A community-based holistic wellness program for adults living with HIV/AIDS

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A Community-Based Holistic Wellness Program for Adults Living with HIV/AIDS

By

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This Scholarly Project Paper, submitted by Renae Selzler, MOTS and Katie Kohler, MOTS in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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4/18/05
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Title: A Community-Based Holistic Wellness Program for Adults Living with HIV/AIDS

Department: Occupational Therapy

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Chapter I: Introduction

HIV/AIDS is a chronic condition that has been in the United States for more than 20 years. It has affected individuals in every part of the country and all parts of society (Avert, 2005). Human Immunodeficiency Virus (HIV) is a virus that attacks and damages the immune system, making it unable to fight infection. Acquired Immunodeficiency Syndrome (AIDS) is the advanced stage of HIV. It is diagnosed when the immune systems is weak. AIDS is indicated by a CD4 count of less than 200 cells or by the presence of specific opportunistic infections. Therefore, a person who is HIV positive does not necessarily have AIDS, but a person with AIDS is HIV positive (University of Ottawa, 2005). However, in this project HIV and AIDS are used interchangeably because the program developed is intended for individuals with both HIV and AIDS. HIV is transmitted through exchange of body fluids, sharing intravenous (IV), sexual intercourse, and vertical transmission from mother to child (Yallop, 2000).

HIV/AIDS is a chronic disease that affects individuals of all ages and ethnicities. As the disease progresses, physical and psychosocial effects become more significant and have a profound impact on quality of life. Few programs have been developed to address the physical and psychosocial needs of individuals with HIV/AIDS.

The following scholarly project describes the development of a community-based holistic wellness program for adults living with HIV/AIDS. The program is designed following an extensive literature review that focuses on the individuals' concerns surrounding HIV/AIDS. The product was developed with a
flexible protocol to meet the needs of these individuals in a supportive
environment. The outcomes of this community-based program will allow
individuals to function with an increased quality of life.

This program is guided by the Model of Human Occupation (MOHO), with
a strong emphasis on individuals' motivation, habits, and occupational
performance that allow them to function in their daily lives. Occupational
therapists are appropriate to direct this program because they look holistically at
the individuals in all areas of their lives. They also have the knowledge and skills
to address the concerns of individuals with HIV/AIDS.
Chapter II: LITERATURE REVIEW

INTRODUCTION

In 2003, it was estimated that there were 37.8 million individuals, worldwide, living with HIV/AIDS. In the United States alone, 850,000 to 950,000 people have HIV infection (National Institute of Allergy, 2004). Given these statistics, HIV/AIDS is a concern in the healthcare profession. Despite the large number of individuals affected by HIV/AIDS, limited research was found after the year 1990. Based on the available information, the review of literature will address the following areas: Physical, psychosocial, and intervention.

Physical

This section focuses on the physical aspects of HIV/AIDS. The areas discussed include: Stages, signs and symptoms, and medications.

Stages

In order to fully comprehend HIV/AIDS, it is important to understand the progression of the disease. Weinstein (1990) and Weinstein and De Neffe (1990) describe the four stage process of HIV/AIDS. Stage one is the infection of the virus, which can occur throughout the lifespan. The modes of transmitting the HIV virus include exchange of body fluids, specifically blood and semen, sharing intravenous (IV) drug needles, receiving a blood transfusion prior to 1985, having sexual contact with HIV infected individuals, and vertical transmission from mother to child. As of 1999, the most common mode of transmission was male to male sexual contact, accounting for 79.2% of HIV infections (Yallop, 2000).
Stage two is referred to as seroconversion in which antibodies are produced and present in the blood. Although there are no symptoms present in this stage, the immune system begins to be compromised. Many individuals at this stage are often not aware that the virus is present (Weinstein & De Neffe, 1990).

AIDS related complex (ARC) symptoms, characterize stage three of the illness. These symptoms include chronic diarrhea, prolonged fever, pulmonary tuberculosis, and pneumonia. As symptoms worsen, the ability to perform functional activities in one’s daily life is decreased. Individuals at this stage may be bedridden for up to 50% of the day (Different stages, 2004).

At stage four, the body is the most susceptible to acquiring infections involving the respiratory, gastrointestinal, nervous, and skin systems. The condition known as wasting syndrome also occurs at this stage as evidenced by weight loss, unexplained chronic diarrhea, and prolonged fever. Because AIDS is a terminal illness, death completes the fourth stage (Weinstein & De Neffe, 1990).

If an individual suspects that he/she has been exposed to HIV virus, it is important to be tested between 6 weeks and 12 months after exposure. This is the most opportune time to be tested because HIV antibodies are not detectable in the blood stream for 1-3 months following infection. Two different antibody tests, Western Blot and ELISA, are used to confirm the diagnosis of HIV/AIDS (United States Department of Health and Human Services [USDHHS], n.d.).
Signs and Symptoms

As with any illness, each person experiences differing symptomology. Clinical manifestation may include lack of energy, weight loss, fevers, sweats, yeast infections, skin rashes, flaky skin, pelvic inflammatory disease, headaches, enlarged lymph nodes, shortness of breath, seizures, dysphasia, diarrhea, vision loss, nausea, vomiting, persistent cough, neuropathy, tremors, dysarthria, hyperreflexia, and generalized muscle weakness (USDHHS, n.d.; Weinstein, 1990). Other features include loss of balance, coordination, ROM, and perceptual motor dysfunction (Pizzi, 1992). Along with the signs and symptoms listed above, an individual may also be affected by various opportunistic infections that involve the respiratory, gastro-intestinal, nervous, and integumentary systems. Common examples of these infections are kaposi's sarcoma, cytomegalovirus, tuberculosis, herpes simplex, and pneumocystis carinii pneumonia (The different stages, 2004).

Medications

Not only must an individual cope with the symptomology of HIV/AIDS, he/she must also learn to manage the numerous medications that aid in fighting infections and cancers. The virus attacks each person differently; therefore, medication regimens are individualized depending on the site of infection. In the past 10 years, several medications have been approved by the U.S. Food and Drug Administration (FDA), allowing an increase in the number of drugs available to treat HIV/AIDS. There are three main categories of medications used to combat HIV/AIDS, which include protease inhibitors, non-nucleoside reverse
transcriptase inhibitors (NNRTI's), and neucleoside reverse transcriptase (RT) inhibitors (USDHHS, n.d.). The combination of RT inhibitors and the protease inhibitors provides a highly active antiretroviral therapy (HAART). These medications have numerous side effects, such as nausea and diarrhea, that need to be closely monitored (USDHHS, n.d.). Due to the development of new medications, individuals with HIV/AIDS are living longer. Interventions such as occupational therapy, physical therapy, and nursing are available to assist individuals in pursuing quality of life through the progression of the illness.

Psychosocial

In addition to the physical aspects of HIV/AIDS, psychosocial issues are also considered. Research indicates that rejection, grief, sexuality, and role changes are areas of an individual's life that can be affected.

Grief

After an individual is diagnosed with HIV/AIDS, he/she may immediately associate the disease with death. Peloquin (1990) identified five AIDS metaphors, one of which compares AIDS to death. Individuals with HIV/AIDS are often perceived as already being dead. This has been used to justify the action of withholding treatment or providing less than adequate care. However, because of research and education on HIV/AIDS, an individual diagnosed with this disease is living a healthier, longer life. However, one may still experience losses in multiple life roles as a result of the disease. These losses may occur within work and/or social roles and result in the need for grieving.
In the workplace, one may experience physical, cognitive, and financial limitations, which create turmoil in his/her role as an employee. Because coworkers may have conflicting values, fear of discrimination is often warranted by individuals with HIV/AIDS. As a worker in today's society, it is expected that one will comply with social norms and follow expectations to fulfill his/her role within the job. Because of the limitations associated with HIV/AIDS, individuals are often unable to meet these expectations. Therefore, one's self-esteem may be negatively affected (Piemme & Bolle, 1990).

In addition to disturbances in work roles, an individual with HIV/AIDS may experience losses in his/her social roles as a friend, lover, family member, and colleague. Because individuals with HIV/AIDS have a negative social stigma, they may feel rejected by society, and therefore isolate from others. This isolation may precipitate into a loss of support from others, causing the individual to continue grieving (Piemme & Bolle, 1990).

According to Pizzi (1992), women, in particular, experience grief over decreased health, body image, sexuality, and child bearing potential. They often possess feelings of being dirty, useless, unwanted, and unlovable, thus decreasing their self-esteem.

**Sexuality**

Sexuality encompasses feelings of masculinity and femininity and how one presents him/herself within social and interpersonal relationships. Bedell (2000) reported that sixty percent of men with AIDS are homosexual and do not fit within the social norms of society. Individuals in this situation, as well as the
majority of persons affected by HIV/AIDS, tend to withdraw from sexual relationships because they feel less desirable and unattractive to others. This can lead to a decreased sense of identity (Bedell).

Rejection

As people with HIV/AIDS begin to cope with the illness, it is important that they consider disclosing their status to others. Mancilla (2004) described disclosure as being a double bind. He explained the double bind as having negative outcomes, regardless of whether or not the person discloses their HIV/AIDS status. For example, if a person chooses to disclose his/her status, there is a risk of the possibility that the partner will choose to no longer engage in sexual behaviors with the individual. However, if a person chooses to withhold his/her HIV/AIDS status, there is a risk of infecting others. Both outcomes, often times result in feelings of rejection.

These feelings of rejection can come, not only from partners, but also from medical professionals. Individuals with HIV/AIDS may feel rejected if they disclose their status to medical professionals, resulting in less than adequate care or refusal of services. As of 2004, there was no law that required individuals to be tested for HIV/AIDS or to disclose their status prior to receiving any type of medical services (Mancilla, 2004).

Role Changes

Because HIV/AIDS is a chronic illness, it is important that diagnosed individuals realize that the roles in their lives will be shifted over time. The best time to initiate a discussion of role transition is when the individuals are
asymptomatic, thus providing them opportunities for making choices in their lives. Often times, individuals with HIV/AIDS wait until symptoms appear to make any changes in their lives, thus creating stress and forcing a change in roles. Some symptoms may include fatigue, neuropathies, and dementia. As these symptoms progress, individuals may experience grief, difficulty with role transitions, and loss of function (Pizzi, 1990).

Initially, many individuals with HIV/AIDS may experience the loss their work role. The Americans with Disabilities Act of 1990 protects individuals against discrimination with regards to disability in employment (United States Department of Justice, 2002). However, situations may arise in which the individuals with HIV/AIDS are terminated from employment. Along with the loss of a job often comes the loss of insurance, resulting in financial difficulties due to costly medical expenses (Piemme & Bolle, 1990).

However, with the advance in medical treatment and therapeutic interventions, individuals with HIV/AIDS are returning to work (Yallop, 2000). Prevocational programs allow individuals to advance their occupations and make decisions about future work opportunities. There is not a guarantee that changes in work roles will bring paid employment, however, the focus is on maintaining wellness by maintaining or improving quality of life. Yallop considers both paid and unpaid employment as options to fulfill one’s work role.

Change can also be experienced, particularly by women, in their roles as caregivers. As they begin experiencing more symptoms, it becomes difficult to care for children. They must also deal with the responsibility of making medical
and end of life decisions for their children, significant others, and themselves.

This task may be difficult because of the physical effects experienced with HIV/AIDS (Pizzi, 1992).

Pizzi (1992) discussed changes in women’s roles regarding sexuality. As an example, some women depend on prostitution as a means of income. When this occupation was interrupted by a diagnosis of HIV/AIDS, individuals not only experience financial difficulties, but also face a decrease in sense of intimacy, human contact, and nurturance.

**Intervention**

Occupational therapy focuses on the increased ability to function within one’s roles and cope with daily stressors. Relevant areas, discussed in research, regarding interventions for individuals with HIV/AIDS include: Stress management, energy conservation, adaptive equipment, education, health promotion, and coping skills.

One model that can be utilized to address these areas is the Model of Human Occupation (MOHO). MOHO, developed by Gary Keilhofner, views human beings as open systems that must interact with and adapt to the environment around them. These open systems contain three subsystems: volition, habituation, and performance. Each subsystem contains additional components. Volition is comprised of personal causation, values, and interests. The habituation subsystem is made up of habits and internalized roles. Performance is comprised of three skills: social, cognitive, and physical actions (Keilhofner, 2002).
MOHO was designed to be used with all age groups and with a variety of diagnoses including traumatic brain injury, dementia, chronic pain, attention deficit hyperactivity disorder, and HIV/AIDS. Common settings that utilize MOHO include hospitals, nursing homes, rehabilitation centers, prisons, and community based organizations (MOHO Clearing House, 2002).

Kielhofner, et al. (2004) utilized MOHO in the development of a vocational program to determine the volition, habituation, performance capacity, and environmental challenges that individuals with HIV/AIDS experience related to work. The results of this study indicate that 56 percent of subjects that completed the vocational program attained employment. In addition, 11 percent either returned to school or began volunteering.

When individuals have HIV/AIDS, their occupational functioning is often disrupted in some ways, thus, affecting one or all of the MOHO subsystems. The individuals may have difficulty responding to their diagnosis within their environment, often leading to a maladaptive cycle of behavior. To combat this cycle, occupational therapists can use MOHO to guide their interventions to promote a balance among work, self-care, leisure (Pizzi, 1990).

**Stress Management**

O'Rourke, (1990) discussed the overall effects that stress has on an individual with HIV/AIDS. Through his research, he found that one's participation in leisure activities often decreased after being diagnosed with HIV/AIDS. O'Rourke also found individuals experienced increased anxiety, decreased concentration, and medication seeking behaviors as a result of stress. Similarly,
Weinstein and De Neffe (1990) found stress lowered immunity and led to severe bleeding in individuals with hemophilia.

Occupational therapists work with individuals diagnosed with HIV/AIDS to facilitate the development of knowledge and skills and assist them to more effectively manage stress. Stress management techniques include progressive relaxation exercises, guided imagery, deep breathing, implementation of a mild exercise routine, gentle stretching, and self-hypnosis (O’Rourke, 2002; Weinstein & De Neffe, 1990).

Energy Conservation

Emotional exhaustion and physical fatigue are two clinical symptoms that have a negative effect on instrumental activities of daily living (IADL’s), employment, and community integration, by decreasing participation in these activities. Energy conservation is used to combat these symptoms. Specific techniques include monitoring energy levels, listening to one’s body, pacing one’s self throughout the day, and simplifying work tasks to improve quality of life for individuals with HIV/AIDS. Even when a person is in the end stages of HIV/AIDS, occupational therapy can play a vital role in assisting clients to maintain quality of life. Therapists educate the clients about utilizing their existing resources as efficiently as possible (Bedell, 2000; Weinstein & De Neffe, 1990).

Adaptive Equipment

Individuals in advanced stages of HIV/AIDS often experience ataxia, gross and fine motor difficulties, balance problems, confusion, memory loss, attention
deficits, and difficulties with mental flexibility (Weinstein & De Neffe, 1990). Adaptive equipment can be used to increase client's functioning in daily life activities. Techniques such as use of scheduling tools, memory devices, and visual safety aids can be used to help the person cope more effectively. Occupational therapists analyze activities and simplify them into single steps, thus making the tasks easier to perform. Adaptive equipment can be used to assist individuals with HIV/AIDS to more efficiently complete dressing, meal planning and preparation activities (Pizzi, 1992).

*Education*

Education is an intervention that is utilized to inform individuals about important aspects surrounding HIV/AIDS. The areas discussed include: Safe sex, HIV/AIDS, health promotion, and coping skills.

