focus on the other person.
- Use attentive body language: sit slightly forward with a relaxed, easy posture.
- Use verbal cues such as “um-hmmm,” “sure,” “ah,” and “yes.”
- Ask open-ended questions.

Use **focused questions** to get a more definitive answer than you would with an open-ended question.

Example:

Counselor: “Where do you spend most of your day?”

Client: “I don’t know — it’s hard to say.”

Focused question: “Okay, let’s take yesterday. Was that a regular day for you? What did you do in the morning?”

Use **laundry list** questions to obtain specific information about something by providing a series of choices and to get information you haven’t been able to get at with open-ended or focused questions.

Example:

Counselor: “What side effects have you experienced from the HIV meds you got?”

Client: “I’m not sure what’s the disease and what’s the drugs.”

Laundry list question: It’s good to distinguish between side effects and disease symptoms, so let me list what side effects can be caused by [NAME OF MEDICINE]. Have you had...[LIST OF POTENTIAL SIDE EFFECTS]...?”

Probe for more information, using open-ended questions or statements to obtain additional information.

Example: “Tell me what you know about HIV.”

Ask **clarifying questions** to help interpret what the other person is saying.

Example:

Client: “Oh, you know I don’t have a fixed address. I am living here and there.”

Clarifying statement: “Tell me a little bit more about what you mean by here and there.”

Paraphrase what the other person has said.

Example:

Client: “I have so much to do – medical appointments, working, taking care of the kids. I don’t know how I’m going to keep it all together.”

Paraphrase: “You’re feeling overwhelmed by all of things going on in your life right now.”

Mirror or **reflect** what the other person has said.

Example:

Client: “Why should I tell any of my partners that I’m HIV positive? Let them find out the way I found out — by getting sick.”

Mirroring statement: “It sounds like you’re angry because no one informed you that you were exposed to HIV.”

HANDOUT 19.8

CLOSED — OPEN-ENDED — FOCUSED QUESTIONS

Closed-ended questions invite a yes or no answer. They begin with:

- Do, Does, Did, Is, Are, Was, Has, Have, Could, Would, and Will

Open-ended questions cannot be answered by yes or no. They begin with:

- Who, What, When, Where, Why, and How

The purpose of open-ended questions is to facilitate engagement with the client so that the client will open up to the navigator. Using such questions can help improve the client-navigator relationship as well as helping the navigator gather more information.

In the following exercise, turn the closed questions into open-ended questions.

1. Closed: Do you live with somebody?

Open: Tell me about your living arrangements and anyone you live with.

2. Closed: Have you ever been really sick before?

Open: _____

3. Closed: Do you work?

Open: _____

4. Closed: Did you have any side effects from the medicines you had to take?

Open: _____

Focused questions

In this exercise, add a focused question the peer navigator (PN) could use to gather more information.

1. PN: Where do you spend most of your time?

Client: I don't know, it's hard to say.

Focused Question: _____

2. PN: Who do you have contact with on a regular basis?

Client: Oh, I guess with some people over at the shelter, and then some other people I meet for a drink now and then.

Focused Question: _____

3. PN: How have you been feeling recently?

Client: Pretty lousy.

Focused Question: _____

4. PN: What kind of work do you do?

Client: A little of this, a little of that. I hustle. Whatever it takes.

Focused Question: _____

HANDOUT 19.9

PARAPHRASING

How to paraphrase:

Repeat the meaning of what the client says, but use different words.

The paraphrase should begin with “You” to reflect what the client is expressing.