*Safe Sex*

Safe sex education is an important part of intervention for individuals with HIV/AIDS. According to the Coalition for Positive Sexuality (1997), safe sex is defined as behaviors in which there is no contact and/or exchange of blood, semen, vaginal fluids, or breast milk between individuals. The Education Training Research Associates (ETR) (2001) devised a plan for safe sex that is comprised of seven suggestions in order to protect against sexually transmitted diseases (STD's). This "Safer Sex Plan" recommends the following: Make a commitment to yourself, know about STD's, practice using the condoms, communicate with your partner, stick to your plan, be prepared to abstain from sex if you partner resists, and keep condoms readily available. The National
Center for HIV, STD, & TB Prevention (NCHSTP) (2003) reported only latex or polyurethane condoms provide the most effective protection against HIV/AIDS. They found that if and when condoms are worn consistently and correctly, the breakage rate of latex condoms is less than 2% in the United States. The ETR (2001) also recommends abstaining from drinking alcoholic beverages or using drugs because they can impair one's judgment and coordination and interfere with the safer sex plan.

**HIV/AIDS**

Not only is it crucial to be educated about safe sex practices, but also it is important to be aware of general information regarding HIV/AIDS and its transmission. Mountain Plains (Brown et al., 2004) identified that healthcare providers play a crucial role in the prevention, detection, and education of HIV/AIDS. This sourcebook emphasized the importance of healthcare providers' roles in increasing awareness about risk reduction and prevention of HIV/AIDS. It also stressed the importance of identifying safe versus high risk behaviors. Examples of behaviors in which there is no risk of transmitting HIV/AIDS included abstaining from sex and IV drug usage. High risk behaviors included having unprotected vaginal or anal intercourse, sharing needles, and becoming pregnant when the immune system is compromised, specifically, during the late stages of the disease.

In addition to educating about risk reduction and prevention of HIV/AIDS it is also pertinent to inform individuals about how the disease is transmitted. The NCHSTP (2003) developed a fact sheet to negate common misperceptions about
HIV/AIDS. To correct these misconceptions, they provided facts about HIV and its transmission. HIV/AIDS is transmitted by sharing needles, engaging in sexual activity with an infected individual, receiving blood transfusions, and through vertical transmission from mother to baby.

Transmission of HIV/AIDS in casual relationships is rare; however, it is still important that standard precautions be followed. Examples of standard precautions include hand washing after contact with body fluids, covering open wounds, wearing gloves when working with blood or other body fluids, and correctly using medical needles and disposing of them properly. There is also emphasis regarding the importance of one-time use of needles, razors, or other objects that penetrate the skin (NCHSTP, 2003).

Health Promotion

Little research was available on utilizing exercise as a treatment intervention for individuals with HIV/AIDS. However, Pizzi (1992) provided information about the importance of including exercise in a wellness program to maintain health and physical function as the disease progresses. Pizzi (1990, p. 259) introduced the importance of Occupational Therapy's role in facilitating interventions focused on "living with HIV" rather than "dying from HIV." He proposed that wellness programs focus on maintaining a balance among work, rest, sleep, and play. This and other occupational therapy strategies support helping people learn to "live with HIV."

In correlation with the promotion of wellness, there was also an emphasis on the importance of proper nutrition for people infected with HIV/AIDS. In a
health promotion class at a day treatment program in New York, NY, the Village Nursing Home emphasized the importance of providing adequate nutrition to individuals with HIV/AIDS. A clinical nutritionist educated the clients on healthy choices regarding the essential nutritional needs of a person with HIV/AIDS. It was recommended that individuals choose foods that are unprocessed, free of preservatives and chemicals, are low in sugar, and contain a variety of nutrients (Gutterman, 1990).

Nutrition was important not only in promoting health and wellness, but also in managing the effects of Wasting Syndrome, which often includes malnutrition as a symptom. During the early stages of the disease process, it was recommended that individuals affected with HIV/AIDS consult with a dietitian regarding nutritional issues. This can have a positive effect on the morbidity rates among individuals with HIV/AIDS (Brown et al., 2004).

An important part of health promotion was encouraging clients with HIV/AIDS to comply with their medication regimes. Failure to comply with the medication routines can result in drug resistance and the increased risk for transmission of the virus. Strategies to increase compliance with medications included: Establish rapport between client and therapist, review and educate about treatment goals, evaluate and monitor for signs of depression, recommend the use of pill boxes, and educate client about side effects of the medications (Brown et al., 2004).
Coping Skills

With all that encompasses having a diagnosis of HIV/AIDS, it is important that the individual be equipped with a variety of coping skills. These skills can be used to help manage both the psychosocial and physical symptoms of the disease.

A case example of effective coping skill utilization was given in *The HIV-Positive Intravenous Drug Abuser* (O’Rourke, 1990). A subject with HIV/AIDS and his occupational therapist worked together to develop a variety of coping skills including interpersonal skills, time management skills, stress management skills, and basic living skills. The subject was taught these skills, allowed opportunities to practice them, and demonstrated understanding of how these skills can assist him in coping with manifestations associated with HIV/AIDS.

Weinstein and De Neffe (1990) also stressed the importance of developing positive coping skills in individuals with HIV/AIDS. Occupational therapists addressed feelings of anger by educating clients on healthy strategies to reduce stress and manage anger. They emphasized the value of practicing effective communication skills in order to express thoughts and feelings about HIV/AIDS to family, friends, neighbors, and co-workers.

Day Treatment Program

A day treatment program was established in New York, NY, in 1988. It emerged from the Village Nursing Home and served approximately 50 clients per day. All clients were diagnosed with HIV/AIDS, with some also having comorbid diagnoses. The program was delivered by an interdisciplinary team including:
Social workers, psychologists, substance use/abuse counselors, psychiatrists, occupational therapists, nurses, acupuncturists, massage therapists, chiropractors, music therapists, recreational therapists, creative writing specialists, dieticians, facilities staff, and administrative personnel. Each team member provided services according to his/her disciplines area of care (Murphy et al., 1999).

Gutterman (1990, p. 235) described the same program, in which she explained that occupational therapy's role, specifically, was to "support clients physically, emotionally, and spiritually, to facilitate adaptive behavior, and act as a catalyst for change where there is receptivity and motivation." This program encouraged clients with HIV/AIDS to regain control by providing an option to participate in a detoxification program, educating individuals about medications and their side effects, providing access to legal services for the implementation of a living will, and offering information on relaxation as a healthy coping skill.

Similarly the vocational program described by Kielhofner, et al. (2004) explored outcomes of vocational experiences of individuals with HIV/AIDS. Areas that were encompassed in the vocational program included health and disability benefits, vocational planning, job search, coping with challenges to increase confidence, job analysis, sustained employment, and completing internships and volunteering experiences. They also reported that in previous literature, there has never been a program addressing vocational services for individuals with AIDS. Also, there is limited information for individuals on issues related to returning to work.
Current literature demonstrates that individuals diagnosed with HIV/AIDS have ongoing needs associated with maintaining productive roles while coping with illness. Occupational therapists can play a vital role in supporting individuals with HIV/AIDS and providing resources to increase their occupational functioning and improve their quality of life. Chapter three describes the process of designing a community-based program for adults living with HIV/AIDS to create and maintain a healthy, balanced lifestyle. MOHO was utilized to guide the process.
Chapter III: Activities & Methodology

It is estimated that the number of persons in the United States with HIV/AIDS is likely to be close to one million (Avert, 2005). This illness affects individuals in all areas of their lives including work, leisure, social participation, and self-care. As the disease progresses, individuals are forced to cope with the physical and psychosocial effects of HIV/AIDS.

The purpose of this project was to develop an occupational therapy community-based program that addresses the needs of individuals diagnosed with HIV/AIDS. An extensive literature review was conducted to determine the physical and psychosocial effects of HIV/AIDS and interventions utilized by occupational therapists and other professionals. A community-based occupational therapist, Lynn Swanson, MOTR/L, Capacity Builder for HIV Prevention Programs for North Dakota, was contacted. The authors met with her to discuss concerns that she has encountered while working with individuals with HIV/AIDS. After determining areas of concern for individuals with HIV/AIDS, these relevant issues were selected to serve as the product's foundation:

- Self-Disclosure
- Sexuality
- Stress Management
- Time Management
- Financial Support
- Nutrition
- Exercise
- Risk Prevention
- Relationships
- Roles
- Communication

- Work
- Leisure
- Self-Esteem
- Spirituality
- Anger Management
- Grief
- Relaxation
- Nutrition
- Money Management
- Medication Management
- Community Resources
These topics were organized into one hour sessions that span a 6 week period. The sessions will run for a total of four hours each week, 7:00 – 9:00 on Tuesday and Thursday nights.

An intake assessment was developed to provide the occupational therapists with information on the individual's current state and issues he/she is experiencing. The program was designed to provide a logical progression of topics that allows flexibility while meeting specific client needs.

Chapter IV provides an overview of the program protocol. The program protocol, tentative schedule, and group activities are found in appendix B. The intake assessment is found in appendix A.
Chapter IV: Program Overview

The mission of this program is to provide a holistic wellness program, guided by MOHO, to individuals with HIV/AIDS in a community-based setting. Throughout its duration, the program will strive to achieve the following goals.

- To provide client-centered services to individuals with HIV/AIDS in the Grand Forks community to increase occupational functioning in their daily roles.
- To serve as a prototype for expanding holistic wellness programs to areas in other states with higher incidence rates of HIV/AIDS.
- To serve as an ongoing resource center for individuals who have completed the program.

The wellness program is presented according to a tentative schedule that can be adjusted according to client needs. The client-centered nature of the program allows for flexibility in topic areas throughout the six weeks.

The program is intended to serve individuals with HIV/AIDS who are newly diagnosed (within 1 year). Referrals will come from Infectious Disease doctors in the surrounding area.

Prior to beginning the program, each individual must present a verification of his/her HIV status. Next, the client will participate in an interview with an occupational therapist. This will allow the therapist to understand the needs and concerns of the client and assist in modifying the program to fit these needs. It will also allow the therapist to better understand the individual's current level of functioning. Once the interview is completed, goals will be developed in conjunction with the client. The occupational therapist will document the results of the intake and the goals in a narrative format (See Appendix A).
From literature reviewed, the following areas were found to be relevant for issues surrounding HIV/AIDS. The significant areas were risk prevention, disclosure, communication, stress management, relaxation, grief/loss, anger management, budgeting, financial support, nutrition, exercise, medication management, time management, sexuality, relationships, roles, work, leisure, self-esteem, spirituality, and community resources. From these areas, a tentative program of activities and education sessions was created.

A program protocol was developed addressing the overall goals of the groups as well as general information about the program (See Appendix B, pgs. 2-5).

The tentative schedule was set up for groups to meet every Tuesday and Thursday evenings from 7:00 – 9:00 p.m., with a social on Tuesday's from 6:30 – 7:00 p.m., for six consecutive weeks (See Appendix B, pg. 6).

Documentation will be completed after each program session. A Subjective Objective Assessment Plan (SOAP) note format will be utilized in order to record client progress.

Upon completion of the six week program, a discharge evaluation will be completed by each client (See Appendix B, pg. 93). This evaluation will allow the client to express feedback about the program and staff. Three months following discharge from the program, a phone call will be made to each client. The client and therapist will discuss how the client is currently functioning in his/her roles, and how information learned in the program has been implemented in his/her life. The information gathered from the initial discharge evaluation and the phone call
will be used to determine the program's effectiveness. This information will also be used to make modifications for future programming.

The proposed program will serve as a prototype in Grand Forks, North Dakota for one to two years. After this time, the intention is to offer this program in other states with higher incidence rates of HIV/AIDS.

Grant funding will be sought to sustain the program. Specific areas of focus include: Community, HIV/AIDS prevention, public health, and human service programs. This program meets eligibility for application to the following grants: Title III Capacity Building Grant Program of Ryan White CARE Act, Preventive Health and Health Services Block Grant, Cable Positive Tony Cox Community Fund, as well as grants provided through the Archibald Bush Foundation and the Ford Foundation. Clients will not be required to pay for services provided by this community-based program.

The handouts that compliment activities are from the following texts, which will be purchased prior to the start of the program. The texts include: Korb-Khalsa, Azok, & Leutenberg, (1989), Korb, Azok, & Leutenberg, (1991), Korb-Khalsa & Leutenberg, (1996), Korb-Khalsa & Leutenberg, (2000), and Butler, (2001).

The program will be staffed by two occupational therapists with a minimum of a four year bachelor's degree. The program will be housed in a community or public health facility. Through research, it is estimated that the program will cost approximately $35,000 per year. This includes the contractual hourly fee of the
occupational therapists, utilities, and program materials. The duration of the program will be six weeks, and offered six times per year.
Chapter V: Summary

The product is a community-based holistic wellness program for adults living with HIV/AIDS. It was developed to address physical and psychosocial factors which may impede an individual’s ability to fulfill daily life tasks and roles. The treatment protocol was aimed at addressing areas including, but not limited to, self-disclosure, sexuality, stress management, time management, budgeting, nutrition, and exercise. Guided by the core components of MOHO, it is a flexible protocol that can be modified according to clients’ needs.

Although this program can be a useful tool for individuals with HIV/AIDS, it presents with certain limitations. North Dakota has a relatively low incidence rate of HIV/AIDS. Because of this, it may not fully support the development of a program of this depth. It is recommended that the proposed program serve as a prototype, with the intent of offering this program in areas of other states with higher incidence rates of HIV/AIDS.

Also, current information is needed to document the outcomes of occupational therapy intervention with individuals diagnosed with HIV/AIDS. There is a limited amount of current literature available regarding occupational therapy outcomes for individuals with HIV/AIDS. It is recommended that occupational therapy intervention outcomes be tracked to evaluate the effectiveness of the program in meeting the needs of the clients.

These recommendations are proposed to enhance the program in order for it to achieve its highest potential to support individuals with HIV/AIDS as they function in their daily lives.
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Appendix A

Initial Intake Form
Initial Intake Form

Name_________________________ Age_____ DOB_____ Gender_____

Address______________________________________________________________

Telephone #_________ Date_________ Referred by__________________________

Marital Status________________

ADL’s (Personal Hygiene/Grooming, Sexual Activity, Sleep/Rest etc…)

____________________________________________________________________

IADL’s (Finances, Medication, Health Management, Home Management, Safety, etc…)

____________________________________________________________________

Education (Formal, In-formal etc…)

____________________________________________________________________

Work (Interests, Job Performance, Volunteer, Retirement etc…)

____________________________________________________________________

Leisure (Exploration, Participation)

____________________________________________________________________

Social Participation and Community Resources (Family, Friends, Community, etc…)

____________________________________________________________________

Cognitive Status (Attention Span, Sequencing, Concentration etc…)

____________________________________________________________________
Communication (Assertiveness, Expression, Relationships etc...)

Engagement in Daily Roles (Friend, Family, Worker etc...)

Self-Concept (Self-Esteem, Spirituality, Self-Identity etc...)

Initial Response to Program (Excited, Hesitant, Optimistic, Doubtful, Anxious etc...)

Questions

Specific Goals for Group Involvement

1. __________________________________________

2. __________________________________________

3. __________________________________________

4. __________________________________________

5. __________________________________________

Therapist Signature ___________________________ Date ___________________________
Appendix B

Program Protocol

Product
Program Protocol

Program Title: Community-based holistic wellness for adults living with HIV/AIDS

Authors: Renae Selzler, MOTS, Katie Kohler, MOTS, and Janet Jedlicka, Ph. D.

Frame of Reference: Model of Human Occupation

Purpose: The program will address physical and psychosocial factors which may impede individuals' with HIV/AIDS ability to fulfill daily life tasks and roles.

Group Membership and Size: The optimal group size is 8-10 members. This number is flexible, depending on the needs of individuals in the community.