1. Client: I don't know how I got this bad cough. I only smoke one cigarette after each meal.

Paraphrase: _____

2. Client: I feel worse when I exercise; I'd rather just sit around.

Paraphrase: _____

3. Client: I have always taken care of myself. I should not have gotten this infection. I blame my boyfriend.

Paraphrase: _____

4. Client: My boss just fired me even though it was only the second time I was late this week.

Paraphrase: _____

HANDOUT 20.1

HELPFUL COMMUNICATION TECHNIQUES

1.	Using silence	
2.	Accepting Yes	Yes Um Humm. I follow what you said.
3.	Giving recognition: It is difficult to talk with someone you don't know	Hello, Jane. We've talked before
4.	Offering self.	I'll be here till 3:00. I'm interested in what you have to say.
5.	Giving broad openings: Is there something you'd like to talk about	I'll be here till 3:00. I'm interested in what you have to say.
6.	Offering general leads	Where would you like to begin?
7.	Placing the event in time or in a sequence	Go on. And then? Tell me about it.
8.	Making observations	What seemed to lead up to...? Was this before or after...? When did this happen?
9.	Encouraging descriptions of perceptions	Your voice sounds shaky when you talk about... It makes me feel uncomfortable when you...
10.	Encouraging comparison	Tell me when you feel anxious. What is happening? What does he do when he "gets ugly"?
11.	Restating (especially useful when you can't identify the feeling)	Was this something like...? Have you had similar experiences?
12.	Focusing	Beneficiary: My lawyer doesn't believe me when I say he hit me when I was pregnant. Navigator: Your lawyer doesn't believe your story.
13.	Exploring	Tell me more about... Will you describe that more fully?
14.	Giving information	This line is answered 24 hours a day. My purpose in being here is...
15.	Seeking clarification	I'm not sure I follow. What would you say is the main point of what you've said?

HANDOUT 20.2

COMMUNICATION STOPPERS

1. Directing, ordering: To tell someone to do something in a manner that gives the other person little or no choice.
2. Warning, threatening: To tell the other person that if a behavior continues, then certain consequences will happen.
3. Moralizing, preaching: To tell someone things they ought to do.
4. Persuading, arguing: To try to influence another person with facts, information, and logic.
5. Advising, recommending: To provide answers to a problem.
6. Evaluating, criticizing: To voice a negative interpretation of someone's behavior.
7. Praising: To express a positive evaluation of someone's behavior.
8. Supporting, sympathizing: To try to talk the other person out of his or her feelings, or to deny someone's feelings.
9. Diagnosing: To analyze the other person's behavior and communicate that you have the behavior figured out.
10. Diverting, bypassing: To change the subject or not talk about the problem presented by the other person.
11. Kidding, teasing: To try to avoid talking about the problem by laughing or by distracting the other person.
12. One upmanship: To try to "top" the person's problems by talking about a worse one.
13. Killer Phrases: Examples include: "Don't worry, things could be worse." "Cheer up." "What do you have to feel sorry about?"

HANDOUT 21. INTERVIEW CHECKLIST

Did the interviewer use:

Open-ended questions? Yes _____ No _____

Comments _____

Appropriate nonverbal communication? Yes _____ No _____

Comments _____

Paraphrasing? Yes _____ No _____

Comments _____

Focused questions? Yes _____ No _____

Comments _____

HANDOUT 22.1 TELLING

1. A good experience that I had with telling someone else that I am living with HIV...
2. A not-so-good experience that I had with telling someone else that I am living with HIV...
3. One thing I do well when deciding whom to tell is...
4. One thing I will change about disclosing my HIV status in the future is...

HANDOUT 23.1 PREPARING FOR DISCLOSURE

“Disclosure” means telling someone that you are living with HIV. Whom to tell about your HIV status and how to tell them can be a complex and personal decision.

There is no one best way to tell someone, just as there is no sure way to gauge their reaction to your news. But it will help to ask yourself a few questions before disclosing:

1. Whom do I want to tell, and why do I want them to know?
2. How much am I ready to share or are they ready to hear?
3. How will disclosing my HIV status affect me, and how will it affect the people around me?
4. Think about the people you rely on for support, such as family, friends, or coworkers.
5. Figure out your relationship with each of these people and the advantages and disadvantages of telling them.
6. Determine any issues the person might have that will affect how much he or she can support you. For example, does the person have any health problems of his or her own? Can you trust the person?
7. Look at the person's attitude and knowledge about HIV. Does she or he have fears or preconceived ideas about HIV?
8. Think about why you'd want to disclose to this person. What kind of support can this person provide?
9. For each person, decide if the person should be told now, later, or to wait and see.

Deciding whom to tell may take a short time or a long time.

There is no right way to do this.

It is a very personal decision that only you can make.