Overall Group Goals:

At the end of the program, members will be able to:

1. Describe and practice techniques for safe sex and cleaning needles (if client uses needles).
2. Demonstrate effective communication skills regarding HIV status and feelings associated with diagnosis.
3. Identify personal stressors, reactions to stressors, and develop more effective ways of managing personal stress.
4. Utilize relaxation techniques to cope with stress.
5. Create a monthly budget and demonstrate understanding of its implementation.
6. Demonstrate understanding of available community resources to assist with healthcare, housing, and other areas of concern.
Rationale:

These goals are appropriate for newly diagnosed individuals with HIV/AIDS. They address issues that are of current concern, or that may be of concern in the future. These goals are appropriate for people with a variety of psychosocial disorders; however they are developed specifically, for this program, to address the needs of individuals with HIV/AIDS.

Outcome Criteria:

An HIV/AIDS program survey was developed to measure the effectiveness of the program to the patient and the therapist. It will be completed by each group member at the conclusion of the program.

Method:

The following media will be used in the program: Handouts, CD’s, pamphlets, surveys, hands-on activities, videos, and guest speakers. The proposed topics to be covered include: Risk Prevention, Disclosure, Communication, Stress Management, Relaxation, Grief and Loss, Anger Management, Money Management, Financial Support, Nutrition, Exercise, Medication Management, Time Management, Sexuality, Relationships, Roles, Community Resources, Work, Leisure, Self-Esteem, and Spirituality.

Time and Place of Meeting:

The tentative schedule is set up for groups to meet every Tuesday and Thursday evenings from 7:00 – 9:00 p.m., with a social on Tuesday’s from 6:30 –
7:00 p.m., for six consecutive weeks. The program will be held in a private room in the Red River Valley Community Action Facility.

**Supplies and cost:**

The following is the breakdown for the program's expenses.

**Therapist's Salaries:**

The program will employ two occupational therapists for 552 hours per year. Each therapist will receive an hourly fee of $25.00. The total yearly salary for both therapists is $27,600.00.

**Utilities:**

For one year, the utilities for operating the proposed program total $1,200.00. This includes electricity, heat, water, and garbage removal.

**Supplies:**

The amount of money that will be allotted for supplies and other materials that are needed throughout the year (including paper, pens, pencils, copy fees, textbooks) is $4,200.00.

**Social Hour:**

Snacks and beverages will be provided every Tuesday night prior to programming including coffee, juice, cookies, cheese and crackers, and other healthy snacks. Also, plates and eating utensils will be purchased. The amount of money allotted for the social hour refreshments is $2,000.00.
Total Expense:

The total amount of money that will be required to operate the program is $35,000.00 per year. This includes the amount of money needed for therapist's salaries, utilities, supplies, and the social hour.
## Tentative Program Schedule

<table>
<thead>
<tr>
<th>Week</th>
<th>Tuesday</th>
<th>Thursday</th>
<th>Tuesday</th>
<th>Thursday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6:30 Social</td>
<td>X</td>
<td>6:30 Social</td>
<td>X</td>
</tr>
<tr>
<td>Week 1</td>
<td>7:00 Introduction</td>
<td>Grief and Loss</td>
<td>7:00 Medication Management</td>
<td>Work</td>
</tr>
<tr>
<td></td>
<td>8:00 Risk Prevention</td>
<td>Anger Management</td>
<td>8:00 Time Management</td>
<td>Leisure</td>
</tr>
<tr>
<td>Week 2</td>
<td>6:30 Social</td>
<td>X</td>
<td>6:30 Social</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>7:00 Disclosure</td>
<td>Money Management</td>
<td>7:00 Sexuality</td>
<td>Self-Esteem</td>
</tr>
<tr>
<td></td>
<td>8:00 Communication</td>
<td>Financial Support</td>
<td>8:00 Relationships</td>
<td>Spirituality</td>
</tr>
<tr>
<td>Week 3</td>
<td>6:30 Social</td>
<td>X</td>
<td>6:30 Social</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>7:00 Stress Management</td>
<td>Nutrition</td>
<td>7:00 Roles</td>
<td>Wrap-Up</td>
</tr>
<tr>
<td></td>
<td>8:00 Relaxation</td>
<td>Exercise</td>
<td>8:00 Community Resources</td>
<td></td>
</tr>
<tr>
<td>Week 4</td>
<td>6:30 Social</td>
<td>X</td>
<td>6:30 Social</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>7:00 Introduction</td>
<td>Grief and Loss</td>
<td>7:00 Medication Management</td>
<td>Work</td>
</tr>
<tr>
<td></td>
<td>8:00 Risk Prevention</td>
<td>Anger Management</td>
<td>8:00 Time Management</td>
<td>Leisure</td>
</tr>
<tr>
<td>Week 5</td>
<td>6:30 Social</td>
<td>X</td>
<td>6:30 Social</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>7:00 Disclosure</td>
<td>Money Management</td>
<td>7:00 Sexuality</td>
<td>Self-Esteem</td>
</tr>
<tr>
<td></td>
<td>8:00 Communication</td>
<td>Financial Support</td>
<td>8:00 Relationships</td>
<td>Spirituality</td>
</tr>
<tr>
<td>Week 6</td>
<td>6:30 Social</td>
<td>X</td>
<td>6:30 Social</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>7:00 Stress Management</td>
<td>Nutrition</td>
<td>7:00 Roles</td>
<td>Wrap-Up</td>
</tr>
<tr>
<td></td>
<td>8:00 Relaxation</td>
<td>Exercise</td>
<td>8:00 Community Resources</td>
<td></td>
</tr>
</tbody>
</table>
Introduction
Group Title:
Introduction

Session Title:
Icebreaker: Who Am I? What Am I?

Purpose:
• To introduce individuals to the social context of the group.
• To facilitate communication among group members.

Materials:
• Tape
• Paper
• Marker
• List of famous individuals, events, or things etc...

Description:

1. Explain that in this exercise the participants will be asked to identify the names of famous persons or things (places, events, etc.)
2. Tape a piece of paper the back of each participant. The paper will have the name of a famous person, event, and/or thing written on it. The group member is not to see what is taped on his or her back.
3. Tell the group members that each of them now has new identity. Their task is to find out who they are.
4. Instruct participants to mill around the room and simultaneously ask each other questions that can be answered with a "yes" or "no." For example: "Am I living?" "Am I a movie star?"
5. Explain that if the participant receives a "yes" answer, he or she can continue to ask that group member questions until a "no" response is given. When the participant receives a "no" response, he or she must move to another group member to ask another question.
6. Explain that when a group member has established his or her new identity, he or she is to remove the tag, write his or her name across the top of the paper, and then tape the tag to his or her chest. The participant may then mill around the room helping other group members discover their identities.
7. The exercise concludes when all of the participants have discovered who they are.
Risk Prevention
Group Title:
Risk Prevention

Session Title:
Protecting yourself and others

Purpose:
- To provide information regarding modes of transmission, risk behaviors, and prevention of STD's and HIV/AIDS.
- To educate individuals about guidelines to follow regarding safe sex and drug usage practices in order to prevent transmission of STD's and HIV/AIDS.

Materials:
- Male and female condom
- Condom Demonstrator
- Syringe
- Bleach
- Water
- Pamphlet (American College Health Association, 2002)
- Pamphlet (Channing Bete Company, Inc., 2002)
- Pamphlet (Channing Bete Company, Inc., 1999)
- Pamphlet (Planned Parenthood, 2001)

Description:
1. Individuals will be divided into small groups of 2-3.
2. Each group will receive a pamphlet about risk behaviors and prevention surrounding STD's and HIV/AIDS.
3. Groups will have approximately 10 minutes to look at and discuss information.
4. Individuals will return to large group and share learned information with others, facilitated by group leader.
5. Following educational discussion, individuals will have the opportunity to apply a condom to a condom demonstrator, as well as practicing syringe sterilization.
6. Time will be allowed for questions and discussion throughout activity.
7. Free condoms will be available for individuals to take to encourage safe sex practices.
Disclosure
Group Title:
Disclosure
Session Title:
Talking about HIV/AIDS

Purpose:
- To explore some of the “how to” issues surrounding self-disclosure of HIV/AIDS.
- To provide a healthy, supportive environment for talking about positive and negative issues of disclosing HIV/AIDS status.
- To educate individuals on the issues surrounding disclosure of illnesses.

Materials:
- Worksheet (Korb-Khalsa & Leutenberg, 2000, p. 37)
- Body Positive (Mancilla, 2004)
- Educational information (New Mexico AIDS Infonet, 2004)

Description:
1. Introduce the topic, disclosure, to group members.
2. Provide each group member with a worksheet.
3. Facilitate a discussion about the information on the worksheet.
4. Ask each group member to share either a positive or negative experience when they disclosed their illness to someone.
5. Take several negative experiences and discuss them each in terms of how they might have been handled differently.
6. Process the benefits of this activity.
Talking about your mental health difficulties to friends, family, peers, or neighbors can be challenging. Should you? Shouldn't you? How can you feel okay about discussing it? Or not discussing it? How much do you say? How about those awkward or nosy questions you sometimes get, when you're least expecting it? It's wise to give it some thought...


WITH whom are you comfortable being completely open and honest?

WITH whom or in what situations do you want to be more discreet, giving less information?

WITH whom do you want to completely keep your privacy?

Then, give yourself permission to respect these decisions.

WHAT TO SAY - WHAT TO SAY - WHAT TO SAY - WHAT TO SAY

☐ THINK, it may be helpful to think what to say before situations arise, so you're not caught off guard. Rehearse your response if you'd like. And remember... there's no right or wrong... find your own ways of talking about it.

☐ HELP others to understand by using language that is medically correct, for example, 'depression' rather than 'nervous breakdown.' Refer to information pamphlets or fact sheets to help explain.

☐ DESCRIBE your symptoms in clear terms. 'Poor concentration,' 'confused thoughts' or 'difficulty sleeping' will help others understand, since these difficulties/concepts are easy enough for most people to grasp.

☐ AVOID or eliminate mysterious, frightening or derogatory words such as 'psycho,' 'crazy' or 'loony.' These words do not portray an accurate picture of mental illness; in fact, they are likely to perpetuate a stigma!

☐ EMPHASIZE the positive aspects of what you are doing, e.g., 'I'm getting a lot of help.' "The program I'm in is teaching me a lot."

DO NOT WANT TO TALK ABOUT - DO NOT WANT TO TALK ABOUT

If you don't want to disclose anything, you have this right. Indicate the subject is off limits, in a pleasant but firm voice. Try something like, "I'm just not comfortable talking about it right now."

'The term 'personal problems' covers a lot but without actually disclosing much, and avoids the problem of outright lying. Similarly, 'internal problems' might be a way of suggesting an illness too delicate for further discussion.

Acknowledge others' concern with "thanks for caring" or "I appreciate your concern." Practice quickly changing the subject, "How are you?", people might actually prefer talking about themselves anyway!
Communication
Group Title: Communication
Session Title: Just Do It

Purpose:
- To increase understanding of communication by practicing assertion.
- To provide a supportive environment that is conducive for group members to practice communication skills.

Materials:
- Scissors
- Container for cut-ups
- Worksheet (Butler, 2001, pp. 25-27)

Description:
1. Introduce the topic, communication, to group members.
2. Divide individuals into small groups of 2-3.
3. Instruct individuals to draw a piece of paper from the container.
4. Approximately 10 minutes will be allowed for group members to think of a role play situation that describes the communication skill on the sheet of paper.
5. Instruct individuals to role play the communication skill with the large group.
6. Discuss feedback with group members regarding the communication skill that was role played.
7. Distribute worksheet that lists the communication skills that were discussed during the session. Instruct group members about the directions of the worksheet.
8. Allow time for processing the benefits of the activity.

(Butler, 2001, pp. 25-27)
# Just Do It!

## Checklist

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>WITNESS INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive and refuse and invitation.</td>
<td></td>
</tr>
<tr>
<td>Make a request.</td>
<td></td>
</tr>
<tr>
<td>Express fear.</td>
<td></td>
</tr>
<tr>
<td>Express anger (assertively, not aggressively)</td>
<td></td>
</tr>
<tr>
<td>Introduce yourself.</td>
<td></td>
</tr>
<tr>
<td>Give a compliment.</td>
<td></td>
</tr>
<tr>
<td>Receive a compliment.</td>
<td></td>
</tr>
<tr>
<td>State a decision without justifying it.</td>
<td></td>
</tr>
<tr>
<td>Express love.</td>
<td></td>
</tr>
<tr>
<td>Ask to borrow something.</td>
<td></td>
</tr>
<tr>
<td>Receive constructive criticism.</td>
<td></td>
</tr>
<tr>
<td>Give constructive criticism.</td>
<td></td>
</tr>
<tr>
<td>Say &quot;No&quot; to a request.</td>
<td></td>
</tr>
<tr>
<td>Start a conversation.</td>
<td></td>
</tr>
<tr>
<td>Receive an invitation and accept.</td>
<td></td>
</tr>
<tr>
<td>Express annoyance. (Use an &quot;i&quot; statement)</td>
<td></td>
</tr>
<tr>
<td>Express an opinion</td>
<td></td>
</tr>
<tr>
<td>Say &quot;I don't know&quot; without apologizing.</td>
<td></td>
</tr>
<tr>
<td>Admit a mistake and accept the consequences.</td>
<td></td>
</tr>
<tr>
<td>Say something positive about yourself.</td>
<td></td>
</tr>
</tbody>
</table>
Stress Management
Group Title:
Stress Management

Session Title:
Beat It...Stress

Purpose:
• To allow group members to identify the causes of stress in their lives.
• To discover ways individuals react to stress, and whether their reactions are appropriate and useful.
• To offer tools, such as a stress diary, to understand daily stressors and reactions to these stressors.

Materials:
• Stress Management Education (Mind Tools Stress, 1995-2005)
• Burnout Self-Test (Mind Tools Burnout, 1995-2005)

Description:
1. Introduce the topic, stress management, to group members.
2. Explain the definition of stress and the kinds of stress.
3. Instruct group members on using the Stress Diary.
   1. The date and time of the entry.
   2. How happy you feel now, using a subjective assessment on a scale of -10 (the most unhappy you have ever been) to +10 (the happiest you have been). As well as this, write down the mood you are feeling.
   3. How efficiently you are working now (a subjective assessment, on a scale of 0 to 10). A 0 here would show complete inefficiency, while a 10 would show the greatest efficiency you have ever achieved.
   4. How stressed you feel now, again on a subjective scale of 0 to 10. As before, 0 here would be the most relaxed you have ever been, while 10 would show the greatest stress you have ever experienced.
   5. The most recent stressful event you have experienced.
   6. The symptom did you feel (e.g. “butterflies in your stomach”, anger, headache, raised pulse rate, sweaty palms, etc.).
   7. The fundamental cause of the stress (being as honest and objective as possible).
   8. How well you handled the event: Did your reaction help solve the problem, or did it inflame it?
   9. Facilitate discussion about areas checked and areas for improvement.
4. Instruct group members to take the Burnout Self-Test and discuss results.
5. Allow time for process and questions about stress management.
**Burnout Self Quiz**

<table>
<thead>
<tr>
<th>#</th>
<th>Question</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you feel run down and drained of physical or emotional energy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Do you find that you are prone to negative thinking about your job?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do you find that you are harder and less sympathetic with people than perhaps they deserve?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you find yourself getting easily irritated by small problems, or by your co-workers and team?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you feel misunderstood or unappreciated by your co-workers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you feel that you have no one to talk to?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you feel that you are achieving less than you should?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you feel under an unpleasant level of pressure to succeed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you feel that you are not getting what you want out of your job?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you feel that you are in the wrong organization or the wrong profession?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Are you becoming frustrated with parts of your job?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you feel that organizational politics or bureaucracy frustrate your ability to do a good job?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Do you feel that there is more work to do than you practically have the ability to do?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Do you feel that you do not have time to do many of the things that are important to doing a good quality job?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Do you find that you do not have time to plan as much as you would like to?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**To score:** 1 point-Not at all, 2 points-Rarely, 3 points-Sometimes, 4 points-Often, 5 points-Very often

**Add up points for each question**

<table>
<thead>
<tr>
<th>Score</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 18</td>
<td>No sign of burnout here</td>
</tr>
<tr>
<td>19 – 32</td>
<td>Little sign of burnout here, unless some factors are particularly severe</td>
</tr>
<tr>
<td>33 – 49</td>
<td>Be careful - you may be at risk of burnout, particularly if several scores are high</td>
</tr>
<tr>
<td>50 – 59</td>
<td>You are at severe risk of burnout - do something about this urgently</td>
</tr>
<tr>
<td>60 – 75</td>
<td>You are at very severe risk of burnout - do something about this urgently</td>
</tr>
</tbody>
</table>

(Mind Tools Burnout, 1995, 2000)
Relaxation
Group Title: Relaxation
Session Title: Taking it easy

Purpose:
• To educate group members about various relaxation techniques that can be utilized as positive coping skills to deal with stressful situations.
• To allow group members to practice using seven different relaxation techniques in a safe, supportive environment.