HANDOUT 23.2 WHO NEEDS TO KNOW YOU ARE HIV-POSITIVE

You do not have to tell everyone that you are living with HIV. You should tell people that you may have exposed to HIV, so that they can be tested and seek medical attention if required.

These people could be sexual contacts or people with whom you have shared needles. If you do not want to tell them yourself, this program can help reach out to your contacts without using your name.

In some countries, there are laws requiring that you disclose your HIV status before knowingly exposing or transmitting HIV to someone else.

You need to tell your doctors and other healthcare providers to ensure you receive appropriate care. Your doctor also needs to know how you were infected to determine if you are at risk for other diseases, such as hepatitis C for people who inject drugs, and other sexually transmitted diseases for women who acquired HIV through sex.

Who does not need to know

You do not have to tell your employer that you are living with HIV. If you do tell, remember that, as long as you are performing your job, your employer cannot legally discriminate against you. You may be protected by local laws under a disability or by other acts.

Who you may want to tell

Beneficiaries often choose to disclose their status to close friends and family. For many, telling those closest to them provides them with both emotional and practical support.

Some people decide to become more public and use their stories to advocate for others with government or media. Others may disclose for educational purposes to neighbors, members of community and religious groups, students and teachers at schools, other people living with HIV, or healthcare providers.

Many people find a sense of purpose and increased self-esteem through telling their story.

You may want to consider how much of your story you are ready to tell. Many people will ask you how you acquired HIV. If you decide not to share that information, have a reply ready, such as, “Does it really matter?” or simply state that you are not ready to talk about that.

HANDOUT 23.3 DISCLOSING TO LOVED ONES

Disclosure and relationships

People who are dating find it difficult to know when to disclose. Should you tell on the first date or only if the relationship is getting serious? While there is no correct answer, the longer you wait, the more difficult disclosing becomes.

Be aware that both women and men are at risk for violence when disclosing their HIV status, especially pregnant women. If you are worried that your partner may become violent, think about having the discussion with a neutral third party present: a navigator, an HIV advocate, or a health professional.

In close relationships, studies show that living with a secret, such as HIV, can be more emotionally harmful than the rejection that could result from disclosure. Many people who have kept a secret for a long time feel a sense of relief after telling. Community-based organizations and other psychosocial support sites can offer resources to guide people through the disclosure process.

Disclosing to children

For people considering telling their children, it is important to ask yourself why you want to tell them:

- Will they be angry if you keep a secret?
- Do they suspect something?
- Are you sick?

Children can react to the news of HIV in the family in many different ways. Older kids may be upset that you kept a secret from them. Younger children may just want to go back to their toys. Partial truths can be helpful when telling children. You may decide to tell them only as much as you consider appropriate for their age.

Do not forget that kids need support too. If you can, give them the name of another adult they can talk to — perhaps an aunt or grandparent.

DISCLOSURE IS YOUR CHOICE

Telling others about your HIV status – disclosure – is a very personal decision. You do have the right to keep it secret from others, except from those who might be at risk of getting infected. It is important you share your status with these people:

- Current and past sex partners
- Anyone with whom you may have shared needles
- Your doctor and dentist

BENEFITS OF DISCLOSURE

Telling others about your status may take pressure off you and relieve stress. This can help you stay healthy. Other benefits include:

- Getting emotional support
- Relief from the burden of secrecy
- Opportunity to connect with others with HIV
- Control over your own disclosure on your own terms

RISKS OF DISCLOSURE

But disclosing may have serious risks for you at home or work. People may make fun of you, harass you, or even try to hurt you. They may try to take away your job or place to live.

Even though there are laws to protect people with HIV, you may have to spend time and money to take people to court or find other legal solutions. Doing so might “out” you as HIV-positive to many more people.

DISCLOSURE: TELLING OTHERS ABOUT YOUR HIV



This brochure focuses on common issues related to disclosure of HIV. It was adapted from a brochure that was produced by the AIDS Clinical Trials Group Social Workers. Further discussion with a clinical social worker can provide additional guidance and understanding of individual issues related to disclosure.



HOW TO TELL

If you feel secure enough with your own emotions to disclose, it may help to think about the words you will say. Write them down and practice a few times. Consider the following:

- What do you need most from the person you are telling? Think about how this person knowing can help your situation or make it worse.
- Who are you most comfortable telling?
Choose someone who can support you in a nonjudgmental way while coping with their own feelings.
- Will this person respect your privacy? Think about how this person regularly deals with others' confidential information.
- How will this person react? If she or he might get upset, provide written information on HIV. Tell the person that HIV is a manageable illness.
- Where would be the best place to tell this other person? You might choose a place that is comfortable and provides enough privacy.

TELLING A CHILD

You may delay disclosing to a child unless:

- Your health is at risk
- You are making frequent trips to the doctor
- You are taking medications
- Your energy level has declined, so your child may be aware that "something is wrong"

You may want to avoid letting your child learn about your status from someone else. If you decide to tell your child:

- Do it when you are physically and emotionally able to assist him or her in adjusting.
- Provide accurate information, both verbal and written, based on what your child knows about HIV.
- Identify other people the child can turn to for support.

OTHER ISSUES PERTAINING TO CHILDREN

When a child is infected:

- Disclosure to school officials is an individual decision, but may prevent accidental disclosure by the child.
- Disclosure to the school can result in the HIV status being on the child's school record (unless medical records are kept separate).
- Disclosure to the school will result in disclosure about the mother's HIV status.
- Disclosure to "play groups" or friends can provide an opportunity for friends to understand and be supportive.
- Disclosure to these groups can result in the same issues as school issues.

TELLING A FAMILY MEMBER OR ROMANTIC PARTNER

Disclosure can result in violence; consider your personal safety, especially if there is a history of physical violence in a relationship. Seek out support and resources before disclosure. If you anticipate a violent response, you need to delay and reconsider. In such situations, a social worker, HIV case manager, or peer navigator may be able to help you identify needed resources.

TELLING YOUR EMPLOYER

You may wish to tell your employer. However, legal advisors often urge caution regarding disclosure of medical conditions to an employer. Consider your reasons for telling and how it would affect your job and health. Limited disclosure may work for you. An example of this might be, "I need to schedule some breaks because I have to take medicines at certain times during the day."

GET MORE SUPPORT

Support from others is an important aspect of living well with HIV. When you have people in your life you can talk to and rely on for help, you are better able to keep HIV in perspective and maintain a positive frame of mind.

If needed, consider ways to increase your sources of support, such as support groups and social or volunteer activities. Many communities offer a variety of social support programs for those living with HIV.

HANDOUT 26.1 ADHERENCE COUNSELING CHECKLIST – INITIAL

Date:_____ Beneficiary UIC:_____ DOB:_____

Name of Navigator:_____

PURPOSE: The purpose of this checklist is to provide guidance for peer navigators working with service beneficiaries to support adherence to their treatment regimens and clinical and diagnostic appointments. After going through the initial steps on this page, navigators should use the **Life Steps Adherence Counseling Tool** (provided with the **Peer Navigation Implementation Guide**) with their beneficiaries to develop step-by-step action plans to address potential barriers to adherence. When/where navigators/beneficiaries do not have sufficient time to conduct the full process of developing a Life Steps action plan, the guidance on the second page can be used.

_____ **Build rapport.**

- Check in on the beneficiary's wellbeing.
- Discuss living with HIV and health maintenance; provide counseling as needed.
- Emphasize that the beneficiary can ask any questions at any time.

_____ **Define and discuss medication adherence.**

- Explain that adherence is the degree to which a person sticks to the prescribed regimen.
- Emphasize the collaborative process and taking an active role in one's treatment.
- Review the potential for nonadherence to lead to medication resistance.

_____ **Discuss the beneficiary's ART regimen.**

- Review the prescription and guidance from the clinician.

_____ **Discuss potential side effects.**

- Review expectations about side effects; emphasize that they generally diminish over time.

_____ **Discuss the importance of clear communication with the beneficiary's clinician.**

- Emphasize the importance of continued communication about side effects.
- Review the importance of asking questions so that the best decisions can be made about medicines.

_____ **Implement the Life Steps Adherence Counseling Tool.***

*If there is not enough time to go through the **Life Steps Adherence Counseling Tool**, proceed to the next page and use the checklist as a guide.