Materials:
• Video (Garrigus, 1999)
• Blankets
• Pillows

Description:
1. Introduce the topic, relaxation, to group members.
2. Give each group member a blanket and a pillow.
3. Give the option of lying on the floor with the blanket and pillow, or sitting up in the chair.
4. Encourage those who are able, to lie on their backs on the floor, as this is the optimal position for relaxation.
5. Show video to group members (40 minutes).
6. Discuss what group members liked/did not like about video.
7. Discuss other options for relaxation.
8. Process the benefits of doing relaxation.

(Garrigus, 1999)
Grief and Loss
Group Title:
Grief and Loss

Session Title:
Dear HIV/AIDS

Purpose:
- To express grief and loss feelings associated with either and HIV/AIDS diagnosis or the death of a friend with HIV/AIDS.
- To educate about the grieving process.
- To provide a safe environment for individuals to share their feelings surrounding the emotional effects of being diagnosed with HIV/AIDS.

Materials:
- Paper
- Pen or Pencil
- Education information (Cruse Bereavement Care, 2005; National Association for Loss and Grief, 2004)

Description:
1. Introduce the topic, grief and loss, to group members.
2. Provide group member with educational information regarding grief/loss.
3. Introduce strategies that can be used to cope with grief.
4. Facilitate a discussion:
   1. What have/are you grieving about?
   2. How did you show your emotions toward the grief that you experienced?
   3. What makes grieving difficult?
   4. What strategies have you learned that will help you deal with grief issues in the future?
5. Hand out a piece of paper to each group member and instruct them to title it, "Dear HIV/AIDS."
6. Encourage individuals to take time to write a letter to their disease, expressing the following:
   1. What are the losses that you've experienced since being diagnosed with HIV/AIDS?
   2. How does HIV/AIDS affect your daily routines, relationships with others, and motivation to anticipate the future?
   3. What are healthy ways that you can express your grief?
7. Have each individual share their letter with the group.
8. Process feelings that everyone is experiencing.
9. Process the benefits of doing this activity.

(Cruse Bereavement Care, 2005)
(National Association for Loss and Grief, 2004)
Anger Management
Group Title:
Anger Management
Session Title:
Blowing Off Steam

Purpose:
- To enable group members to describe feelings of anger and its effects on them.
- To educate group members about coping strategies to utilize when angry.
- To offer group members communication tools to assist them in dealing with anger in relationships.

Materials:
- Paper cup
- Grocery bag
- Tape

Description:
1. Introduce the topic, anger management, to group members.
2. Ask the group members to reflect on the last time that they were angry. Have them focus on where that anger came from and how they dealt with the anger.
3. Explain the game “Blowing Off Steam”
   1. Have group members sit around a table. Place a cup at one end of the table. Tape the grocery bag to the other end. The group must attempt to blow the cup into the grocery bag by blowing air with their mouths.
   2. Repeat the activity until the group members have worked out a technique to do it quickly, and with less frustration.
4. Discuss feelings of frustration the group members may have experienced throughout the activity.
5. Brainstorm with group about healthy strategies to utilize when angry such as going for a walk, listening to music, relaxation techniques, etc.

(Nagel-Smith, n.d.)
Money Management
Group Title: 
Money Management

Session Title: 
It all makes cents

Purpose:
• To educate group members on the importance of budgeting their money.
• To look at one’s income sources and identify ways to save money.
• To develop a balanced budget for group members to utilize in their daily lives.

Materials:
• Worksheet (Adapted from Korb-Khalsa & Leutenberg, 2000, p17)

Description:

1. Introduce the topic, money management, to group members.
2. Provide each group member with a handout.
   1. Have group members complete the handout.
   2. Discuss current sources of income and strategies to save money.
3. Provide information to the group members about community resources (i.e. public transportation, discount coupons).
4. Discuss benefits of spending money within one’s budget.
5. Ask group members to share one insight gained from this session.

(Adapted from Korb-Khalsa & Leutenberg, 2000)
Most people live on a fixed income and need to be knowledgeable about their income source and careful about expenses.

INCOME – The money we have coming in every month sets the stage for our budget. Although it can be difficult to spend within our means, managing money well is a major stress management technique!

- My current source(s) of income is/are: ________________________________.
- I receive $_______ per month.
- The address of nearest Human Service Center is: ____________________.
- The phone number for the Human Service Center is: _____-____-______.
- Check off one of the following:
  - I expect no major changes in my income in the next year.
  - I expect the following changes in my income in the next year.

HOW CAN I SAVE MONEY $$$? – We all have monthly expenses that take big bites out of our financial resources. Can we reduce these expenses thereby using our money more wisely?

Under each expense below, list strategies that we could use to reduce these amounts.

1. RENT:
   a. get a roommate
   b. live on second floor
   c. ________________
   d. ________________

2. CLOTHING:
   a. go to thrift stores
   b. buy items “on sale”
   c. ________________
   d. ________________

3. FOOD:
   a. use coupons
   b. buy generic brands
   c. ________________
   d. ________________

4. UTILITIES:
   a. turn off lights when not in use
   b. keep heat low at night
   c. ________________
   d. ________________

5. TRANSPORTATION:
   a. use bus ticket
   b. walk
   c. ________________
   d. ________________

6. RECREATION:
   a. utilize free activities
   b. attend movie matinees
   c. ________________
   d. ________________

(Adapted from Korb-Khalsa & Leutenberg, 2000)
Financial Support
Group Title:
Financial Support

Session Title:
You don't have do it alone

Purpose:
- To educate group members on how to deal with financial issues that may arise as a result of being diagnosed with HIV/AIDS.
- To establish a contact person for group members if and when questions arise regarding their financial situation.
- To provide a safe environment for group members to share financial concerns and ask questions of a professional.

Materials:
- Individual with a degree in either Social Work or experience with Case Management

Description:

1. Introduce the topic, financial support, to group members.
2. Introduce guest speaker to group.
3. Encourage group members to ask questions.
Nutrition
Group Title:
Nutrition

Session Title:
Healthy Eating for Life

Purpose:
- To identify current healthy nutritional habits and areas for possible improvement.
- To educate about nutrition and HIV/AIDS.

Materials:
- Worksheet (Korb-Khalsa, Azok, & Leutenberg, 1989, p. 20)
- Education information (Woods, Potts, & Connors, 2004)

Description:
1. Introduce the topic, nutrition, to group members.
2. Engage group members in activity:
   1. Hand the following foods out among individuals – bologna, ramen noodles, pop tarts, spinach, whole wheat bread, and yogurt.
   2. Instruct individuals to look at the nutrition label on their food item and share with the group, the general nutritional value.
   3. Discuss and compare fat, sodium, fiber, and vitamin/mineral content.
3. Next, distribute worksheet and instruct individuals to check all the appropriate boxes.
4. Allow necessary time for group members to complete worksheet.
5. Facilitate discussion about areas checked and areas for improvement.
6. Following discussion, provide educational information on HIV nutrition and health.
7. Allow time to ask questions and process activities.
Your eating habits

Check all appropriate boxes:

ON AN EVERYDAY BASIS...

1. ☐ I eat one “fresh” fruit and one “fresh” vegetable.
2. ☐ For my age, height, body frame, and activity level, I have learned what my appropriate daily needs are to maintain or change my weight.
3. ☐ I control my calorie intake.
4. ☐ I am aware of and limit my cholesterol and fat intake.
5. ☐ I am aware of the possible effects of sugar and limit my sugar intake.
6. ☐ I am aware of my fiber intake.
7. ☐ I am aware of my calcium intake.
8. ☐ I regulate my caffeine intake.
9. ☐ I eat at least three times each day.
10. ☐ I eat slowly in relaxed, appropriate surroundings.
11. ☐ I concentrate on eating during mealtime and do not allow myself to become distracted.
12. ☐ My meals and table arrangements are carefully and thoughtfully planned in advance.
13. ☐ I drink at least eight 8-ounce glasses of water.

WITHIN THIS PAST WEEK...

14. ☐ I ate baked or broiled fish.
15. ☐ I ate oatmeal or stone-ground whole-grained bread or crackers.
16. ☐ I have tried 1 “new food” — (a food I never ate before).
17. ☐ I ate at a fast food restaurant no more than 1 time.

CORE:

3-0 Unoh! Take care of yourself soon!
4-7 OK... However, your work is cut out for you!
8-13 Good, with a need for some improvement.
14-17 WOW! FOR WELLNESS!!! Wondertful!!
Exercise
Group Title:
Exercise
Session Title:
Get Fit

Purpose:
- To increase understanding of the importance of exercise for individuals with HIV/AIDS.
- To educate group members about the different types of exercise and precautions to be aware of when exercising.
- To provide an opportunity for the group members to take an inventory of exercises that they currently implement in their daily routine and choose possible future exercises.

Materials:
- Worksheet (Korb-Khalsa, Azok, & Leutenberg, 1989, p. 10)
- Educational information (Gay Men's Health Crisis, 2003)

Description:

1. Introduce the topic, exercise, to group members.
2. Educate group members about the benefits of exercise for individuals with HIV/AIDS.
3. Provide information about the types of exercise, such as aerobic and anaerobic.
4. Provide additional information about the precautions to follow when exercising such as overtraining and listening to body signals.
5. Hand out worksheet that lists a variety of exercise activities.
6. Provide instruction for completing the worksheet.
   1. Group members are to check the exercise if they presently engage in it or will participate in the exercise in the future.
7. As a group, discuss the activities that are of interest to them and community resources that are available.
8. Allow time to process information and ask questions.
EXERCISE INTEREST CHECKLIST

It is well known that exercise is of benefit to everyone. Choosing which exercise to do is not an easy task! It depends on present physical condition, doctor recommendations if necessary), personal likes and dislikes, etc.

Here’s a list of choices. Put a "P" (present) in the first box if you presently do this two or more times each week. Put an "F" (future) in the second box if you are going to continue doing his or are considering doing this one or two times each week in the future.

- Jogging
- Walking
- Running
- Swimming
- Bicycling
- Dancing
- Aerobics
- Downhill Skiing
- Cross Country Skiing
- Water Skiing
- Bowling
- Yardwork
- Tennis
- Golf
- Weight Lifting
- Stretching
- Aquatics
- Yoga
- Work-out Machines
- Racquetball

List of "P"s

List of "F"s

List 3 "F"s that you are not doing presently and identify what you’ll need to do to GET STARTED.

1. 
2. 
3. 

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Medication Management
Group Title:
Medication Management

Session Title:
Pill Pizzazz

Purpose:
- To educate group members on the importance of establishing a medication routine.
- To establish a contact person for group members if and when questions arise regarding their medications.
- To educate group members about the side effects and other implications of medication management.
- To provide group members with tools, such as pill organizers, to utilize for managing medications.

Materials:
- Registered Nurse

Description:
1. Introduce the topic, medication management, to group members.
2. Introduce guest speaker to group.
3. Encourage group members to ask questions.
Time Management
Group Title:
Time Management

Session Title:
Balance your Wheel

Purpose:
- To introduce group members to the concept of time management.
- To allow group members an opportunity to examine the balance among leisure, individual care, free/unscheduled time, and work/school activities in their lives.
- To educate group members on the importance of balancing the above areas.
- To promote healthy daily routines that balance leisure, individual care, free/unscheduled time, and school work activities.

Materials:
- Handout (Korb, Azok, & Leutenberg, 1991, p. 27)
- Red, Green, Yellow, Blue Markers

Description:
1. Introduce the topic, time management, to group members.
2. Provide general education on the benefits of practicing good time management.
3. Distribute one hand out to each group member.
4. Spread markers out on the table for group members to share.
5. Give the following instructions.
   1. On this handout is a wheel divided into 24 sections.
   2. Assume that every section is one hour of your day.
   3. Indicate through writing, how each hour of your day is spent.
   4. When all sections are filled in, use the yellow marker to color the sections that fit into individual care tasks (i.e. sleep, dressing, relaxation, etc...).
   5. Use the red marker to color sections that fit into leisure.
   6. Use the blue marker to color in the sections that are free/unscheduled time.
   7. Use the green marker to color sections that fit into school/work activities.
6. When everyone is finished, have group members share their wheel one at a time. Look at the balance among activities.
7. In discussion format, talk about changes that can be made to each wheel to create a more balanced lifestyle for each group member.
8. Process the benefits of doing this activity.

(Korb, Azok, & Leutenberg, 1991, p. 27)
Sexuality
Group Title: Sexuality

Session Title: The What, Why, and How

Purpose:
- To educate group members on the differences between gender and sexuality.
- To discuss the role of power in sexual decision making.
- To examine the effects of increased vulnerability as a result of an HIV/AIDS diagnosis.
- To learn about possible approaches that can be utilized when dealing with issues that surround sexuality.

Materials:
- Handout (Gupta, 2000)
- Paper
- Pens

Description:
1. Distribute handout to group members the day prior to when this topic will be discussed to allow time to read the handout.
2. At the beginning of the group session, ask group members to share one thing that they learned or found interesting from the reading.
3. Facilitate a discussion on the issues that surround sexuality.
4. If time allows, encourage individuals to write down as many questions that they have on a piece of paper (without their name on the paper).
5. Collect the questions and read each question aloud.
6. Educate group members as necessary, and ask for feedback.
7. If a question is not able to be answered in group, refer individuals to a source that can give them more information or follow-up with question in the next evening's session.
8. Process the benefits of doing this activity in a group setting.
The focus of my talk, as the title suggests, is on the what, why, and how of gender, sexuality, and HIV/AIDS. I would like to thank my colleagues and friends, Ellen Weiss from ICRW and Purnima Mane of the Population Council, for helping me put this talk together. The talk is limited to issues related to the heterosexual transmission of HIV because that has been the focus of my work over the last decade. I recognize that heterosexual transmission is only one aspect of the epidemic, but it is by no means irrelevant since the most recent statistics show that heterosexual transmission of HIV remains by far the most common mode of transmission globally. We have known for at least a decade that gender and sexuality are significant factors in the sexual transmission of HIV, and we now know that they also influence treatment, care, and support. Both terms, nevertheless, continue to remain misunderstood and inappropriately used.

Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other. Gender is a culture-specific construct—there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women’s and men’s roles, access to productive resources, and decision making authority. Typically, men are seen as being responsible for the productive activities outside the home while women are expected to be responsible for reproductive and productive activities within the home. And we know from over twenty years of research on women’s roles in development that women have less access over and control of productive resources than men—resources such as income, land, credit, and education. While the extent of this difference varies considerably from one culture to the next, it almost always persists (Sivard et al. 1995; Buvinic 1995). Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive. An individual’s sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behavior; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one’s gender, age, economic status, ethnicity and other factors, influence an individual’s sexuality (Zeidenstein and Moore 1996; Dixon Mueller 1993). At the Center at which I work, we talk about the components of sexuality as the Ps of sexuality—practices, partners, pleasure/pressure/pain, and procreation. The first two refer to aspects of...
behavior—how one has sex and with whom; while the others refer to the underlying motives. But we have learned through data gathered over many years that there is an additional P of sexuality that is the most important—power. The power underlying any sexual interaction, heterosexual or homosexual, determines how all the other Ps of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how, and with whom sex takes place. Each component of sexuality is closely related to the other but the balance of power in a sexual interaction determines its outcome (Weiss and Rao Gupta 1998). Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favors men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supercedes female pleasure and men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behavior, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power. Research supported by ICRW and conducted by researchers worldwide has identified the different ways in which the imbalance in power between women and men in gender relations curtails women’s and men’s risk and vulnerability to HIV (Weiss and Rao Gupta 1998; de Bruyn et al. 1995; Heise and Elias 1995). Let me first briefly go through the factors associated with women’s vulnerability to HIV.

**Women’s Vulnerability**

First, in many societies there is a culture of silence that surrounds sex that dictates that “good” women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive in negotiating safer sex (Carovano 1992). Second, the traditional norm of virginity for unmarried girls that exists in many societies, paradoxically, increases young women’s risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Virginity also puts young girls at risk of rape and sexual coercion in high prevalence countries because of the erroneous belief that sex with a virgin can cleanse a man of infection and because of the erotic imagery that surrounds the innocence and passivity associated with virginity. In addition, in cultures where virginity is highly valued, research has shown that some young women practice alternative sexual behaviors, such as anal sex, in order to preserve their virginity, although these behaviors may place them at increased risk of HIV (Weiss, Whelan, and Rao Gupta 2000). Third, because of the strong norms of virginity and the culture of silence that

*HIV positive women bear a double burden: they are infected and they are women.*

surounds sex, accessing treatment services for sexually transmitted diseases can be highly stigmatizing for adolescent and adult women (Weiss, Whelan, and Rao Gupta 2000; de Bruyn et al. 1995). Fourth, in many cultures because
motherhood, like virginity, is considered to be a feminine ideal, using barrier methods or non-penetrative sex as safer sex options presents a significant dilemma for women (Heise and Elias 1995; UNAIDS 1999). Fifth, women's economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection, and less likely that they will leave a relationship that they perceive to be risky (Heise and Elias 1995; Mane, Rao Gupta, and Weiss 1994; Weiss and Rao Gupta 1998). And finally, the most disturbing form of male power, violence against women, contributes both directly and indirectly to women's vulnerability to HIV. In population-based studies conducted worldwide, anywhere from 10 to over 50 percent of women report physical assault by an intimate partner. And one third to one-half of physically abused women also report sexual coercion (Heise, Ellsberg, and Gottemoeller 1999). A review of literature on the relationship between violence, risky behavior, and reproductive health, conducted by Heise and colleagues (1999) shows that individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs. This relationship is also apparent in the findings from a study conducted in India. In this study men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who had not. And men who reported STD symptoms were 2.4 times more likely to abuse their wives than those who did not (Martin et al. 1999). And from other research we also know that physical violence, the threat of violence, and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky (Mane, Rao Gupta, and Weiss 1994; Weiss and Rao Gupta 1998). Additionally, data from a study conducted in Tanzania by Maman, Mbwambo, and colleagues (2000) suggest that for some women the experience of violence could be a strong predictor of HIV. In that study, of the women who sought services at a voluntary HIV counseling and testing center in Dar es Salaam, those who were HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were HIV negative.

Men's Vulnerability

Let us move on now to the way in which the unequal power balance in gender relations increases men's vulnerability to HIV infection, despite, or rather because of, their greater power. First, prevailing norms of masculinity that expect men to be more knowledgeable and experienced about sex, put men, particularly young men, at risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and coerce them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood (UNAIDS 1999). Second, in many societies worldwide it is believed that variety in sexual partners is essential to men's nature as men and that men will seek multiple partners for sexual release—a hydraulic model of male sexuality that seriously challenges the effectiveness of prevention messages that call for fidelity in partnerships or a reduction in the number of
sexual partners (Mane, Rao Gupta, and Weiss 1994; Heise and Elias 1995). Third, notions of masculinity that emphasize sexual domination over women as a defining characteristic of manhood contribute to homophobia and the stigmatization of men who have sex with men. The stigma and fear that result force men who have sex with men to keep their sexual behavior secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female or male (UNAIDS 1999). Fourth, men in many societies are socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need or stress (WHO 1999). This expectation of invulnerability associated with being a man runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk. Overall, these manifestations of traditional notions of masculinity are strongly associated with a wide range of risk-taking behavior. For example, a national survey of adolescent males aged 15 to 19 in the U.S. found that young men who adhered to traditional views of manhood were more likely to report substance use, violence, delinquency, and unsafe sexual practices (Courtenay 1998).

**Power Imbalance and HIV/AIDS**

In addition to increasing the vulnerability of women and men to HIV, the power imbalance that defines gender relations and sexual interactions also affects women's access to and use of services and treatments. For example, the Tanzanian study conducted by Maman, Mbwambo and colleagues (1999) found that there were gender differences in the decision-making that led to the use of HIV voluntary counseling and testing services. While men made the decision to seek voluntary counseling and testing independent of others, women felt compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing VCT services. Women's social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma and discrimination associated with HIV infection. HIV positive women bear a double burden: they are infected and they are women. In many societies being socially ostracized, marginalized, and even killed are very real potential consequences of exposing one's HIV status. Yet, HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child. In a recent study conducted by researchers in Botswana and Zambia in collaboration with researchers from ICRW, men and women expressed concern for women who test positive because they felt that men would be likely to abandon a HIV positive partner. On the other hand, it was expected that women would initially get angry with a HIV positive partner, but ultimately accept him (Nyblade and Field 2000).

**Overcoming Inequality**

How is one to overcome these seemingly insurmountable barriers of gender and sexual inequality? How can we change the cultural norms that create these damaging, even fatal, gender disparities and roles? An important first step is to recognize, understand, and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic. There has been a definite shift in the international public and political rhetoric on HIV/AIDS over the last two

(Gupta, 2000)
years. The dominant discourse now reflects an increased acknowledgment of the role that gender plays in fueling the epidemic. Unfortunately, aside from a few exceptions, such public discourse on sex and sexuality is still invisible. There is an urgent need to break that silence because we know that talking openly about sex is the first step to reducing denial and bringing about acceptance of our collective vulnerability. In contrast, public health discourse, as seen in scientific journals and forums, reflects definite progress in understanding the importance of both gender and sexuality. But because this increased understanding is fueled in large part by the need to interpret the dynamics of the AIDS epidemic, the analysis of gender and sexuality is situated firmly within a framework of disease. Sexuality as seen through the public health prism, therefore, is still a potential determinant of ill health and little else. As a result, safer sex is the mainstream theme within this discourse, while sexual health, pleasure, and rights remain on the margins. It is also important to note that the progress in the public health discourse on gender and sexuality is not matched by progress in action. There is a substantial gap between the talk and the walk. This is partly because it is easier now to explain the why and what with regard to gender, sexuality, and HIV/AIDS, but there is less known about the how—how to address these issues in a way that has an impact on the epidemic. It must be said, however, that this relatively little information on the how is not due to a lack of innovation and trying. Although there are still no clear-cut answers and there is very little data to establish the impact of the efforts that have been tried, it is possible to look back and identify clear-cut categories of approaches—approaches that fall at different points on a continuum from damaging to empowering. To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interventions should, at the very least, not reinforce damaging gender and sexual stereotypes. Many of our past and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection. This poster, in which a sex worker is portrayed as a skeleton, bringing the risk of death to potential clients, is an example of the latter which, from experience we can predict, probably succeeded in doing little other than stigmatizing sex workers, thereby increasing their vulnerability to

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and behaviors.

infection and violence. There are many other examples of such damaging educational materials. A particularly common type is one that exploits a macho image of men to sell condoms. No amount of data on the increase in condom sales is going to convince me that such images are not damaging in the long run. Any gains achieved by such efforts in the short-term are unlikely to be

(Gupta, 2000)
sustainable because they erode the very foundation on which AIDS prevention is based—responsible, respectful, consensual, and mutually satisfying sex.

**Approaches that Do No Harm**

In comparison, gender-neutral programming is a step ahead on the continuum because such approaches at least do no harm. Examples include prevention education messages that are not targeted to any one sex, such as “be faithful” or “stick to one partner,” or treatment and care services that make no distinction between the needs of women and men, not recognizing, for example, that women clients may need greater social support than men or that women might prefer female counselors and health care providers to male providers. While such gender-neutral programs are better than nothing, they often are less than effective because they fail to respond to the gender-specific needs of individuals.

**Gender-sensitive Approaches**

In contrast, gender-sensitive programming that recognizes and responds to the differential needs and constraints of individuals based on their gender and sexuality is another step forward on the continuum of progress. The defining characteristic of such interventions is that they meet the different needs of women and men. Providing women with a female condom or a microbicide is an example of such programming. It recognizes that the male condom is a male controlled technology and it takes account of the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use by providing women with an alternate, woman initiated technology. Efforts to integrate STD treatment services with family planning services to help women access such services without fear of social censure is another example of such an approach. We know that such pragmatic approaches to programming are useful and necessary because they respond to a felt need and often significantly improve women’s access to protection, treatment, or care. But by themselves they do little to change the larger contextual issues that lie at the root of women’s vulnerability to HIV. In other words, they are necessary, even essential, but not sufficient to fundamentally alter the balance of power in gender relations.

**Transformative Approaches**

Next on the continuum are approaches that seek to transform gender roles and create more gender equitable relationships. The last few years have seen a burgeoning of such efforts. Two excellent examples of this type of intervention are the Men as Partners (or MAP project) being conducted by the Planned Parenthood Association of South Africa in collaboration with AVSC International and the Stepping Stones program.1 Both programs seek to foster constructive roles for men in sexual and reproductive health. The curricula for these programs use a wide range of activities—games, role plays, and group discussions—to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as to reduce violence against women. What is novel about these programs is that they target men, particularly young men, and work with them and women to redefine gender norms and encourage healthy sexuality. These are just two of an increasing number of innovative efforts to work with men, women, and communities. There is an urgent need now to rigorously evaluate the impact of these and other creative curricula.

(Gupta, 2000)
in the settings for which they were developed and to find ways to replicate their use on a larger scale. There is also a need to find ways to intervene early to influence the socialization of young boys to foster gender equitable attitudes and behaviors. Recent research conducted by Barker (forthcoming) in Brazil suggests that one way to do this is to study the many adolescent boys who do not conform to traditional expectations of masculinity. By studying these “positive deviants,” Barker was able to identify a number of factors associated with gender equitable attitudes among young adolescent males. These

Reducing the imbalance in power between women and men requires policies that are designed to empower women.

factors include: acknowledgement of the costs of traditional masculinities, access to adults who do not conform to traditional gender roles, family intervention or rejection of domestic violence, and a gender equitable male peer group. These factors underscore the importance of male role models, within the peer group and the family, who behave in gender-equitable ways. More such creative research on masculinity and its determinants is necessary in order to identify the best approaches to promote gender-equitable male attitudes and behaviors. Other programs that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual women or men. Couple counseling in HIV testing clinics to help couples deal with the results of their tests and in family planning programs that promote dual protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power imbalance by including both partners in the intervention. Some programs, however, have reported difficulty in being able to find and recruit couples who are willing to participate, although many couples who do participate describe couple counseling as a positive experience. Research is needed to identify ways to overcome the barriers to couple counseling and to test the effectiveness of this method in creating more gender-equitable relationships and in reducing vulnerability and stigma.

Approaches that Empower

And finally, at the other end of the continuum—far away from programs that foster damaging gender stereotypes—are programs that seek to empower women or free women and men from the impact of destructive gender and sexual norms. These are programs that empower women by improving their access to information, skills, services, and technologies, but also go further to encourage participation in decision-making and create a group identity that becomes a source of power—a group identity separate from that of the family because for many women the family is often the social institution that enforces strict adherence to existing gender norms. The Sonagachi sex worker project of West Bengal, India, is an excellent example of a project that sought to empower a community through participation and mobilization. What began as an HIV/AIDS peer education program was transformed into an empowering community

(Gupta, 2000)
organizing effort that put decision-making in the hands of the most disempowered—the sex workers (West Bengal Sexual Health Project 1996). How can we replicate Sonagachi in multiple sites worldwide? What are the ingredients that contributed to its success in mobilizing and organizing a disempowered community? Without the answers to these questions Sonagachi will remain the exclusive exception rather than the rule. In the ultimate analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women. Policies that aim to decrease the gender gap in education, improve women’s access to economic resources, increase women’s political participation, and protect women from violence are key to empowering women. We now have two international blueprints—the Cairo Agenda and the Beijing Platform for Action—that delineate the specific policy actions that are essential for assuring women’s empowerment. Since governments worldwide have committed to these blueprints, it would be useful for the HIV/AIDS community to join hands with the international women’s community to hold governments accountable for their promises by ensuring that the actions recommended in these documents are implemented. Creating a supportive policy and legislative context for women is crucial for containing the spread of the HIV/AIDS epidemic and mitigating its impact.

Moving Ahead

It is clear that the sensitive, transformative, and empowering approaches to gender and sexuality that I have just outlined are not mutually exclusive. They must occur simultaneously and efforts should be made to expand the portfolio of options within each category. In this, as in other AIDS programming, we need a multi-pronged approach. We must continue to address the differing needs and concerns of women and men, while we work on altering the status quo in gender relations, in minor and major ways. As we look to the future, let us be alert to the potential impediments to our success. Let us ensure that new, promising HIV/AIDS biomedical technologies, such as vaccines, which have the potential for making a substantial dent in the epidemic, are not impeded by entrenched gender barriers. Let us acknowledge that no biomedical technology is ever gender-neutral. To ensure equal access for all, women and men, girls and boys, we must work hard now, way before these technologies are ready for use, to identify the potential gender-specific constraints to their use and find ways to overcome them. And let us work together to fight against two commonly held beliefs that continue to stand in the way of our efforts. The first mistaken belief is that empowering women will disempower men. This is not true. Empowering women empowers households, communities and entire nations. And the second is the fear that changing gender roles to equalize the gender power balance conflicts with the value of multiculturalism and diversity. In point of fact, by changing gender roles what is being altered is not a society’s culture but rather its customs and practices, which are

*Empowering women empowers households,*

(Gupta, 2000)
typically based on an interpretation of culture. I believe that customs and practices that seek to subordinate women and trap men in damaging patterns of sexual behavior are based on a biased interpretation of culture that serves narrow interests. We know that the customs and practices associated with male and female roles and sexuality in many societies today are compromising the rights and freedoms of individuals and promoting a cycle of illness and death. This must stop. There can be no more powerful reason for change; gender roles that disempower women and give men a false sense of power are killing our young and our women and men in their most productive years. This must change. That is the message that must be communicated—without any caveats, ifs, or buts. Thank you.

Acknowledgments
This speech benefited greatly from the input of my colleagues, Ellen Weiss of ICRW and Purnima Mane of the Population Council. I am also deeply indebted to Horizons, a global operations research project on HIV/AIDS funded by USAID, and to my executive assistant, Michele Briley. I dedicate this speech to women everywhere who have overcome the formidable barriers imposed by societal norms and stigma in the battle against HIV/AIDS.

AVSC International is now called EngenderHealth.

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Relationships
Group Title:
  Relationships
Session Title:
  Healthy Boundaries
Purpose:
  • To identify healthy versus unhealthy boundaries in relationships.
  • To provide group members with strategies to develop healthy boundaries.
  • To identify ways to achieve intimacy or distance within a relationship.
  • To provide group members with a safe environment to discuss relational issues.
Materials:
  • Board
  • Marker
  • String
  • Tape or chalk
  • Pencils
  • Paper
Description:
  1. Introduce the topic, relationships, to group members.
  2. Instruct group members to make a circle with string, tape, or chalk.
  3. Instruct individual to stand in the circle with another group member invading the circle.
  4. Ask the question, “How does it feel when someone gets in your personal space?”
  5. Discuss with group how it feels to be smothered by or obsessed with trying to control someone.
  6. Instruct the group members to do the following activity:
     1. Draw circles on board, and mark one, “me”. Ask group members to guess at which circle represents a stranger, acquaintance, close friend, family member, spouse, or lover.
     2. Discuss the value (in the closest relationship) of some parts overlapping and some areas autonomous (the importance of shared interests and/or experiences and of maintaining individuality).
     3. Provide situations in which one person is dominated by another and discuss what happens to each.
     4. Instruct group members to draw circles on paper of themselves, and significant others in their lives and note how they feel about the relationships.
  7. Allow time for peer feedback about drawings on board about their relationships.
     1. Discuss ways to gain autonomy from domineering people or establish distance from someone that controls them.
     2. Emphasize balance of unity and individuality in healthy relationships.

(Butler, 2001, pp.188)
Discuss healthy boundaries and identify if we are overshadowed by or smothering toward a significant other. Identify ways to achieve more closeness or distance.

Board, marker, string, tape or chalk, pencils, papers.
(Be sure to retain the string or tape after group, as these could be dangerous.)

Volunteer makes a circle with string, tape or chalk and stands inside. Another 'invades his/her space' (circle) and asks, "How does it feel when I get in your personal space?"
Discuss how it feels to be smothered by or obsessed with trying to control someone.

Draw circles on board and mark one, 'me'. Ask volunteers to guess which circle represents a stranger, an acquaintance, a close friend and a close family member, spouse or lover. (See attached diagram. Draw only the circles on board and have participants write the labels.)
Discuss the value (in the closest relationship) of some parts overlapping and some areas autonomous (the importance of shared interests and/or experiences and of maintaining individuality).

On board, someone depicts a person totally dominated by another (one circle on another with 95% - 100% overlap) and discusses what happens to each (consumed by the other) and the disadvantages of no individuality.
People draw circles on paper: themselves, and significant others in their lives and note how they feel about the relationships – they may wish they were closer or more independent. They should position their circles to portray their relationships and not copy exactly from the board. Possibly a parent and child or husband and wife may be far apart or enmeshed.

People share their drawings on board and receive peer feedback about their relationships.
Brainstorm ways to achieve more closeness or distance. Discuss ways they have gained autonomy from a domineering person or given 'space' to someone they tried to control.
Emphasize balance of unity and individuality in healthy relationships.

NOTE: The goal is not to do in depth relationship therapy but to identify healthy versus unhealthy boundaries and to refer for professional therapy as needed. Physical or sexual abuse may be discovered and warrants individual discussion, reporting and referral.

Example:

![Diagram of circles representing relationships and individuality]

OVER-DOMINATING PARENT OR LOVER

INDIVIDUALITY

COMMON BONDS

56
Roles
Group Title:
Roles
Session Title:
Which Roles Do You Play?

Purpose:
• To allow group members to identify the current roles that they have in their life.
• To explore areas of strength and areas of improvement within the roles that individuals have.
• To provide a supportive environment for group members to talk about changing roles, as a result of their HIV/AIDS diagnosis.

Materials:
• Role Note Cards

Description:
1. Introduce topic, roles, to group members.
2. Explain the activity to group members.
   1. Distribute role note cards with one of the following roles defined on each: Parent, sibling friend, caregiver, self-cares, student, employment/volunteer, leisure, financial/bills, church/spirituality, car maintenance, yard work.
   2. Each group member will take one card.
   3. One at a time, group members will talk about their engagement in the role on the card they chose.
   4. They will answer the following questions:
      1. Is this a role you have now?
      2. If yes, what do you do well in this role; what do you need to work on in this role?
      3. If no, would you like to have this as a role in your life? Why or why not?
   5. Once everyone has shared, therapist will collect the cards and re-distribute them.
3. Encourage group members to interact and ask questions after individuals share.
4. Allow time at the end to process the benefits of the activity.
Community Resources
Group Title: Community Resources
Session Title: Strengthening Community Ties

Purpose:
- To increase awareness about community resources available regarding issues surrounding HIV/AIDS.
- To provide education on the procedures to follow in order to utilize the available community services.
- To provide a resource that outlines services offered in the area.

Materials:
- North Dakota Resources (Williams, 2004)

Description:
1. Introduce topic, community resources, to group members.
2. Give each group member a North Dakota Resource Binder, supplied by the Grand Forks Public Health Department.
3. Orient group members to the contents of the binder.
4. Facilitate a discussion about information presented in the binder.
5. Encourage group members to ask questions and discuss issues and personal situations regarding topics that arise during session.
6. Process the benefits of this activity.
Work
Group Title: Work
Session Title: HIV/AIDS and Employment

Purpose:
- To increase group members’ awareness about protective employment measures established by the Americans with Disabilities Act that are available to working citizens.
- To provide group members with examples of situations in which individuals with HIV/AIDS remained employed and utilized employment accommodations.
- To provide group members with a chance to explore employment opportunities based on their interests and knowledge.

Materials:
- ADA handout (U.S. Department of Justice, n.d.)
- Pencil
- Paper

Description:
1. Introduce the topic, work, to group members.
2. Instruct group members to retrieve ADA handout that was previously given to them.
   1. Ask for any general reactions to handout.
   2. Discuss the definition of the word “disability” relating to individuals with HIV/AIDS.
   3. Ask group members if they have experienced any situations that relate to the handout regarding reasonable accommodations.
   4. Discuss governmental resources on handout that protects HIV/AIDS individuals.
3. Instruct group members to write down their interests on piece of paper.
4. Brainstorm employment and volunteer opportunities that compliment their interests.
5. Discuss with group the available community resources that support their employment and volunteer opportunities.
6. Allow time for group process and questions.

(U.S. Department of Justice, n.d.)
QUESTIONS AND ANSWERS:
The Americans with Disabilities Act
And Persons with HIV/AIDS

I. Introduction

1. Q: What is the ADA?
   
   A: The Americans with Disabilities Act (ADA) gives federal
civil rights protections to individuals with disabilities similar
to those provided to individuals on the basis of race, color,
sex, national origin, age, and religion. It guarantees equal
opportunity for individuals with disabilities in public
accommodations, employment, transportation, State and local
government services, and telecommunications.

2. Q: Are people with HIV or AIDS protected by the ADA?
   
   A: Yes. An individual is considered to have a “disability”
if he or she has a physical or mental impairment that
substantially limits one or more major life activities, has a
record of such an impairment, or is regarded as having such an
impairment. Persons with HIV disease, both symptomatic and
asymptomatic, have physical impairments that substantially limit
one or more major life activities and are, therefore, protected
by the law.

Persons who are discriminated against because they are regarded
as being HIV-positive are also protected. For example, a person
who was fired on the basis of a rumor that he had AIDS, even if
he did not, would be protected by the law.

Moreover, the ADA protects persons who are discriminated against
because they have a known association or relationship with an
individual who is HIV-positive. For example, the ADA would
protect an HIV-negative woman who was denied a job because her
roommate had AIDS.

II. Employment

1. Q: What employers are covered by the ADA?
   
   A: The ADA prohibits discrimination by all private
employers with 15 or more employees. In addition, the ADA
prohibits all public entities, regardless of the size of their
work force, from discriminating in employment against qualified
individuals with disabilities.

2. Q: What employment practices are covered by the ADA?
   
   A: The ADA prohibits discrimination in all employment
practices. This includes not only hiring and firing, but job
application procedures (including the job interview), job assignment, training, and promotions. It also includes wages, benefits (including health insurance), leave, and all other employment-related activities. Examples of employment discrimination against persons with HIV/AIDS would include:

- An automobile manufacturing company that had a blanket policy of refusing to hire anyone infected with the AIDS virus.

- An airline that extended an offer to a job applicant and then rescinded the offer when, after the applicant took an HIV test as part of the airline's required medical examination, the applicant tested positive for HIV.

- A restaurant that fired a waitress after learning that the waitress had HIV.

- A university that fired a physical education instructor after learning that the instructor's boyfriend had AIDS.

- A company that contracted with an insurance company that had a cap on health insurance benefits provided to employees for HIV-related complications, but not on other health insurance benefits.

3. Q: Who is protected by the employment provisions of the ADA?

A: The ADA prohibits employment discrimination against qualified individuals with disabilities. A "qualified individual with a disability" is a person who meets legitimate skill, experience, education, or other requirements of an employment position he or she holds or seeks, and who can perform the "essential functions" of the position with or without reasonable accommodation.

4. Q: What is an "essential function" of the job?

A: Essential functions of the job are those core duties that are the reason the job position exists. For example, an essential function of a typist's position is the ability to type; an essential function of a bus driver's position is the ability to drive. 

Requiring the ability to perform "essential" functions assures that an individual with a disability will not be considered unqualified because of his or her inability to perform marginal or incidental job functions.

5. Q: What is a "reasonable accommodation"?

A: A "reasonable accommodation" is any modification or adjustment to a job, the job application process, or the work environment that will enable a qualified applicant or employee with a disability to perform the essential functions of the job, participate in the application process, or enjoy the benefits and
privileges of employment. Examples of "reasonable accommodations" include: making existing facilities readily accessible to and usable by employees with disabilities; restructuring a job; modifying work schedules; acquiring or modifying equipment; and reassigning a current employee to a vacant position for which the individual is qualified.

For example:

- An HIV-positive accountant required two hours off, bimonthly, for visits to his doctor. He was permitted to take longer lunch breaks and to make up the time by working later on those days.

- A supermarket check-out clerk with AIDS had difficulty standing for long periods of time. Her employer provided her with a stool so that she could sit down at the cash register when necessary.

- A secretary with AIDS needed to take frequent rest breaks during her work day. Her boss allowed her to take as many breaks as she needed throughout the day, so long as she completed her work before going home each evening.

- A machine operator required time off from work during his hospitalization with pneumocystis carinii pneumonia. He had already used up all his sick leave. His employer allowed him to either take leave without pay, or to use his accrued vacation leave.

- An HIV-positive computer programmer suffered bouts of nausea caused by his medication. His employer allowed him to work at home on those days that he found it too difficult to come into the office. His employer provided him with the equipment (computer, modem, fax machine, etc.) necessary for him to work at home.

- An HIV-positive newspaper editor who tired easily from walking began to use an electric scooter to get around. His employer installed a ramp at the entrance to the building in which the editor worked so that the editor could use his scooter at the office.

6. Q: Does an employer always have to provide a needed reasonable accommodation?

A: An employer is not required to make an accommodation if it would impose an undue hardship on the operation of the business. An undue hardship is an action that requires "significant difficulty or expense" in relation to the size of the employer, the resources available, and the nature of the operation. Determination as to whether a particular accommodation poses an undue hardship must be made on a case-by-case basis.

Customer or co-worker attitudes are not relevant. The potential loss of customers or co-workers because an employee has HIV/AIDS does not constitute an undue hardship.
An employer is not required to provide an employee's first choice of accommodation. The employer is, however, required to provide an effective accommodation, i.e., an accommodation that meets the individual's needs.

7. Q: When is an employer required to make a reasonable accommodation?

A: An employer is only required to accommodate a "known" disability of a qualified applicant or employee. Thus, it is the employee's responsibility to tell the employer that he or she needs a reasonable accommodation. If the employee does not want to disclose that he or she has HIV or AIDS, it may be sufficient for the employee to say that he or she has an illness or disability covered by the ADA, that the illness or disability causes certain problems with work, and that the employee wants a reasonable accommodation. However, an employer can require medical documentation of the employee's disability and the limitations resulting from that disability.

8. Q: What if an employer has concerns about an applicant's ability to do the job in the future?

A: Employers cannot choose not to hire a qualified person now because they fear the worker will become too ill to work in the future. The hiring decision must be based on how well the individual can perform now. In addition, employers cannot decide to not hire qualified people with HIV or AIDS because they are afraid of higher medical insurance costs, workers' compensation costs, or absenteeism.

9. Q: Can an employer consider health and safety when deciding whether to hire an applicant or retain an employee who has HIV/AIDS?

A: Yes, but only under limited circumstances. The ADA permits employers to establish qualification standards that will exclude individuals who pose a direct threat -- i.e., a significant risk of substantial harm -- to the health or safety of the individual or of others, if that risk cannot be eliminated or reduced below the level of a "direct threat" by reasonable accommodation. However, an employer may not simply assume that a threat exists; the employer must establish through objective, medically supportable methods that there is a significant risk that substantial harm could occur in the workplace. By requiring employers to make individualized judgments based on reliable medical or other objective evidence -- rather than on generalizations, ignorance, fear, patronizing attitudes, or stereotypes -- the ADA recognizes the need to balance the interests of people with disabilities against the legitimate interests of employers in maintaining a safe workplace.

Transmission of HIV will rarely be a legitimate "direct threat" issue. It is medically established that HIV can only be transmitted by sexual contact with an infected individual,

(U.S. Department of Justice, n.d.)
exposure to infected blood or blood products, or perinatally from an infected mother to infant during pregnancy, birth, or breast feeding. HIV cannot be transmitted by casual contact. Thus, there is little possibility that HIV could ever be transmitted in the workplace.

For example:

- A superintendent may believe that there is a risk of employing an individual with HIV disease as a schoolteacher. However, there is little or no likelihood of a direct exchange of body fluids between the teacher and her students, and thus, employing this person would not pose a direct threat.

- A restaurant owner may believe that there is a risk of employing an individual with HIV disease as a cook, waiter or waitress, or dishwasher, because the employee might transmit the disease through the handling of food. However, HIV and AIDS are specifically not included on the Centers for Disease Control and Prevention ("CDC") list of infectious and communicable diseases that are transmitted through the handling of food. Thus, there is little or no likelihood that employing persons with HIV/AIDS in food handling positions would pose a risk of transmitting HIV. A fire chief may believe that an HIV-infected firefighter may pose a risk to others when performing mouth-to-mouth resuscitation. However, current medical evidence indicates that HIV cannot be transmitted by the exchange of saliva. Thus, there is little or no likelihood that an HIV-infected firefighter would pose a risk to others.

Having HIV or AIDS, however, might impair an individual's ability to perform certain functions of a job, thus causing the individual to pose a direct threat to the health or safety of the individual or others.

For example:

- A worker who operates heavy machinery and who has been suffering from dizzy spells caused by the medication he is taking might pose a direct threat to his or someone else's safety. If no reasonable accommodation is available (e.g., an open position to which the employee could be reassigned), the employer would not violate the ADA by laying the worker off.

- An airline pilot who is experiencing bouts of dementia would pose a direct threat to herself and her passengers' safety. It would not violate the ADA if the airline prohibited her from flying.

As noted above, the direct threat assessment must be an individualized assessment. Any blanket exclusion -- for example, refusing to hire persons with HIV/AIDS because of the attendant health risks -- would probably violate the ADA as a matter of law.

10. Q: When can an employer inquire into an applicant's or
employee's HIV status?

A: An employer may not ask or require a job applicant to take a medical examination before making a job offer. It cannot make any pre-offer inquiry about a disability or the nature or severity of a disability. An employer may, however, ask questions about the ability to perform specific job functions. Thus, for example, the owner of an outdoor cafe could not ask an individual with KS lesions who was applying for the position of a waiter whether the applicant had AIDS. The owner could, however, ask the applicant whether he can be in the sun for extended periods of time.

An employer may condition a job offer on the satisfactory result of a post-offer medical examination or medical inquiry if this is required of all entering employees in the same job category. However, if an individual is not hired because a post-offer medical examination or inquiry reveals a disability, the reason(s) for not hiring must be job-related and consistent with business necessity. HIV-positive status alone, without some accompanying complication (e.g., dementia, loss of vision, etc.) can almost never be the basis for a refusal to hire after a post-offer medical examination.

After a person starts work, a medical examination or inquiry of an employee must be job-related and consistent with business necessity. Employers may conduct employee medical examinations where there is evidence of a job performance or safety problem, when examinations are required by other Federal laws, when examinations are necessary to determine current "fitness" to perform a particular job, and/or where voluntary examinations are part of employee health programs. For example, an employer could not ask an employee who had lesions on his face or who had recently lost a significant amount of weight, but whose job performance had not changed in any way, whether the employee had AIDS. An employer could, however, require an employee who was experiencing frequent dizzy spells, and whose work was suffering as a result, to undergo a medical examination.

11. Q: What obligations does an employer have if an employee discloses his or her HIV status?

A: The ADA requires that medical information be kept confidential. This information must be kept apart from general personnel files as a separate, confidential medical record available only under limited conditions.

12. Q: What obligations does an employer have to provide health insurance to employees with HIV/AIDS?

A: The ADA prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees and/or from entering into contracts with health insurance companies that discriminate on the basis of disability. Insurance distinctions that are not based on disability, however, and that are applied equally to all insured employees, do not

(U.S. Department of Justice, n.d.)
discriminate on the basis of disability and do not violate the ADA.

Thus, for example, blanket pre-existing condition clauses that exclude from the coverage of a health insurance plan the treatment of all physical conditions that predate an individual's eligibility for benefits are not distinctions based on disability and do not violate the ADA. A pre-existing condition clause that excluded only the treatment of HIV-related conditions, however, is a disability-based distinction and would likely violate the ADA.

Similarly, a health insurance plan that capped benefits for the treatment of all physical conditions at $50,000 per year does not make disability-based distinctions and does not violate the ADA. A plan that capped benefits for the treatment of all physical conditions, except AIDS, at $50,000 per year, and capped the treatment for AIDS-related conditions at $10,000 per year does distinguish on the basis of disability and probably violates the ADA.

13. Q: What can an applicant or employee do if he or she believes that he or she is being discriminated against on the basis of his or her HIV status?

   A: An applicant or employee who believes that he or she is the victim of HIV discrimination should first try to explain to his or her employer what the ADA requires. If the issue is not resolved satisfactorily, the employee may file a complaint with the nearest Equal Employment Opportunity Commission office. The complaint must be filed within 180 days of when the discrimination occurred. The EEOC will investigate the complaint and either act to correct the problem or give the employee a "right to sue" letter. The right to sue letter permits the employee to sue the employer directly. The employee may be entitled to the job he or she was denied, back pay, benefits, or other compensatory and punitive damages.

For more information about the ADA's employment requirements, please call the Equal Employment Opportunity Commission at (800)669-4000 (voice) or (800)669-6820 (TDD).

III. Public Accommodations

1. Q: What is a public accommodation?

   A: A public accommodation is a private entity that owns, operates, leases, or leases to a place of public accommodation. Places of public accommodation include a wide range of entities, such as restaurants, hotels, theaters, doctors' offices, dentists' offices, hospitals, retail stores, health clubs, museums, libraries, private schools, and day care centers. Private clubs and places run by religious organizations are not considered places of public accommodation.

2. Q: What constitutes discrimination?
Discrimination is the failure to give a person with a disability the equal opportunity to use or enjoy the public accommodation's goods, services, or facilities. Examples of ADA violations would include:

- A dentist who categorically refused to treat all persons with HIV/AIDS.

- A moving company that refused to move the belongings of a person who had AIDS, or that refused to move the belongings of a person whose neighbor had AIDS.

- A health club that charged extra fees to persons who were HIV-positive, or that prohibited HIV-positive members from using the steam room or sauna, or that limited the hours during which HIV-positive members could use the club's facilities.

- A day care center that categorically refused admission to HIV-positive children or the children of HIV-positive mothers.

- A funeral home that refused to provide funeral services for a person who died from AIDS-related complications.

- A building owner who refused to lease space to a not-for-profit organization that provided services to persons living with HIV/AIDS.

The ADA also requires public accommodations to take steps to ensure that persons with disabilities have equal access to their goods and services. For example, the ADA requires public accommodations to make reasonable changes in their policies, practices, and procedures; to provide communication aids and services; and to remove physical barriers to access when it is readily achievable to do so.

3. Q: What types of changes in policies, practices, or procedures would a public accommodation have to make to ensure equal access to persons with HIV/AIDS?

   A: Even though a public accommodation may not intend to discriminate against persons with HIV/AIDS, its customary way of doing business may unintentionally exclude persons with HIV/AIDS or provide them with lesser services. If reasonable modifications in the business' policies, practices, or procedures would rectify the problem, the public accommodation would be required to make those changes.

For example:

- A hotel does not allow pets. It would be a reasonable modification of the hotel's policy to allow a person who has lost his vision from cytomegalovirus retinitis (CMV), an AIDS-related illness, to have his guide dog stay with him in the hotel.

- A pharmacy requires customers to stand in line to be served. A
person with AIDS finds it too tiring to stand in line. It would be a reasonable modification of the pharmacy's procedures to allow the person to announce her presence and/or take a number and then sit down until her prescription is filled. It would also be a reasonable modification if the pharmacy provided curbside service and/or home delivery.

4. Q: Are health care providers required to treat all persons with HIV/AIDS, regardless of whether the treatment being sought is within the provider’s area of expertise?

A: No. A health care provider is not required to treat a person who is seeking or requires treatment or services outside the provider’s area of expertise. However, a health care provider cannot simply refer a patient with HIV/AIDS to another provider simply because the patient has HIV/AIDS. The referral must be based on the treatment the patient is seeking, not the patient’s HIV status alone.

For example:

- An HIV-positive individual suffers a severe allergic drug reaction while on vacation and goes to the nearest emergency room. The hospital routinely treats people suffering from allergic drug reactions. Sending the patient to another hospital that allegedly has an “AIDS unit” would violate the ADA.

- An HIV-positive individual is in a car accident and suffers severe third degree burns. He is taken to the nearest hospital, which does not have a burn unit. Sending the patient to another hospital that has a burn unit would not violate the ADA.

- A person with AIDS goes to the dentist for a teeth cleaning. The dentist refers her to another dentist because the dentist claims he is “not equipped” to treat persons with AIDS. Because there is no special equipment necessary for providing routine dental care to persons with HIV/AIDS, this “referral” would violate the ADA.

- A person with AIDS goes to the dentist because she has an oral lesion on the roof of her mouth. The dentist tells the patient that she has a lesion that the dentist is not able to identify and does not know how to treat. The dentist refers the patient to an oral surgeon for diagnosis and treatment of the lesion, with the understanding that the patient will return to the dentist for the provision of routine dental care. This would not violate the ADA.

5. Q: What types of communication aids and services would a public accommodation be required to provide to persons with HIV/AIDS?

A: A public accommodation is required to provide auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities, unless an undue burden (i.e., a significant difficulty or expense) or fundamental
alteration would result. Thus, if a person with HIV or AIDS has an impairment -- such as a vision, hearing, or speech impairment -- that substantially limits his or her ability to communicate, the public accommodation must provide auxiliary aids or services that will ensure equal access to the goods, services, or facilities that the public accommodation offers. The impairment can be one that the person has had from birth, or one that has recently developed as a result of an AIDS-related complication.

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the length and complexity of the communication involved. Some examples of auxiliary aids and services are -- exchanging written notes, typing back and forth on a computer, providing a qualified sign language interpreter, or having a telecommunication device for deaf persons (TDD) for customers with hearing impairments; reading aloud, providing large print, audiotapes, or braille materials, or locating merchandise for customers with vision impairments; and using TDDs or computer terminals for persons with speech impairments.

For example:

- A person who was born deaf and uses American Sign Language as his primary means of communication goes to his physician to receive the results of his HIV test. The test results have come back positive. The physician may be required to obtain and pay for a sign language interpreter, as the communication between the physician and his patient is likely to be lengthy and complex and may only be effective if a sign language interpreter is provided.

- A person with AIDS has recently lost his vision as a result of an AIDS-related complication. It would be appropriate for a restaurant waiter to read aloud the contents of the menu.

6. Q: Can a public accommodation charge for reasonable modifications in its policies, practices, or procedures, or for the provision of communication aids and services?

A: No. A public accommodation may not impose a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs necessary to provide nondiscriminatory treatment.

For example:

- A law firm routinely prepares wills and trusts. A woman with AIDS who recently has suffered vision loss requests that the firm draft her will and guardianship papers, and requests that the firm provide her with all drafts of her documents in large print. The law firm cannot charge the woman extra for preparing the documents in large print.

7. Q: Can a public accommodation exclude a person with HIV/AIDS because that person allegedly poses a direct threat to the health and safety of others?
A: In almost every instance, the answer to this question is no. Persons with HIV/AIDS will rarely, if ever, pose a direct threat in the public accommodations context.

A public accommodation may exclude an individual with a disability from participation in an activity, if that individual's participation would result in a direct threat to the health or safety of others. "Direct threat," however, is defined as a "significant risk to the health or safety of others" that cannot be eliminated or reduced to an acceptable level by reasonable modifications to the public accommodation's policies, practices, or procedures, or by the provision of appropriate auxiliary aids or services. The determination that a person poses a direct threat to the health or safety of others may not be based on generalizations or stereotypes about the effects of a particular disability; it must be based on an individual assessment that considers the particular activity and the actual abilities and disabilities of the individual. The individual assessment must be based on reasonable judgment that relies on current medical evidence.

For example:

- A restaurant's refusal to admit an individual with AIDS would violate the ADA, because HIV cannot be transmitted through the casual contact typical among restaurant patrons.

- A gynecologist's refusal to treat an HIV-positive woman would be a violation. Health care providers are required to treat all persons as if they are infectious for HIV and other bloodborne pathogens, and must use universal precautions (gloves, mask, gown, etc.) to protect themselves from the transmission of infectious diseases. Failure to treat a person who acknowledges her HIV-positive status would be a violation, because so long as the physician utilizes universal precautions, it is safe to treat persons with HIV/AIDS.

- A day care center's refusal to admit a child who is HIV-positive, because of the fear that the child might bite and might therefore transmit HIV to other children, is also a violation. It is incorrect to assume that all young children bite. Moreover, current medical evidence indicates that HIV is not transmitted by saliva. Even if an HIV-positive child were to bite another child, the only bodily fluid that would be transmitted from the infected child to the non-infected child would be saliva.

- A health club's revocation of an HIV-positive person's membership, because of the fear that the person may transmit the virus through the sweat he leaves on the club's weight machines, also violates the ADA. There is no evidence that HIV can be transmitted by sweat.

8. Q: What types of physical barriers to access is a public accommodation required to remove? Why is this important to

(U.S. Department of Justice, n.d.)
Persons with HIV/AIDS?

A: Persons with HIV or AIDS may find that they have less strength to open doors, or may tire more easily when walking or climbing stairs. They may use a wheelchair, electric scooter, or other device for mobility purposes. The ADA's barrier removal requirements address these situations.

The ADA requires that public accommodations remove all physical barriers to access in their existing facilities, where it is "readily achievable" to do so. "Readily achievable" means "easily accomplishable and able to be carried out without much difficulty or expense."

Examples of barrier removal may include installing ramps, making curb cuts in sidewalks and entrances, rearranging furniture, widening doors, installing accessible door hardware, and installing grab bars in toilet stalls. The obligation to engage in readily achievable barrier removal is a continuing one.

The ADA requires that all newly constructed places of public accommodation be readily accessible to and usable by individuals with disabilities. The ADA also requires that all alterations made to existing facilities be readily accessible to and usable by individuals with disabilities.

9. Q: What can a person do if he or she is being discriminated against by a place of public accommodation on the basis of his or her HIV status?

A: A person who believes that he or she is being discriminated against should first try to educate the manager or owner of the public accommodation about what the ADA requires. The person should suggest reasonable policy changes that will provide equal access, request a communication aid, or ask that a barrier be removed. An individual may also wish to seek out mediation services provided by community or private mediation services. If the situation is not resolved satisfactorily, a complaint may be filed with the Department of Justice.

The Department of Justice is authorized to investigate complaints and to bring lawsuits in cases of general public importance, or where there is a "pattern or practice" of discrimination. Due to resource limitations, the Department is unable to investigate every complaint. The Department may seek injunctive relief (i.e., having the public accommodation correct its discriminatory practices), money damages, and civil penalties. Complaints should be sent to the following address:

Disability Rights Section
Civil Rights Division
Department of Justice
P.O. Box 66738
Washington, D.C. 20035-6738

Individuals are also entitled to bring private lawsuits. If a
person files a private lawsuit, he or she may not seek money damages. However, the person may seek injunctive relief and attorney's fees and costs.

IV. State and Local Governments

1. Q: Does the ADA also prohibit State and local governments from discriminating against persons with HIV/AIDS?

   A: Yes. The ADA applies to all State and local governments, their departments and agencies, and any other instrumentalities or special purpose districts of State or local governments.

   For example:

   - A public school system may not prohibit an HIV-positive child from attending elementary school.
   - A county hospital may not refuse to treat persons with HIV/AIDS.
   - A local police station must make sure that TDD users, including persons with HIV/AIDS, can call 911 and other emergency phone numbers directly, without having to go through a relay system.
   - A city emergency medical technician may not refuse to transport a person with AIDS.
   - A state-owned nursing home may not refuse to accept patients with HIV/AIDS.
   - A county recreation center may not refuse admission to a summer camp program to a child whose brother has AIDS.

2. Q: What can a person do if he or she is being discriminated against by a State or local government on the basis of his or her HIV status?

   A: A person who believes he or she is being discriminated against by a State or local government should first try to educate officials involved about the ADA's requirements. Individuals may also file a complaint with the Department of Justice. Complaints must be filed within 180 days of when the discrimination occurred. Complaints should be sent to the following address:

   U.S. Department of Justice
   Civil Rights Division
   Disability Rights Section
   Post Office Box 66738
   Washington, D.C. 20035-6738

   Individuals are also entitled to bring private ADA lawsuits against State and local governments and seek injunctive relief, compensatory damages, and reasonable attorney's fees.

(U.S. Department of Justice, n.d.)
V. Telecommunications, Housing, Air Transportation

1. Q: What is a relay service?

   A: Telecommunications relay services bridge the gap between TDD users -- including persons with HIV/AIDS who have recently experienced hearing loss -- and regular voice telephone users. The relay service enables persons who have TDDs to carry on telephone conversations with persons who do not, through use of an intermediary person -- the relay operator. The relay operator reads the TDD message to the person without the TDD and types the person's spoken message back to the TDD user.

   The ADA requires the telephone industry to provide free telephone relay service through 800 numbers. The relay service must be available twenty-four hours a day, seven days a week, without restrictions on the type, length, or number of calls made by any relay user.

2. Q: Does the ADA prohibit discrimination in the sale, rental, and other terms of housing?

   A: Housing discrimination is not covered by the ADA. However, the Fair Housing Amendments Act of 1988, which is primarily enforced by the U.S. Department of Housing and Urban Development, prohibits housing discrimination against persons with disabilities, including persons with HIV/AIDS. Persons who believe that they have been discriminated against in housing because of their HIV-positive status should contact their State or local government's Fair Housing and Equal Opportunity Office.

3. Q: Does the ADA prohibit discrimination by airlines?

   A: Discrimination by air carriers in areas other than employment is not covered by the ADA, but rather, by the Air Carrier Access Act (ACAA). Persons who believe that they have been discriminated against by airlines because of their HIV-positive status should contact the U.S. Department of Transportation.