_____ **Create a daily medication schedule (beneficiary's adherence plan).**

- Develop a concrete, simple adherence plan using appropriate tools (e.g., pillboxes).
- Discuss when the doses will be taken in different circumstances (e.g., at home, at work, when using substances if applicable).
- Review food restrictions and ensure that the plan accommodates specific medications.

_____ **Develop reminder strategies.**

- Specifically address the involvement of the partner and/or other support people.
- Suggest and discuss reminder strategies (e.g., watch, timer, notes, ribbons placed in the home).

_____ **Discuss family, community, social support, and privacy.**

- Discuss who knows the beneficiary's HIV status and how they can help with adherence.
- If necessary, strategize how the beneficiary can keep his or her HIV status private and still maintain adherence.

_____ **Address potential barriers to adherence.**

- Brainstorm potential barriers to adherence and ways to overcome such obstacles.

_____ **Address what to do when the beneficiary misses a dose.**

- Emphasize that although the goal is optimal adherence, no one is perfect.
- Discuss ways to get back on track as soon as possible after a missed dose.

_____ **Discuss appointment attendance and contact information.**

- Discuss how the beneficiary will get to future appointments; if necessary, strategize about potential barriers to attendance (e.g., transportation).
- Make sure that the service beneficiary has contact information for potential questions or emergencies.

_____ **Review what has been covered and answer any questions.**

- What questions do you have about your regimen?

HANDOUT 26.2 ADHERENCE COUNSELING CHECKLIST – FOLLOW-UP

Date:_____ Beneficiary UIC:_____ DOB:_____

Name of Navigator:_____

PURPOSE: *The purpose of this checklist is to provide guidance for peer navigators working with service beneficiaries to support ongoing adherence to their treatment regimens and clinical and diagnostic appointments. Navigators can review progress/challenges based on the Life Steps adherence counseling plans developed in a previous session and/or use the checklist below.*

_____ **Continue to build rapport.**

- Encourage the beneficiary to start the session with any concerns or questions.
- Emphasize that the beneficiary can ask a question at any time.

_____ **Ask about the beneficiary's experience with adherence.**

- Confirm that the beneficiary understands the importance of medication adherence.
- Confirm that the service beneficiary understands the relationship between adherence and resistance.
- Answer any questions and correct any misunderstandings; consult a clinician if necessary.
- Emphasize that ART should not be shared with others.

_____ **Discuss side effects.**

- Ask the service beneficiary if he/she is experiencing any side effects, and/or if he/she has any questions.
- Assist the beneficiary in eliminating or reducing side effects; consult a clinician if necessary.

_____ **Review the status of the beneficiary's doctor-patient communication.**

- Ensure that the beneficiary is comfortable talking to his/her clinician about treatment issues.
- If problems exist, assist the beneficiary to improve communication.

_____ **Review the beneficiary's ART regimen.**

- If the beneficiary is still unfamiliar with the regimen or the regimen has changed, review the particulars of each drug — what it looks like, its name, what it does, and how it is taken.
- Answer any questions related to the ART regimen; consult a clinician if necessary.

_____ **Review the beneficiary's daily medication schedule.**

- Adjust the adherence plan as necessary.

_____ **Review reminder strategies.**

- Ask about the effectiveness of the reminder strategies being used, including partner support.
- Suggest alternatives and new approaches as appropriate.

_____ **Review the role of family, community, and social support, and assess privacy.**

- Discuss how the service beneficiary's family and friends are helping or hindering adherence.
- Determine if privacy issues are negatively influencing adherence.
- Suggest alternatives and new approaches as appropriate.

_____ **Discuss new/emerging barriers to adherence.**

- Determine if any new barriers to adherence have arisen; help address these issues.

_____ **Address missed doses.**

- Ask the service beneficiary how he/she has handled missed doses.
- Discuss ways to handle similar situations in the future; consult a clinician if necessary.

_____ **Discuss appointment attendance.**

- If the beneficiary is having trouble attending appointments, discuss alternative strategies.
- Make sure that the beneficiary has contact information for questions or emergencies.