VI. Resources

The following section provides the telephone numbers of federal agencies providing information on the ADA, as well as the telephone numbers of other federal agencies providing information of interest to persons living with HIV/AIDS.

Department of Justice offers technical assistance on the ADA Standards for Accessible Design and other ADA provisions applying to businesses, non-profit service agencies, and state and local government programs; also provides information on how to file ADA complaints.

ADA Information Line for documents and questions
800-514-0301 (Voice) 800-514-0383 (TDD)
Equal Employment Opportunity Commission offers technical assistance on the ADA provisions applying to employment; also provides information on how to file ADA complaints.

Employment questions
800-669-4000 (Voice) 800-669-6820 (TDD)

Employment documents
800-669-3362 (Voice) 800-800-3302 (TDD)

Department of Transportation offers technical assistance on ADA provisions applying to public transportation and air carrier access.

ADA documents and questions
202-366-1656 (Voice) 202-366-4567 (TDD)

ADA legal questions
202-366-1936 (Voice) TDD: use relay service

ADA complaints and enforcement
202-366-2285 (Voice) 202-366-0153 (TDD)

Federal Communications Commission offers technical assistance on ADA telephone relay service requirements.

Relay service - documents and questions
202-418-0190 (voice) 202-418-2555 (TDD)

Relay service - legal questions
202-418-2357 (voice) 202-418-0484 (TDD)

Access Board, or Architectural and Transportation Barriers Compliance Board, offers technical assistance on the ADA Accessibility Guidelines, and answers questions pertaining to access to federal facilities and post offices.

ADA documents and questions
800-872-2253 (voice) 800-993-2822 (TDD)

Department of Education funds ten regional centers to provide
technical assistance on the ADA.

Disability & Business Technical Assistance Centers
800-949-4232 (voice/ TDD)
(call automatically connects to the closest center)

President s Committee on Employment of People with Disabilities funds the Job Accommodation Network (JAN), which provides advice on accommodating employees with disabilities.

Job Accommodation Network
800-526-7234 (voice/ TDD)

Internal Revenue Service provides information and publications about tax code provisions including tax credits (section 44) and deductions (section 190) that can assist businesses in complying with the ADA.

Tax code information
800-829-1040 (voice) 800-829-4059 (TDD)

To order Publication 907
800-829-3676 (voice) 800-829-4059 (TDD)

Legal questions
202-622-3110 (voice) TDD: use relay service

Fair Housing Information Clearinghouse is run by the Department of Housing and Urban Development and provides information concerning issues of housing access.

Information and publications
800-343-3442 (voice) 800-483-2209 (TDD)

CDC National AIDS Clearinghouse provides comprehensive HIV/AIDS information to health professionals, managers of HIV/AIDS programs, educators, and information providers.

National AIDS hotline
800-342-AIDS (voice) 800-243-7889 (TDD)
800-344-SIDA (Spanish)

Clearinghouse services
800-458-5231 (voice) 800-243-7012 (TDD)

HIV/AIDS Statistics Info Line
404-332-4570

Food and Drug Administration provides information concerning the safety and efficacy of drugs, biologics, vaccines, and medical devices used in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-associated opportunistic infections.

Office of AIDS and Special Health Issues
301-443-0104

(U.S. Department of Justice, n.d.)
National AIDS Program Office of the U.S. Public Health Service provides information concerning the Public Health Service's AIDS-related activities.

National AIDS Program Office
202-690-5471

Bulletin Board System
202-690-5423

This document is available in the following formats for persons with disabilities --
- Braille
- Large print
- Audiocassette; and
- Electronic file on computer disk and electronic bulletin board, (202) 514-6193.

To obtain these documents in alternate formats, call the Department of Justice ADA Information Line, (800) 514-0301 (voice), (800) 514-0383 (TDD).

Note: Reproduction of this document is encouraged.
Group Title:  
Leisure  
Session Title:  
A Healthy Life  

Purpose:  
• To increase awareness of leisure activities and provide a variety of leisure opportunities.  
• To determine feasibility of pursuing appealing leisure interests.  
• To increase awareness of community resources to utilize for leisure participation.  

Materials:  
• Worksheet (Korb-Khalsa & Leutenberg, 1996, p. 22)  
• Worksheet (Korb-Khalsa & Leutenberg, 1996, p. 23)  

Description:  
1. Introduce the topic, leisure, to group members.  
2. Hand out worksheet on leisure opportunities to group members.  
   1. Instruct group members to complete worksheet individually.  
   2. Ask each member to share two or three leisure activities of interest.  
   3. Request that each member share one activity he/she would like to do, but can't afford.  
   4. Problem solve as a group ways to see if there are solutions as to how it might be affordable.  
3. Hand out worksheet about community resources for the leisure activities.  
   1. Instruct group members to find out contact information for the community resources associated with the leisure interests, utilizing phonebooks and other resources.  
   2. Share information with other group members.  
4. Allow time for group process and questions.  

(Korb-Khalsa & Leutenberg, 1996, pp. 22, 23)
# The LEISURE LINK

"Your link to a healthier life"

<table>
<thead>
<tr>
<th>LEISURE INTERESTS</th>
<th>DOES THIS INTEREST YOU?</th>
<th>CAN YOU AFFORD THIS?</th>
<th>WHAT DO YOU NEED TO DO BEFORE YOU BEGIN THIS ACTIVITY?</th>
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<tbody>
<tr>
<td>Play Cards • Board/Table Games</td>
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<td>Garden • Plants • Yardwork</td>
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<td>Woodworking</td>
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<td>Paint • Draw • Sketch</td>
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<td>Attend Concerts/Plays</td>
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<td>Attend/Rent Movies</td>
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<td>Listen to Music • Dance</td>
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<td>Camp • Fish • Hunt</td>
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<td>Golf</td>
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<td>Swim • Sunbathe</td>
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<td>Bowl</td>
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<td>Go to Parks • Hike • Picnic</td>
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<td>Exercise • Jog • Walk • Lift Weights</td>
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<td>Basketball • Baseball • Football • Volleyball</td>
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<td>Bicycling</td>
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<td>Travel/Vacations</td>
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<td>Socialize • Party • Visit People</td>
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<td>Crossword/Seek &amp; Find Puzzles</td>
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<td>Video/Electronic Games</td>
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<td>Fairs • Circus • Zoo • Amusement Park</td>
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<td>Science • Art/History/Health Museums</td>
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<td>Write Stories/Poems/Journals</td>
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<td>Collecting</td>
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<td>Cook • Bake</td>
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<td>Read</td>
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<td>Sew • Knit • Embroider • Crochet</td>
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<td>Shop • Garage Sales • Flea Markets • Antiques</td>
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<td>Crafts • Models • Projects</td>
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<td>Church • Temple Activities</td>
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<tr>
<td>Attend/Watch Sporting Events</td>
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<td>Home Decorate/Renovate</td>
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<td>Auto Racing/Mechanics</td>
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<td>Leatherwork</td>
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<td>Computer</td>
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<td>Volunteer</td>
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<td>Miscellaneous</td>
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<tr>
<td>Others:</td>
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Put an "A" beside activities that you do alone. Put a "P" after the activities that require planning.
<table>
<thead>
<tr>
<th>NAME:</th>
<th>TYPE OF SERVICE:</th>
<th>ADDRESS:</th>
<th>PHONE #:</th>
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Self-Esteem
Group Title:
Self-Esteem

Session Title:
Affirmation Cards

Purpose:
- To increase group members' self-esteem by providing them an opportunity to reflect on positive aspects of themselves.
- To create a tangible product as a reminder to engage in positive rather than negative self talk as a positive coping skill.
- To increase group members' self-esteem.

Materials:
- Note cards
- Stickers
- Magazines
- Glue sticks
- Markers
- Crayons

Description:
1. Introduce the topic, affirmations, to group members.
2. Explain the purpose of affirmation cards to group members:
   1. Identify positive aspects of oneself.
   2. Create a tangible reminder of positives.
   3. Look at cards each day to help change negative self talk into positive self talk.
3. Instruct group members to use the supplies to create a minimum of five affirmation cards.
4. Provide examples
   1. I love myself.
   2. I can learn to love myself.
   3. I have courage to change.
   4. I am intelligent.
   5. I am a caring person.
   6. My higher power loves me.
   7. I feel relaxed.
5. Encourage clients to put affirmation cards some place where they will be visible (i.e. on mirror in bathroom, in car, on refrigerator).
6. Have group members share their affirmations with the group.
7. Process the benefits of making affirmation cards.
Spirituality
Group Title:  
Spirituality  

Session Title:  
Finding peace within  

Purpose:  
• To provide a supportive environment for group members to talk about issues surrounding their spirituality.  
• To give group members an opportunity to discover their spiritual identity.  
• To provide group members with tools they can utilize to express their spirituality.  

Materials:  
• Handout (Inspirational Quotes, 2003)  
• Handout (Hyink & Blackman, 2003).  
• CD (Hambleton, 2003)  
• Paper  
• Pen or Pencil  

Description:  
1. Introduce the topic, spirituality, to the group members.  
2. Ask group members to identify thoughts and feelings that come to mind when they hear the word “spirituality.”  
3. Facilitate a discussion about how people practice spirituality and/or their experiences with spirituality.  
4. Ask everyone to take a piece of paper and a pen or pencil.  
5. Instruct the to write their own meditation, given the following guidelines:   
   1. Address the meditation to anyone you want (i.e. God, self, nature)  
   2. Write about issues that you are concerned about. You can draw pictures, write a narrative, write a poem, request guidance, forgiveness etc...  
6. While the group members are writing their meditations, insert the CD and let it play quietly in the background to help individuals relax and feel open with their spirituality.  
7. When everyone is finished writing their meditation, invite anyone who feel comfortable, to share their prayer with the group.  
8. If time allows, let the CD continue to play, and pass out the handouts to each group member.  
9. Instruct the group that the handouts contain various types of inspirational and spiritual quotations.  
10. Have each member read one quote from the handout. Proceed around the group until all of the quotes have been read.  
11. Process thoughts and feelings about the session as a whole.
Inspirational Quotations

The future depends on what we do in the present.
Mahatma Gandhi

Try not to become a man of success but a man of value.
Albert Einstein

If you have built castles in the air, your work need not be lost; that is where they should be. Now put foundations under them.
Henry David Thoreau

Nothing is predestined: The obstacles of your past can become the gateways that lead to new beginnings.
Ralph Blum

To find what you seek in the road of life, the best proverb of all is that which says: "Leave no stone unturned."
Edward Bulwer Lytton

Men do less than they ought, unless they do all they can.
Thomas Carlyle

Happy are those who dream dreams and are ready to pay the price to make them come true.
Leon J. Suenes

The power of imagination makes us infinite.
John Muir

Never let the fear of striking out get in your way.
George Herman "Babe" Ruth

(Adapted from Inspirational Quotes, 2003)
Inspirational Quotations

Ask and it will be given to you; seek and you will find; knock and the door will be opened to you. For everyone who asks receives, he who seeks finds; and to him who knocks, the door will be opened.
- Matthew 7:7-8 (see also verses 9-12)

"Have faith in God," Jesus answered. "I tell you the truth, if anyone says to this mountain, 'Go, throw yourself into the sea,' and does not doubt in his heart but believes that what he says will happen, it will be done for him. Therefore I tell you, whatever you ask for in prayer, believe that you have received it, and it will be yours."
- Mark, 11:22-24

We are not human beings on a spiritual journey. We are spiritual beings on a human journey.
- Stephen Covey

All consumed are their imperfections,
Doubts are dispelled, their senses mastered,
Their every action is wed to the welfare of their fellow creatures:
Such are the seers who enter Brahman* and know Nirvana*.
- Bhagavad Gita, chapter 5

[God says], do not fear, for I am with you; do not be dismayed, for I am your God.
I will strengthen you and help you; I will uphold you with my righteous right hand.
- Isaiah 41:10 (New International Version)

For I am mindful of the plans I have for you, says the Lord, plans for your good and not for evil, to give you a future and a hope. You call upon me and come and pray to me, and I heed you. You seek Me and find Me: Now you seek Me with all your heart and I am at hand for you, says the Lord...
- Jeremiah 29:11-14a; Matthew 7:7

Who are you that you should be afraid of a man who should die and of a son of man who shall be made of grass? ... Do not be afraid of their faces; for I am with you to deliver you.
- Isaiah 51:12; Jeremiah 1:8

...do not fear, for I am with you;
do not be dismayed, for I am your God.
I will strengthen you and help you;
I will uphold you with my righteous right hand.
- Isaiah 41:10 (New International Version)

(Adapted from Hyink & Blackman, 2003)
Wrap-Up
Group Title:
Wrap-up
Session Title:
What did you learn?

Purpose:
• To review important facts and information regarding HIV/AIDS.
• To gather input regarding client satisfaction with HIV/AIDS program.
• To provide an opportunity for group members to share feedback about benefits and areas of improvement of the HIV/AIDS program.

Materials:
• “What did you learn?” Game
• HIV/AIDS Program Survey
• Pencil/Pen
• Certificate of Completion

Description:
1. Inform group members of the order of activities for the session.
   1. Survey
   2. “What did you learn?” Game
   3. Benefits
   4. Certificates
2. Distribute one survey to each group member, along with a pen or pencil.
3. Instruct group members to complete survey, and hand in to therapist when finished. Remind group members not to write their name on the survey.
4. Next, explain the “What did you learn?” game to group members.
5. Divide the group into two teams.
6. Play game and give an award to the winning team (i.e. box of condoms, relaxation CD).
7. Facilitate a discussion surrounding the benefits and areas of improvement of the HIV/AIDS program. Encourage each group member to participate.
8. Distribute certificates of completion to each group member.
9. Say good-bye to group members.
“What Did You Learn” Game Questions

1. What are three examples of methods of contraception?
2. What is one reason why individuals with HIV/AIDS have difficulty disclosing their illness to others?
3. What is the definition of assertive communication?
4. What are two symptoms of stress?
5. What is a situation in which relaxation techniques may be useful?
6. What are two strategies to utilize to help cope with grief issues?
7. What are three healthy strategies to utilize when angry?
8. Name two community resources to utilize for money management.
9. What is the importance of creating a monthly budget?
10. Why is it important to read nutrition labels?
11. What are two precautions to be aware of when exercising?
12. What is one tool to utilize for managing medications?
13. What is a strategy to utilize for time management?
14. What is the difference between gender and sexuality?
15. Distinguish the difference between healthy versus unhealthy boundaries in relationships.
16. What are three roles that you identified during the role activity?
17. What can an individual with HIV/AIDS do if he/she is being discriminated against by a State or local government on the basis of his/her HIV status?
18. What are two community resources to utilize for leisure participation?
19. What is an example of positive versus negative self-talk?
20. What are two examples of tools to utilize when practicing spirituality?
HIV/AIDS Program Questionnaire

1. The group sessions focused on issues that you felt were important?
   Not at all  A little  Quite a bit  A lot
   Comments:

2. You felt that the staff respected your thoughts and opinions.
   Not at all  A little  Quite a bit  A lot
   Comments:

3. The staff encouraged you to share information during group sessions.
   Not at all  A little  Quite a bit  A lot
   Comments:

4. The information provided was easy to understand and clearly explained.
   Not at all  A little  Quite a bit  A lot
   Comments:

5. You felt comfortable sharing personal information, knowing that it would stay within the group.
   Not at all  A little  Quite a bit  A lot
   Comments:

6. You felt that you could ask questions and share your opinions without being judged.
   Not at all  A little  Quite a bit  A lot
   Comments:

7. The environment promoted your learning experience.
   Not at all  A little  Quite a bit  A lot
   Comments:

Date __________________________

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CERTIFICATE OF COMPLETION

IS HEREBY GRANTED TO:

NAME

FOR SUCCESSFULLY COMPLETING THE
HIV/AIDS COMMUNITY WELLNESS
PROGRAM

DATE
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