HANDOUT 26.3 TOOLS FOR TRANSITION FROM NAVIGATION SERVICES

UIC: _____

Navigator: _____

Enrollment Date: _____

First visit: _____

Last visit: _____

Total number of encounters: _____

Navigation Action Plan

Needs:

- | | | |
|---|---|---|
| <input type="checkbox"/> Health Care | <input type="checkbox"/> Education | <input type="checkbox"/> Health Insurance |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Dental Health Care | <input type="checkbox"/> Clothing |
| <input type="checkbox"/> Optical Health Care | <input type="checkbox"/> Legal Services | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Substance Abuse Services | |
| <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Food/Nutrition | <input type="checkbox"/> Fitness |
| <input type="checkbox"/> Employment/Income | <input type="checkbox"/> Violence Recovery | <input type="checkbox"/> Other Services |

HIV-Services:

- | | |
|--|--|
| <input type="checkbox"/> Adherence (take medications properly) | <input type="checkbox"/> HIV Care and Treatment
and/or CD-4/Viral Load Monitoring |
| <input type="checkbox"/> Complementary Health Options (massage, acupuncture, herbal therapy) | |

Action Plan Review

Accomplishments: _____

Remaining Goals & Challenges:

Referrals:

The above list of my accomplishments, future goals and the possible challenges to accomplishing my future goals has been discussed with my navigator. I have also received a list of referrals for services and support that I may utilize to assist me in overcoming some of my future challenges. I understand that my participation in this program and contact with my navigator ends on _____.

_____	_____	_____	_____
Beneficiary	Date	Navigator	Date

ANNEX 2. PEER NAVIGATOR TERMS OF REFERENCE

Summary

Peer Navigators are defined as HIV-positive, medication-adherent role models who share experience and community membership with the populations with whom they work. They generally undergo the same training as peer educators, with additional training to ensure they have expert knowledge of all relevant facility- and community-based services available to their clients. In collaboration with a facility-based case manager, peer navigators assist 20 to 40 clients to identify and overcome barriers that interfere with achieving health-related personal goals, and help ensure that they effectively navigate and remain within the HIV services continuum.

Peer navigators are employed full time, and their work may include most or all of the following: community outreach and education, referral for HIV testing, case finding, pre- and/or post-test counseling, referral to clinical, psychosocial, and other care and support services, accompaniment to appointments including support with transportation, adherence support, routine appointment reminders, follow-up for missed appointments, and tracking of those lost-to-follow-up. While specific services may vary based on the needs of a given program, it is essential that peer navigators build the trust of their clients without judgment or prejudice.

Specific roles and responsibilities:

- 1. Identify, reach, and mobilize clients for HIV testing.** As trained peer educators, peer navigators understand how to access networks or social groups of individuals who may be at risk of acquiring and transmitting HIV and/or other STIs. They rely on these networks to identify individuals in the community, provide them with state-of-the-art strategic behavioral communication and essential commodities, including condoms, lubricants, and/or safe injection equipment, and emphasize the importance of knowing one's HIV status.
- 2. Refer clients to facility- and community-based testing, and/or provide-community based testing services.** Peer navigators help ensure that clients at risk are effectively referred to, and access HIV testing services (HTS). Based on available services, this may include referral to mobile testing within the community, referral to static testing sites at public or community-based facilities, or provision of community-based HTS via a “test-for-triage” approach (i.e. oral HTS with referral for confirmatory testing at a facility for those who test positive). Peer Navigators also support clients to attend HTS, including accompaniment, and/or support for transportation as needed. Ideally, Peer Navigators provide clients with a directory of available services, and/or guidance on where clients can access more information by phone, on the internet, or in person at drop-in-centers or other client-friendly sites.
- 3. Provide tailored post-test counselling and support to clients.** Peer Navigators understand that each individual has a unique set of circumstances and requires tailored support based on his/her needs. Peer Navigators are skilled in providing strategic behavioral communication, motivational messages, and support based on their clients' serostatus. For those who are HIV negative, Peer Navigators will emphasize routine testing and consistent use of condoms and lubricants with their sexual partners. For those who have tested HIV positive or already know their status, Peer Navigators will provide active and relevant support in positive living, including follow-up for routine medical care and support.
- 4. Refer clients to clinical, psychosocial, and other support services.** Peer Navigators are knowledgeable of the health, psychosocial, and other support services in their catchment area and beyond. They maintain a current directory of services, strong relationships with clinical and other support staff, and help ensure that the services to which they refer clients are non-stigmatizing, client-friendly, and confidential. Peer Navigators support newly-identified persons living with HIV to access clinical diagnostic services, and to initiate treatment. They also ensure that clients are aware of peer support groups, legal aid, psychological support, and case management services.

- 5. Liaise with health and other social service providers as needed.** Peer Navigators support clients to build an open and trustful relationship with their health and other support providers, helping them to overcome communication, transportation, and other barriers. They organize and attend regular (i.e. weekly) program support groups for HIV positive clients, assist group facilitators, and help introduce discussion topics. Peer Navigators may liaise directly with their clients' clinician, social worker, case manager, health educators, legal support providers, and or other providers to ensure that their clients effectively access all appropriate and relevant services available to them in the community. They support their clients to remain within the services continuum.
- 6. Support clients to adhere to their treatment regimen.** Working in tandem with case managers, Peer Navigators support their clients to obtain treatment adherence self-efficacy. They employ a combination of counseling, goal setting, tips, suggestions, and strategies, including the development of treatment adherence plans, taking into consideration potential barriers and challenges. They provide practical advice about medication-taking cues, reminders, and/or organizational tools that have worked for them. Support may include regular calls/messages, accompaniment to appointments, evaluation and adjustment of adherence plans, and/or delivery of medication as needed.
- 7. Provide counseling and emotional support.** Peers Navigators work in conjunction with case managers, social workers, and/or psychosocial counselors to provide basic counseling and support to their clients as they relate to navigating the services continuum, adhering to treatment, and living positively with HIV. They are also able to recognize and properly refer clients for mental health issues, gender-based violence, sexually transmitted infections, and family planning as needed. They serve as role models, reflecting on personal experience with HIV diagnosis, treatment, adherence, and overcoming barriers to living positively with dignity. Their function as both a role model and counselor requires a mixture of humility and pride, while avoiding becoming too distant, professional, or 'expert.' It also requires them to be honest about the challenges of living with HIV. Peer Navigators are skilled in recognizing complex cases, and recognize when to refer clients to professionals for enhanced counseling and support.
- 8. Give feedback and support to team members.** Peer Navigators are uniquely positioned to receive first-hand information from clients about challenges in accessing services, breaches of confidentiality, and both positive and negative feedback on the services provided within the network. In order to ensure that the continuum of care meets international best practice standards in terms of accessibility and quality, Peer Navigators consolidate and report client insights in regular continuum-of-care provider forums. Based on their experience with the client population, they may also provide technical support into the design/re-design of community- and facility-based interventions to ensure that they are culturally relevant, appropriately catered to the needs of their clients, and strategic.

Desired qualifications:

- **Knowledge:** Applicants must have a good knowledge of HIV and STIs, and the vulnerability of key populations to these infections. They must know the life context of key populations and factors affecting key populations access to or uptake of HIV and STI services. They must be familiar with international and national guidelines for HIV prevention, testing, care and treatment for key populations. They must be able to identify key populations-friendly health facilities in order to refer clients for services.
- **Experience:** At least one year of provision of psychosocial or peer education services to key populations or people living with HIV is highly preferred but not required. Applicants with a work experience as community workers for the national peer health navigator system are welcome.
- **Skills/Abilities:** Peer navigators should have good interpersonal and communication skills. They should also master the various tools needed in their daily work including usage of forms, screening tools, and written resources.
- **Education:** Completion of Primary School and basic HIV training is required.

TRAINING EVALUATION FORM

For participants in the Peer Navigator Training

Date: _____

Trainer(s): _____

Please indicate your level of agreement with the statements below:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The training met my expectations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I will be able to apply the knowledge learned.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The training objectives for each topic were identified and followed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The content was organized and easy to follow.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The materials distributed were pertinent and useful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The trainer(s) was(/were) knowledgeable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The quality of instruction was good.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The trainer met the training objectives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Participation and interaction were encouraged.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Adequate time was provided for questions and discussion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How do you rate the training overall?

Excellent	Good	Average	Poor	Very Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. What did you like most about the training?
11. What aspects of the training could be improved?
12. Please share your comments or expand on previous responses here: