NSW Department of Corrective Services

Prison AIDS Project

HIV Prison Peer Education Program

TRAINER'S MANUAL

INFORMATION & LIBRARY SERVICES
NSW DEPARTMENT OF CORRECTIVE SERVICES

Prepared jointly by CEIDA and the Prison AIDS Project. For enquiries contact the Project on (02) 289.1565 March 1993
365.660944 HIV

HIV prison peer education program:

1993 AGH-9241
This manual is designed to be used by non-custodial correctional centre staff and community educators conducting HIV Peer Education training with inmates in NSW correctional centres.

This manual enables you to:

* provide inmates in your correctional centre with the knowledge and skills necessary to avoid HIV infection

* motivate inmates to play an active role in HIV prevention activities with other inmates

* develop inmate Peer Educators with the ability and the willingness to inform other inmates about HIV transmission and about safe/safer practices

* assist Peer Educators to develop the skills and willingness to actively support other inmates who are HIV positive

* establish a support infrastructure of correctional centre management, custodial staff, non-custodial staff and inmates who will work together to actively facilitate all HIV prevention activities

* develop an understanding of and a sensitivity to the particular learning needs of diverse groups of inmates
  * those with a developmental disability
  * those from non-English speaking backgrounds
  * Aboriginal and Torres Strait Islanders
  * Women

* access appropriate and up to date information, resources and support.
The HIV Prison Peer Education Program aims to prevent the spread of HIV amongst the inmate population by enabling inmates to obtain the knowledge, skills and attitudes needed to avoid infection.

This is achieved by:

* directly involving inmates so that they "own" the process of HIV/AIDS prevention within the prison system

* establishing structures within correctional centres which provide long term support to inmates' self management in preventing the spread of HIV/AIDS

* providing comprehensive HIV educational programs that are consistent with the traditions and cultures already established in the prison system

This manual was originally developed by CEIDA for the Prison AIDS Project. Whilst the majority of content remains the same, changes have been made to provide current, up to date information, and to meet the changing needs of the NSW correctional centre population.

Disclaimer

The possession or use of many drugs is illegal. Nothing in this manual should be taken as recommending their use. The manual is intended to be a guide for educating inmates about safer practices related to HIV transmission.

HIV Language and Terminology

The language you use when you talk or write about AIDS reflects your assumptions and attitudes as well as your understanding of the issues. An educator's language has a powerful influence on the learners. Terms such as "innocent victims" or "AIDS carrier" help to create and maintain discrimination against people who are HIV positive.

For these reasons, you will find a list of recommended terms and an explanation of why they are important at the end of this manual. A glossary of HIV terms and jargon is also included.
The NSW Prison AIDS Project

The Prison AIDS Project is responsible for all preventative education activities within the NSW correctional centre system. The program is based on the philosophy that everyone, staff and inmates, have some impact on preventing the spread of HIV in the system.

Aims of the Prison AIDS Project

* To minimise the transmission of HIV and other communicable diseases in correctional centres.

* To significantly increase the level of awareness and understanding of a range of HIV and AIDS issues amongst both staff and inmates.

Objectives of the Prison AIDS Project

* To provide a policy platform for the introduction of appropriate HIV/AIDS programs in correctional centres.

* To provide accurate educational and preventative programs for both staff and inmates of all correctional centres.

* To assist in the provision of a minimum level of information and equipment to ensure a safer working environment and reduce unsafe behaviour at all correctional centres.

* To provide assistance and advice on potential HIV transmission incidents or as required.
Inmates as a central force for HIV prevention education in the gaols

The Peer Education approach to preventing the spread of HIV/AIDS aims to build and reinforce inmates' ability and motivation to manage their own health and well being. This self management method has been shown to be a powerful way of achieving behaviour and attitude change where other methods have failed.

It is widely understood amongst educators that simply providing someone with information does not necessarily lead to a change in that person's behaviours. There can be compelling reasons why people do not do "what is good for them". Before someone is able to act on "good advice", it is essential to first understand what is maintaining their risk behaviour. It is only after this is clear that it is possible to find realistic ways of changing their behaviour.

The correctional centre setting is special. HIV education strategies are unlikely to succeed if they are imposed from a central authority. If they are going to become part of the culture of both inmates and staff, they need to evolve in a way that will be relevant and acceptable to the particular correctional centre.

Why peers are so effective:

Peer Educators are effective in limiting the spread of HIV/AIDS in correctional centres for a number of reasons:

* since HIV transmission in prison often involves illegal practices the Peer Educator may be the only person able to speak candidly to other inmates about HIV transmission.

* Peer Educators' input is not viewed with the same suspicion as the "propaganda" from the correctional centre hierarchy.

* Peer Educators are more able to realistically discuss the alternatives to risk behaviour that are available to inmates, acknowledging the real problems that people face.

* Peer Educators are more likely to be able to respond to issues as they arise and in an ongoing way, rather than providing a formal service within a limited time and setting.

* Peer Educators are able to judge which educational strategies would work within their correctional centre and link HIV/AIDS prevention to the existing culture and informal power structure.
THE PRISON AIDS PROJECT

Organisational Structure

The current staffing of the Prison AIDS Project is shown in the chart below.

Project Manager

<table>
<thead>
<tr>
<th>Regional AIDS Co-ordinators x four</th>
<th>Co-ordinator</th>
<th>Manager’s Assistant</th>
<th>Representative P.O.V.B.</th>
<th>Lecturer (Academy based)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Co-ordinator</td>
<td>Prison Peer Education Program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefits for the Peer Educators

Attendance at the Peer Education Program has produced some very positive spin-offs for the Peer Educators. As the course is experiential and designed to build on the learners’ existing strengths, inmates find it very personally confirming and enjoyable. For some, this is their first positive or rewarding experience of formal learning.

Despite limited formal education or perhaps literacy problems, participants discover that they are able to learn something new and important and also that they already have useful skills to bring to the situation. This is a very empowering and positive experience.

There is also a certain status attached to being elected by the AIDS committee to become a Peer Educator. Once they have completed the course, these inmates gain credibility from others in the correctional centre and the formal recognition that comes with a certificate of attainment and they have successfully completed the program.

Finally the opportunity to implement the skills and ideas that they have learned in the program reinforces their ability to plan, to organise, to get things happening and to communicate in a non-judgmental manner. These skills are transferable to other areas of their lives.

There are numerous reports of Peer Educators undertaking other training courses and initiating other projects as a result of the confidence and skill they gained from participating in the Peer Education program.

For all of these reasons there has been no trouble attracting inmates to the program.
AIDS Committees - The Structure To Support Peer Education

The AIDS Committee is designed to promote "ownership" of HIV prevention programs by inmates and staff. It is made up of inmates, custodial and non-custodial staff and develops locally appropriate HIV prevention strategies. It is also instrumental in selecting Peer Educators.

The AIDS Committee aims to help reduce the transmission of HIV in their correctional centre by designing, conducting and evaluating various HIV prevention activities that:
* are relevant and interesting to the diverse needs of various inmate groups
* are presented in a way that communicates persuasively and meaningfully with inmates
* build inmates' motivation and ability to take responsibility for their own health and survival
* are widely advertised on the grapevine

How to establish and develop an AIDS Committee

The AIDS Committee is the backbone of HIV prevention in a correctional centre. It is the forum where inmates and staff are able to decide what approaches will work in their correctional centre and how the HIV prevention goals can best be achieved.

To start an AIDS Committee:

* Seek support for Peer Education from the Governor. Outline the program's goals, rationale and strategies. Describe the success of the program elsewhere and explain how the AIDS Committee will benefit the correctional centre.

* Seek support from custodial and non-custodial staff (who may be already involved in OH & S activities or some other existing group) and inmates (who may be involved in an inmate support group or a reception committee).

* Conduct introductory AIDS information sessions for both inmates and staff. Invite interested people who attend the information sessions to join the AIDS Committee.

* Motivate people to become involved in HIV prevention by describing what has been achieved in other correctional centres.

* Provide resources, support and encouragement to the AIDS Committee as it develops, aiming to make it a group that truly represents the needs of the people in the correctional centre. Be clear that the task is to facilitate the committee, not run it.

* Encourage the AIDS Committee to request that a Prison Peer Education Program be conducted. Make sure that the inmates selected to be trained as Peer Educators are representative of the groups in the correctional centre.
Prison Peer Education Program Outline

PRE-PROGRAM MEETING

This meeting provides an opportunity for the group and the educator to meet and discuss:

* the aims of the Program
* the role of the Peer Educator
* the commitment needed to undertake the program
* the ongoing role of Peer Education within the correctional centre system
* an agreement of participation and consideration within the group

SESSION 1
Introduction to HIV and the Spread of the Virus
In this session participants:

* gain an outline of the program, its aims and objectives
* identify their current knowledge of HIV/AIDS
* focus on the issues faced by Peer Educators in the correctional centre system
* discuss the history of HIV and look at its predicted spread patterns in Australia

SESSION 2
Biomedical Aspects of HIV and Universal Infection Control
This session covers:

* the modes of HIV transmission
* the stages of HIV infection
* the types of tests available to diagnose HIV
* the current treatment options
* the principles of HIV transmission
* Universal Infection Control Guidelines

SESSION 3
Assessment of Risk
This session covers:

* the behaviours that put people at risk of infection with HIV
* why these behaviours are safe or unsafe
* an introduction to the communication skills involved in risk assessment
SESSION 4
Safe and Safer Drug Use
This session covers:

* the concept of "harm reduction"
* safer drug use techniques, including a needle cleaning demonstration
* options for drug users in and out of the correctional centre system

SESSION 5
Safe and Safer Sex
This session covers:

* sexuality/sensuality issues
* safe/safer sex practices
* the options available both in and out of the correctional centre
* instructions in the use of condoms, dams and gloves

SESSION 6
Pre-Test Education
This session covers:

* the process of testing for HIV
* the advantages and the disadvantages of taking a test
* the importance of pre and post-test information and education
* pre-test education techniques are closely considered and practiced

SESSION 7
Post-Test Support
This session covers:

* what support people need after an HIV test
* the resources and services available for people who test HIV positive
* the skills needed to provide support
* practice in providing support

SESSION 8
Planning Peer Education
This session covers:

* how adults learn
* the range of activities that Peer Educators can initiate
* the resources and support which Peer Educators may need
* how a Peer Educator can plan activities
PRE-COURSE MEETING

Aims of the meeting

To provide an opportunity for the participants and the trainer/s to meet and discuss:

* the aims of the program
* the roles of the Peer Educator, the Trainer and the AIDS Committee
* the ongoing task of the Peer Educator in the correctional centre
* participant’s commitment to the program (or opportunity to withdraw if necessary).

Meeting structure

The meeting needs to be as informal as possible so that everybody gets a chance to meet each other and to talk generally about the program. There should be plenty of opportunity for people to ask questions.

The Regional AIDS Co-Ordinator should be present in this meeting so they can immediately act to resolve any organisational or administrative problems that may emerge.

Meeting agenda

1. Introductions:

Introduce yourself and describe your role and the role of the Regional AIDS Co-Ordinator in the program. Make sure everyone knows each other. Explain if, when and how you will be available outside of formal session times.

2. The overall aim of Peer Education

Talk about the aim of Peer Education which is to prevent the transmission of the virus within the correctional centre system by encouraging inmates to use their ability to inform and educate others. Talk about how they are in a position to use their skills and contact with other inmates to share knowledge and information to reduce the risk of transmission.

Explain that the whole course is designed for two reasons:

1. to encourage inmates to be responsible for their own behaviour,
2. to increase HIV/AIDS awareness and information throughout the correctional centre system.
3. **Skills and commitment**

Explain that a successful Peer Educator is someone who:

* is able to communicate openly with other inmates about how to prevent transmission of the virus in their correctional centre.

* provides accurate and up to date information about:
  * how HIV/AIDS is transmitted
  * what behaviours place a person at risk of infection
  * how to reduce the likelihood of infection
  * the HIV/AIDS test.

* is available to other inmates to provide support and education about HIV testing both before and after a test is performed (wherever possible).

* plans and conducts various activities that are suitable for that correctional centre, to increase other inmates' awareness of HIV/AIDS and how it can be prevented.

Emphasise that you don't have to have a university degree to be a peer educator, but you must be prepared to put some work into positive attitudes and good communication skills. Explain that they will be provided with the knowledge, and their skills will be built on to make them more confident.

Explain that this program has been designed to make it easier for those people who have problems with reading and writing, however if there are problems with this, they can feel comfortable coming to the trainer/s or to the AIDS Co-Ordinator. It is not a test to see who can read and write best. Also explain that a "buddy" system has worked well for people in the past.

Use questions to promote further discussion about the role of the Peer Educator.

4. **Describe the ongoing role of the Peer Educator in the correctional centres:**

Provide some examples of peer education activities already in place in this or other correctional centres:

* AIDS Committee
* Information Sessions
* Newsletters
* Fundraising
5. The practical problems of a Peer Education Course

Make it clear to the participants that they are to share the responsibility in making arrangements for their normal daily commitments to take place around the Peer Education Course. Methadone and other medication times need to be clarified here, as does the need for re-organisation of visits, legal visits, phone calls etc. (if possible).

If you are unable to conduct a pre-course meeting due to time constraints, contact the Regional AIDS Co-Ordinator, or the Program Organiser for that correctional centre.

6. Outline of the course:

Describe how the course is intended to increase their existing knowledge and skills. Explain that they will be actively involved in a variety of tasks to solve some of the down-to-earth problems that exist in the correctional centre.

7. Seek a decision from participants:

People should be asked to decide whether they want to be part of the program. Everyone should have the opportunity to ask questions about what will be expected of them and they can opt to withdraw at this point if they wish.

8. Pre-course questionnaire:

Explain that this is not a test and we do not need their names. For statistical reasons, we need to keep information that they can give us before and after the Peer Education Course.
SESSION 1

INTRODUCTION AND EPIDEMIOLOGY

OBJECTIVES

Participants will be able to:

* outline the program and its aims
* identify their current level of knowledge about HIV/AIDS
* identify their needs as Peer Educators in the area of HIV/AIDS
* identify issues particular to correctional centres in HIV/AIDS education
* identify the role/s Peer Educators can play within the correctional centre system
* identify the skills/support they will need as Peer Educators
* discuss the history and spread of HIV to date
* discuss the predicted spread patterns of HIV particularly in relation to correctional centres

STRATEGIES

1. DESCRIBE THE PROGRAM AND ITS AIMS

Briefly revise the description of the program that the participants received in the pre-program meeting. If time for a pre-program meeting was unavailable, quickly go over the details outlined in that session.

Provide a copy of the course outline and explain the objectives of this session.

Reinforce with the group that if anyone has any problems with the course or they are finding the course difficult, they can approach the trainer confidentially.

2. ESTABLISH GROUP GROUNDRULES

2.1 Describe what groundrules are and how they can make the program run smoothly. This set of groundrules is an agreement between the Trainer/s and the participants, which sets out what the group considers to be acceptable or unacceptable behaviour in the sessions. It is intended to protect the participants' rights and could include issues such as confidentiality, use of ridicule or abuse, interruptions etc.

It may at first seem strange to construct more rules for inmates, so emphasise the benefits of being explicit, planning ahead and working as a team to ensure that the course runs smoothly.
2.2 Explain the purpose of "brainstorming".

Describe how during the course, the group will make a lot of use of this particular technique. Since sometimes good ideas are missed because they seem crazy at first, a brainstorm collects all the group’s ideas.

The person recording the brainstorm does not have the right to censor or change anyone’s ideas. Emphasise that the recorder does not have to be able to spell or write perfectly.

2.3 Ask for a volunteer to record the group’s first brainstorm. The writer records on butchers paper (whiteboard), a list of the group’s suggestions of what should be included in the groundrules.

2.4 Pose the question: “what are some rules we can agree to, that will make it easier for us to be in and learn from this group?”

2.5 When the list has been agreed to, leave it to be added to at any time during the course.

3. HOPES AND FEARS

This task is designed to elicit peoples’ personal agendas and to give permission for people to express their hopes and fears.

3.1 Give everybody 1 blank index card of one colour. Ask people to write 1 or 2 fears they have about HIV/AIDS.

Give everybody 1 blank index card of another colour. Ask people to write 1 or 2 hopes they have about HIV/AIDS.

Ensure that participants understand that they only need to write one word if they want. They don’t have to fill the whole card.

Collect cards and put them in two piles in centre of room.

3.2 Ask people to pick one card from each pile.

Ask everybody, in turn, to read out what fears are written down.

Ask everybody, in turn, to read out what hopes are written down.

3.3 In pairs, have participants discuss their own fears, their own hopes, and those of the group as a whole.

3.4 Explain the connection between what hopes and fears have been expressed and what is hoped they will gain from the course. Make also the connection between these hopes and fears and those they will be presented with as Peer Educators.

3.5 Ask participants what hopes and fears they have about being a Peer Educator.
4. INFORMATION CONTINUUM

4.1 Draw an imaginary line (with two extremes) across the room

| No knowledge of HIV | Considerable knowledge of HIV |

Ask everybody to place themselves somewhere on the continuum.

4.2 Ask participants to pair off with someone not near them and then:

* discuss why they stood where they did
* list what they need to develop (attitudes, skills and knowledge) to become Peer Educators.

4.3 Return to the large group and collect the list of needs that people expressed. Discuss how these needs will be addressed during the course.

5. INFORMATION CONTINUUM/HOPES AND FEARS 2

Place a frisbee or some other item in the centre of the room and call it the HIV. Ask participants to stand as close to the virus as they feel safe. Ask them to express why they stood where they did. Continue as in Information Continuum or Hopes and Fears.

6. EPIDEMIOLOGY (or the spread of the virus)

Based on the teaching notes and with the help of the overheads, posters or sketches, discuss the following:

* brief history of the virus
* the distinction between HIV and AIDS
* number of AIDS cases worldwide
* the number of HIV cases worldwide
* patterns in the spread of HIV
  * stages of spread within a society
  * factors affecting the speed of spreading
* brief introduction to how HIV is transmitted
* preventing the spread of infection.

7. REVIEW AND LINK

Check whether there are any further questions and explain the links between epidemiology and the next session which will be on the bio-medical aspects of HIV and universal infection control.

Find out how participants are feeling about the difficulty of the material and emphasise that although it is useful for them to understand how HIV is spread and have up-to-date knowledge about HIV and AIDS, they are not be required to be experts.
Epidemiology Teaching Notes

1. BRIEF HISTORY

It was in 1981 that the Centre for Disease Control (CDC) in Atlanta USA first noted the appearance of a pattern of unusual illnesses amongst people living in San Francisco, New York and Los Angeles. Those first identified as being affected (in the USA at least) were primarily young male homosexuals. It was for this reason that the disease was initially called GRIDS (Gay Related Immunodeficiency Syndrome) and was so strongly connected with gays.

That the term GRIDS was a inappropriate soon became obvious. It didn’t take long for other cases to emerge that made it clear that the agent (whatever it was) was likely to be blood borne and transmitted both sexually as well as through blood to blood contact and thus not specifically gay related. Consequently, they changed the name to AIDS.

In 1983 French researchers discovered what the agent was that causes AIDS. It turned out to be a virus and this virus is now known at the Human Immunodeficiency Virus - HIV.

2. THE GLOBAL PANDEMIC

By July 1992, a cumulative total of 501,272 cases of AIDS had been reported worldwide in 168 countries. However, the WHO estimates that 2 million people, including over half a million children have developed AIDS, but many have not yet been reported.

At July 1992, research suggests that there are:

* 7 - 9 million people infected in Africa
* 1 - 2 million people infected in the USA
* 30,000 + people infected in Australia

Figure 1

ESTIMATED GLOBAL DISTRIBUTION OF CUMULATIVE ADULT HIV INFECTIONS

GLOBAL TOTAL 10-12 MILLION

Figure 2

CUMULATIVE ADULT AIDS CASES
Mid 1992

REPORTED: 501 272
AFRICA 30%
EUROPE 12%
USA 12%
OTHER 1%
AMERICAS 1%

ESTIMATED: 1 700 000
AFRICA 60%
EUROPE 8%
USA 16%
OTHER 1%
AMERICAS 1%

* Excluding USA
GLOBAL PROGRAMME ON AIDS
July 1992
In Australia, the increase in AIDS cases has reflected world trends. In 1984 there were 42 new cases reported. By July 1992, the number of cases of AIDS had reached 3,421.

New South Wales, particularly Sydney, has the highest concentration of AIDS cases in Australia. There are several factors which are likely to have led to this situation. Firstly, Sydney is the main point of entry to Australia, particularly from the USA. Secondly, Sydney is the nation's largest population centre. Finally, Sydney not only has Australia's highest concentration of gay men (the first sub-cultural group to be infected here), but also Australia's highest number of injecting drug users (IDU's).

When speaking of AIDS cases it is important to remember that they represent only the tip of the HIV infection Iceberg. The idea of the infection iceberg is illustrated in Overhead 3. (The iceberg concept reflects the current global picture of HIV transmissions and is accurate only if transmission continues unabated, i.e. if there is a constant rate of newly infected people at the bottom. In Australia, there has so far been a very low rate of transmission since 1985 and therefore the iceberg concept does not yet apply. The trend may be towards the "melting away" of the base of the iceberg with fewer new infections and more cases of AIDS.)

![Image of HIV infection iceberg diagram]
People who currently have AIDS were typically infected somewhere between five and ten years ago: it is only now that they have become seriously ill. At any given time, there are many more people infected with HIV who have not developed AIDS: while we have seen over 500,000 cases of AIDS worldwide, the WHO estimates that the total number of HIV infected people is probably around 10 - 12 million.

3. EPIDEMIOLOGICAL PATTERNS

On a global scale there are three stages that can be identified in the spread of HIV infection and the emergence of AIDS cases:

GLOBAL INFECTION - STAGES

INITIAL INFECTION

INFECTION AMONGST SUB CULTURAL GROUPS

GENERALISED INFECTION

* initial introduction of infection. Eastern Europe and Asia are still at this stage.

* establishment of the infection within subcultural groups (e.g. in the USA, HIV infection is established amongst homosexual men and injecting drug users). In Australia, prior to intervention, HIV was becoming established amongst homosexual men and this was also a possibility amongst IDU’s.

* generalised infection. Africa and New York have reached this stage. All countries will progress to the stage of generalised infection unless there is effective intervention to prevent this from happening.

These stages occur when there is no effective intervention in relation to the transmission and spread of HIV. Again, using the WHO’s world map, we can see that we have not yet, nor are we likely to, reach the stage of generalised infection.

Several factors have been identified that can influence how quickly a country progresses through these stages:
* the transmission circles associated with the infected sub groups. For example, in New York, where needles and syringes are scarce, large numbers of people have shared the same equipment in "shooting galleries". This is an example of a very open transmission circle. Where needles and syringes are more readily available, sharing is more likely to be only between two or three people who regularly use together. This is an example of a relatively small transmission circle.

* economic/technological differences. Australia has, for example, been able to afford the technology required to make our blood supply safe. This has prevented the further transmission of HIV infection via blood and blood products, in transfusions etc. African countries have in general not been able to afford such protective measures and thus many people continue to be infected in this way.

* political factors. The degree to which governments have recognised the existence and seriousness of HIV infection in their countries and responded with appropriate legislation, education and other harm reduction strategies has been another key factor in influencing the rate of spread of infection. Comparisons between the approach of authorities in Amsterdam with that taken by those, say, in New York is particularly revealing in this regard.

* education. Appropriate education is one of the most effective ways of helping to control the spread of HIV infection.

4. TRANSMISSION OF THE VIRUS

To understand why HIV can spread so quickly, we need only look at the three modes of HIV transmission.

<table>
<thead>
<tr>
<th>MODES OF HIV TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BLOOD TO BLOOD</td>
</tr>
<tr>
<td>eg. by sharing needles and syringes</td>
</tr>
<tr>
<td>2. UNSAFE SEX</td>
</tr>
<tr>
<td>eg. sex without a condom</td>
</tr>
<tr>
<td>3. MOTHER TO CHILD</td>
</tr>
<tr>
<td>during pregnancy, at birth or through breast feeding</td>
</tr>
</tbody>
</table>

AIDS is essentially a sexually transmitted disease (STD) with HIV being transmitted through unprotected sexual practices or exchange of bodily fluids, between men and women (heterosexual intercourse) or between men and men or women and women (homosexual intercourse). Like other STD's, HIV infection can also be transmitted through blood, blood products, or donated organs or semen (parenteral transmission). Parenteral transmission principally involves the reuse of unsterile needles, syringes or other skin-piercing instruments, and the transfusion of infected blood. The third mode of transmission of the HIV is from a woman to her foetus or infant (perinatal transmission).
In contrast to the case of homosexual men, overseas experiences lead us to expect a rapid increase in the rate of spread amongst IDU's who share needles and syringes, especially as a pool of infected people becomes established and if insufficient attention is paid to prevention strategies. As a consequence, we can also expect rapid spread amongst the sexual partners of injecting drug users and spread of HIV infection to their children. In this way, injecting drug use will act as the main "bridge" for the spread of HIV infection to the wider (heterosexual) population.

5. PREVENTING THE SPREAD OF INFECTION

In deciding what preventative action is most appropriate Australia has been more fortunate in that HIV was introduced to the Australian population some years later than it was in North America and parts of Europe, enabling us to implement prevention programs prior to the emergence of major problems.

Overhead 7 shows very clearly that the rate at which HIV has spread amongst IDU's has varied enormously from one population centre to another even within the same country.

ACTION CAN INFLUENCE RATE OF SPREAD AMONGST IDU POPULATIONS

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDINBURGH:</td>
<td>51%</td>
</tr>
<tr>
<td>GLASGOW:</td>
<td>5%</td>
</tr>
<tr>
<td>NEW YORK:</td>
<td>50%</td>
</tr>
<tr>
<td>SAN FRANCISCO:</td>
<td>20%</td>
</tr>
</tbody>
</table>

On the most general level, the key to success or otherwise in significantly slowing transmissions within the IDU community (and so to the general community) appears to be whether intravenous drug use has been approached as a law and order issue or a public health issue.

Looking more closely, a number of factors can be identified that influence how rapidly HIV spreads amongst IDUs.
HIV SPREAD THROUGH IDU POPULATIONS
UP TO 50% OF IDU POPULATION CAN BE INFECTED IN LESS THAN 4 YEARS

MILAN: 0.7% 35% IN 6 YEARS
GENEVA: 7% 52% IN 4 YEARS
EDINBURGH: 0% 51% IN 2 YEARS
BANGKOK: 1% 40% IN 2 YEARS

* Access to needles and syringes

Where possession of needles and syringes is illegal and this law is rigidly enforced (eg. New York, Edinburgh), these items become scarce and therefore shared by many people. This leads to very rapid transmission.

* Access to drug treatment and a range of treatment options

In New York for example, funding cuts to both methadone and drug free treatment programs has meant that there are not enough places available for IDU’s seeking treatment. Many agencies with long waiting lists actually exclude HIV infected IDU’s on the grounds that they expect them to die anyway. This means that many infected IDU’s who would like to stop using, are refused treatment and continue to use and continue to share needles and syringes, thereby spreading HIV infection.

* Education

Education is of course the other major factor in influencing the rate of HIV transmission. Where injecting drug user’s are not aware of the precautions they can take to avoid HIV, they continue to engage in risk behaviours. This was the experience in Milan where IDU’s continued to share needles and syringes and not use condoms, even though they were readily available. Similarly, it is too late to tell women about mother-to-child transmission when they are already pregnant.
SESSION 2

BIO-MEDICAL ASPECTS AND UNIVERSAL INFECTION CONTROL

OBJECTIVES

Participants will be able to:

* describe how the HIV virus affects the immune system
* describe the four categories of the virus
* identify modes of HIV transmission
* identify the modes not implicated in HIV transmission
* describe the different types of tests used to diagnose HIV
* describe current treatment options for HIV infection
* practice appropriate infection control guidelines

STRATEGIES

1. INTRODUCTION

Ask the group whether they have any questions from the previous session. Encourage them to share any further feelings/ideas they have about their roles as Peer Educators.

Do not feel that you are responsible for immediately resolving all of the issues raised. Provide information where this is all that is required, and where appropriate, ask the members of the group to offer each other comments and suggestions. It is useful for any concerns to be verbalised and for ideas and issues to be put "onto the agenda" for attention in subsequent sessions. Do ensure that all requests for information and support are followed up.

Link the biomedical aspects of HIV/AIDS to the epidemiology session, and explain the importance of having an overview of these issues. Reassure people that it is not necessary for them to fully understand and remember all of the biomedical details.

2. BIO-MEDICAL ASPECTS OF HIV

Based on the teaching notes and with the help of the overheads, posters or sketches, make sure you cover the following:

* the principles of transmission
* how HIV can be transmitted
  * blood and blood products
  * sexual body fluids
  * breast milk
* some of the myths about how HIV is transmitted
* blood tests that can detect HIV transmission
* the "window period"
* how HIV affects the body’s ability to fight disease (immune system)
* categories of HIV and progression of the disease
* treatment options available for HIV infected people

Since there is a lot of new and technical material to present, it is important to vary the presentation style, pace and method.

Start with a True/False questionnaire to cover the material. This can be done verbally or written. It is useful to finish with the same questionnaire.

2. Limit the use of the lecture style as it can be alienating. Pose questions, use overheads, seek opinions from the group, discuss their implications.

3. Take frequent, regular, short breaks. Explain that it is very important to be relaxed and focussed in order to learn unfamiliar material. Use a mixture of methods to re-focus attention.
* have people stand up and stretch
* throw a ball to someone as you ask them a question
* have people take deep breaths, or run on the spot, or touch their toes, or swing their arms.

After the break ask participants to tell another group member what they learned in the first part of the session. These pairs can then bring that information back to the group.

2.5 As a group, brainstorm a list of the most likely questions that Peer Educators might be asked about the biomedical aspects of HIV.

3. VIDEO - HIV/AIDS

4. EXERCISING KNOWLEDGE

Ask participants at random to ask a question of anyone else in the room, relating to the session. Explain that although it is not vital that all information be taken in, as much as they can get is good. Ensure that the questions are not always directed at one or two people only.

5. UNIVERSAL INFECTION CONTROL
(See teaching notes)
With the help of the overhead, "Procedures for universal infection control" and posters/sketches, explain:
* the principles of Universal Infection Control guidelines for exposure to:
  * blood and other bodily fluids
  * needle stick injuries
  * environmental considerations (eg. kitchen, laundry etc)
  * disposal issues.
6. REVIEW AND LINK

Check whether there are any further questions and link universal infection control to the next session which will provide further information on what are high risk behaviours.
Bio-medical Aspects Teaching Notes

This session is an overview of biological and medical aspects of HIV infection. It is not necessary for Peer Educators to be able to remember all the details. Write on the whiteboard the following points they do need to have a general understanding of:

* how HIV affects the body’s immune system
* medical treatment currently available for HIV infected people
* blood tests that can detect HIV infection
* how HIV can be transmitted from one person to another
* the "window period"

WHAT IS HIV/AIDS?

SOME DEFINITIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus (HIV) A person infected with HIV can progress to AIDS</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome (AIDS) acquired, not inherited, comes from outside immune deficiency the immune system becomes much less efficient syndrome, collection of symptoms and illnesses</td>
</tr>
<tr>
<td>ANTIGEN (Ag)</td>
<td>Foreign substances e.g., virus, bacteria which cause the body to make antibodies</td>
</tr>
<tr>
<td>ANTIBODIES (Ab)</td>
<td>Are produced by B-cells as part of the body's defense against foreign substances in the blood</td>
</tr>
</tbody>
</table>

AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is "acquired" in the sense that it is not inherited, i.e. it is not a genetic disease. "Syndrome" is a term that applies to a collection of illnesses.

It is also important to understand the definitions of the terms ANTIGEN (Ag) and ANTIBODY (Ab):

An antigen is a foreign substance such as a virus or bacteria that causes the body's immune system to make antibodies.

Antibodies are produced by B-cells in the immune system as part of the body's defense against foreign substances in the blood.
Overhead 9 (virus) shows a diagram of the Human Immunodeficiency Virus (HIV) the virus that causes AIDS.

The virus itself is surrounded by a fatty envelope with protein spikes attached. When these spikes connect with the receptors on the cell, this envelope molds in with the outer layer of the cell, allowing the core to enter. There are two strands of RNA in the core of the virus. Genetically, we are made up of DNA. The reverse transcriptase turns the RNA into virus DNA, which breaks into and combines with the host cell DNA. At this point, it becomes irreversible.

HIV, as its name implies, is a virus that infects humans and can result in the weakening or breakdown of the immune system. When talking about the immune system we are generally talking about the white blood cells (lymphocytes).

Lymphocytes can be divided into two types: B-cells and T-cells, as shown in overhead 1. As already mentioned, B-cells manufacture antibodies. These antibodies are tailor made to destroy specific antigens. Unfortunately, in the case of HIV, they are not very effective against the virus because although antibodies can destroy free HIV in blood, they cannot deal with HIV which has been incorporated into chromosomes of the T-cells.
T-cells are of two basic types:

1. T4 (helper cells) and T8 (suppressor cells). T4 cells recognise malignant (cancerous) cells and invading organisms (such as viruses, bacteria or fungi) and stimulate the production of antibodies by the B-cells.

2. T8 cells regulate the immune response, suppressing it (turning it off) when the malignant cells or invading organisms have been destroyed.

The T4 and T8 cells thus act in balance, activating and suppressing the immune response. The ratio of T4 cells to T8 cells is normally about 1.5:1. The T4 (CD4) count in healthy people ranges from 500-1800.

To put it in terms of workers, the B-cells are the managers. Their radar detects the entry of the antigen (virus) and instructs the T4 cells to get to work. The T4 cells then pull the lever that activates the production of antibodies. The T8 cells determine when the virus is backing off and switches the process off.

Infection with HIV can weaken the immune system in two main ways. Firstly, HIV attacks CD4 cells so that the immune system is less able to recognise invaders and stimulate the production of antibodies. Secondly, the loss of T4 cells destroys the normal balance between T4 and T8 cells. T8 cells start to outnumber the T4 cells and thus the immune response is further suppressed.

The immune system of a person infected with HIV can often manage to keep the virus in check (without destroying it) for a considerable period of time. Infection can progress to more serious stages where the immune system begins to break down. When this happens a person becomes vulnerable to infection and may succumb to organisms their body normally would deal with easily.

These are known as opportunistic illnesses, e.g. pneumocystis carinii pneumonia (PCP), Cytomegalovirus and Microbacterium Avium Complex. People with compromised immune systems can also become susceptible to rare forms of cancer such as Kaposi's Sarcoma (KS) and Lymphoma. A healthy immune system is able to deal with them effectively. The development of each opportunistic illness leads to a diagnosis of AIDS, one of the sub groups of category 4 HIV infection. The four categories of HIV infection are discussed in the next section.
2. CATEGORIES OF HIV INFECTION

The four categories of HIV infection are summarised in overhead 12. It is not uncommon for people to shift back and forth between the categories.

<table>
<thead>
<tr>
<th>CATEGORY OF INFECTION</th>
<th>SYMPTOMS</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ACUTE</td>
<td>Glandular fever symptoms of varying degrees</td>
<td>Occurs 2-6 weeks after infection and lasts for a short time only</td>
</tr>
<tr>
<td>2. ASYMPTOMATIC</td>
<td>Usually feels well but will test HIV Ab positive</td>
<td>Variable, may be indefinite</td>
</tr>
<tr>
<td>3. PERSISTENT GENERALISED IMMUNODEFICIENCY (PGL)</td>
<td>Swollen Lymph Glands for 2 months or longer in the absence of other illness</td>
<td>Variable</td>
</tr>
<tr>
<td>4. SEVERE HIV INFECTION (INCLUDING AIDS AND AIDS RELATED CONDITIONS)</td>
<td>Variable including opportunistic infections (e.g. P.C.P.), cancers (K.S.) and neurological conditions</td>
<td>Variable - Those in need remain longer as treatments are improved</td>
</tr>
</tbody>
</table>

Category 1: Acute HIV Infection

This is a short period of illness, also known as "sero-conversion", that occurs 1-3 weeks after infection. It reflects the widespread dissemination of HIV throughout the body that accompanies the body's immune response and the production of antibodies. The number of antibodies in the blood reaches a detectable level in most people in up to three months (window period).

The symptoms of the illness typically last about one or two weeks and resemble glandular fever (fever, malaise, fatigue, loss of appetite, nausea, vomiting, headaches, sensitivity to light, rash and diarrhoea). Note that these symptoms are wide-ranging and can occur for a number of reasons e.g. flu, viruses. Not everyone will have such symptoms. Some people may not notice anything and others may notice symptoms that are much less severe than described above. Some may, in fact, progress straight to Category 2.

Category 2: Asymptomatic HIV Infection

The word "asymptomatic" means "without symptoms". People in this category test positive to an HIV antibody test, but feel well and usually have no symptoms of disease. This stage can last for an extended period of time (perhaps 10 or more years). It is important to remember that people in this stage are HIV positive and therefore can infect others. The precise causes of progression of infection beyond this stage remain unclear although several factors have been identified that may be associated with progression. These will be mentioned in more detail later.
Category 3: Persistent Generalised Lymphadenopathy

This is characterised by swollen lymph glands (excluding in the groin area) persisting for more than three months in the absence of another illness or condition that might explain the symptoms.

Category 4: Severe HIV Infection (AIDS and AIDS Related Conditions)

This category includes all serious diseases attributable to HIV infection, such as neurological complications, opportunistic infections and cancers. It has 5 sub-groups A-E:
(not all people in category 4 will go on to develop all these cancers and infections)

A: Constitutional disease lasting more than 30 days. This includes fever, unexplained weight loss, diarrhoea, persistent cough, night sweats, fungal infections, fatigue and/or loss of appetite. This is often described as AIDS Related Complex (ARC)

B: Neurological diseases (e.g. dementia)

C: Secondary or opportunistic infections (e.g. pneumonia caused by infection with pneumocystis carinii)

D: Secondary cancers known to be associated with HIV infection (e.g. Karposi’s Sarcoma)

E: Other HIV related conditions. (Groups B - E are classified as AIDS).

3. NATURAL HISTORY OF HIV INFECTION

There is generally a long, but quite variable latency period between initial infection with HIV and the development of AIDS or other forms of severe HIV infection. It is not known exactly what percentage of HIV infected people will eventually progress to Category 3 or 4 infection. The only factor clearly correlated with progression so far has been time, meaning that the longer a person has been infected, the more likely they are to progress to more severe categories of infection.

As already mentioned, it is not clear why some people progress to categories 3 or 4 (or progress more quickly than others). We do know, however, that certain diseases, conditions and drugs (whether taken for recreational or medicinal purposes) may cause the immune system to either be stimulated (perhaps resulting in increased replication of the virus) or depressed (perhaps further compromising a person with a reduced immune response).

For these reasons, it is often recommended that infected people avoid unnecessary recreational drug use, unnecessary stress on the body, exposure to sexually transmitted diseases (STD’s) or further exposure to HIV. Others have proposed such measures as improving nutrition, adopting stress management techniques and so on, in order to resist progression through the categories.
4. WINDOW PERIOD

Early after infection, the virus replicates quickly, and levels of virus in the blood (as opposed to embedded in the cells) increase rapidly. Responding to this the immune system begins to manufacture antibodies. This is referred to as sero-conversion. It can take about 2 - 6 weeks but is more often as long as three months for there to be enough antibodies so that they can be detected in an antibody test. During this "window period" an antibody test on anyone who is infected may come back negative.

Later, HIV antibodies can be detected, but "free" antigen cannot (since it is hidden in T4 cells). This situation continues for a long time until the immune system begins to break down and the person progresses to a more severe category of HIV infection. When this happens, the level of antibodies drops off and free antigen becomes detectable again. This is an important warning sign that the person may become seriously ill and that treatment may be appropriate.

LEVELS OF HIV ANTIGEN AND ANTIBODY IN THE BLOOD OVER TIME

5. TREATMENT OF HIV INFECTION

Information taken from HIV Briefs (Australian Federation of AIDS Organisations). It is a good idea to provide for each participant a copy of the HIV Briefs as this provides up to date information there is on current medical treatments.

Testing HIV positive is not necessarily a death sentence, and people can live well and healthy for a number of years with the virus and, without developing the illnesses related to AIDS. On average, people may remain asymptomatic for 10 - 11 years, but some claim it can be as long as 14 - 16 years. However, the average survival time for people who are diagnosed with Category 4 (Severe HIV Infection) is 12 months.

While biomedical research concentrates on the important work of searching for a cure or a vaccine, many people with HIV or AIDS are looking to improve the quality of their lives. This often means combining medical interventions with those from a wide range of alternative therapies.
Broad Categories of Intervention:

4.1 General Health Maintenance - through a healthy lifestyle including such areas as diet and exercise. This category also includes work on emotional health through counselling and support groups or relaxation techniques.

4.2 Alternative Therapies - including naturopathy; acupuncture; massage; herbal therapies (Chinese); aromatherapy and other herbal treatments.

4.3 Medical Treatment

* antiviral medicines - In Australia this really means only AZT (Zidovudine, Retrovir); ddl (Didanosine, Videx) and ddC (Zalcitabine, Hivid). These drugs are classed as Nucleoside analogues. They are designed to interrupt at the point in the virus’s lifecycle when the reverse transcriptase is turning the RNA into virus DNA. They slow down or stop further replication of the HIV. Often, these drugs are used in combination with one another to balance out the side effects and to provide a much more effective slowing of progression. It must also be recognised that AZT taken at the time of exposure has not yet been proven to prevent sero-conversion. It is prescribed for needlestick and other accidental injury as an emergency procedure.

* Opportunistic illness treatments - These can fall into two groups:

1. treatment of the illness when is becomes problematic (acute therapy)
2. Prophylaxis - that is the prevention of the infection from occurring when they are eg. trimethoprim which is used in low doses to prevent PCP.

Advances in the treatment of the identified opportunistic illnesses has resulted in effective measures of preventing and treating the conditions, and therefore keeping people well longer and improving quality of life.

Handout - HIV briefs. These are produced by the National Treatments Program of the Australian Federation of AIDS organisations.

There are a number of potential vaccines currently under trial, but we are still looking some years down the track for any of these to be freely available. The closest is a vaccine for HIV positive people to prevent progression to the later stages of the disease.
5. TESTING

There are two ways of testing for the HIV virus in the blood:
* with an Antibody (Ab) test (eg. Eliza)
* with an antigen (Ag) test (eg. Western Blot).

HIV antibody tests don’t test for the virus itself, but for antibodies to the virus. These are relatively easy to perform and are the most common type of test used.

Antigen tests on the other hand, test for the virus directly. Because they are generally more complicated and more expensive to perform, they are used primarily as a research tool.

Compulsory testing of inmates applies upon reception and 6 weeks prior to release. This is for statistical purposes and positive inmates are notified of their results.

6. PRINCIPLES OF HIV TRANSMISSION

Overhead 14 summarises the four principles of HIV transmission:

<table>
<thead>
<tr>
<th>PRINCIPLES OF TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV MUST EXIT THE BODY OF AN INFECTED PERSON</td>
</tr>
<tr>
<td>2. HIV MUST SURVIVE IN THE ENVIRONMENT</td>
</tr>
<tr>
<td>3. HIV MUST ENTER THE BLOODSTREAM OF ANOTHER PERSON</td>
</tr>
<tr>
<td>4. HIV MUST BE IN SUFFICIENT QUANTITY TO CAUSE INFECTION</td>
</tr>
</tbody>
</table>

For HIV to be successfully transmitted from one other person to another all of the conditions listed above need to be fulfilled.

HIV is found in all body fluids and throughout the body. However, it is only in blood (and blood products), semen, vaginal/cervical secretions and breast milk that HIV is present in sufficient quantities to cause infection.
Overhead 15 lists the three modes of HIV transmission.

### MODES OF HIV TRANSMISSION

1. **BLOOD TO BLOOD**  
   eg. by sharing needles and syringes
2. **UNSAFE SEX**  
   eg. sex without a condom
3. **MOTHER TO CHILD**  
   during pregnancy, at birth, or through breast feeding

6.1 Blood to Blood (Parenteral)

The vast majority of cases of people becoming infected with HIV in this way involved the transfusion of unscreened or the sharing of needles and syringes by injecting drug users (IDU’s). Transmission may also occur through infected donated organs.

In Australia all donated blood is now tested for HIV antibodies and procedures have been adopted that reduce the incidence of donation of infected blood to an absolute minimum. These measures have been very effective in ensuring that Australia’s blood supply is very safe. No transmission has occurred this way since May 1985.

In the early to mid 80’s, a number of haemophiliacs were infected through their treatment with Factor 8. This is a blood by-product used to clot the blood in those suffering from haemophilia. Again, there has been no reported cases of this type since 1985 in Australia.

In the case of IDU’S, transmission is not related to the type of drug used or the length of drug use. The issue is purely one of contaminated blood being introduced into the body or bloodstream of another person, by the sharing injecting equipment whereby traces of blood are often also shared.

6.2 Unsafe sex

Unsafe sex is any sexual activity that enables transmission of HIV to take place through the direct contact between infectious body fluids (i.e semen, vaginal/cervical secretions and blood) and the bloodstream of the exposed person. This can occur in several ways.

* Anal intercourse without a condom (both male-female and male-male): In this case both receptive and insertive partners are at risk. Transmission to the receptive partner may occur because the rectum tears very easily allowing semen and possibly blood to enter the bloodstream. Transmission to the insertive partner can take place through the urethra and also through tears or lesions on the penis, many of which would not be noticeable.
Vaginal intercourse without a condom: Again both receptive and insertive partners are at risk, as exchange of bodily fluids will occur. i.e. Both male to female and female to male transmission can occur.

The USA has witnessed a growth in the incidence of female to male transmission as the number of infected women increases. HIV if found (in sufficient quantity to cause infection) in vaginal/cervical secretions; menstrual blood and semen. Transmission may occur either through the fragile linings of the vagina or cervix or through lesions or tears.

Condoms should be used to prevent the exchange of body fluids in anal and vaginal intercourse. These should be made of latex and used correctly with a water based lubricant. People who have not used condoms previously should be encouraged to practice using them beforehand.

To date (Sept 1992) there have been a couple of confirmed cases of transmission of HIV through oral sex. In each of these cases there were lesions present in the mouth. Evidence suggests that oral sex is to be considered a low risk activity.

Apart from unsafe sex, there are several factors that are associated with a higher risk of sexual transmission of HIV. These include:

**Sexual practices that cause rectal or vaginal trauma**

These activities increase the likelihood of blood being present thus increasing the risk of transmission e.g. sexual assault, fisting, followed by intercourse etc.

**Number of Sexual Partners**

The greater the number of partners an individual has, the greater the likelihood of encountering any sexually transmissible disease. However, when talking about HIV, and other Sexually Transmitted Diseases, the real issue is not so much the numbers of partners but whether the sexual contact is infected with HIV. Infection has occurred through one contact and has been documented. The risk of transmission increases according to the number of unsafe practises.

**Practising monogamy**

This has been suggested by many people as a good way of dealing with the HIV/AIDS issue. It is worth noting that a person's interpretation of monogamy should be examined to ensure the safeness of this measure. For instance, some people may assume monogamy to mean "serial monogamy", which is where people are involved in a number of monogamous relationships, one after the other. If people in such situations don't practice safe sex, they are obviously at risk of HIV infection.
Genital ulceration and STD’s

African studies have found an association between herpes and syphilis infection and HIV infection. A HIV infected person with a history of STD’s may be more likely to progress to more serious stages of HIV infection (and AIDS) because of the effect that STDs (and possibly the drugs taken for them) have on the immune system. Other studies have shown a higher risk of HIV infection due to the open wounds associated with genital ulceration and Sexually Transmitted Diseases.

6.3 Mother to Child (peri-natal)

HIV infection can pass from mother to child before, during or after birth. Although perinatal transmission is not yet well understood, it is thought that it can occur in several ways:

* Woman and foetus share the same circulation, therefore the same blood
* can occur after birth through the ingestion of breast milk
* transmission during labour and delivery may well be possible, although only intrauterine (during pregnancy) and post natal (after birth) cases have been documented to date.

A foetus also shares the mothers antibodies, and it is not until they are approximately 18 months old that their own immune systems are developed. Therefore, all babies of HIV positive mothers are born HIV antibody positive. However, they are not necessarily HIV antigen positive and until their own immune systems have developed, their HIV status is not easily detected.

6.4 Some of the ways HIV is NOT transmitted

Remembering the modes of HIV transmission and the fluids involved, it is possible to list a number of ways that HIV is not transmitted.
Insects

Thinking about the modes of transmission, it is apparent that the likelihood of transmission by insects is non-existent. HIV stands for HUMAN Immunodeficiency Virus. It does not live in animals. If mosquitoes, for example could transmit the virus, then it would be much more widely spread. Other scientific studies have shown that the virus cannot survive outside of the human body and is inactivated (through chemicals in their gastrointestinal system) in the bodies of other animals.

Social, non sexual contact

Studies of the patterns of the spread of HIV have also shown no evidence for this means of transmission e.g. a New York study of families of HIV infected people showed no transmission to other members of the family, as did a study of a French school of HIV infected haemophiliacs amongst live in students.

Oral or respiratory routes

HIV is in insufficient quantity in saliva and nasal secretions to present a risk and there are no cases of HIV having been transmitted in these ways, in any setting (including social, household, school, work or prison settings).
Universal Infection Control is based on the principle that all body fluids should be treated in a specific manner - regardless of the infectious status of the individual i.e. the same procedures apply to everybody.

This means that the procedures undertaken are simple, uniform and adequate to provide protection against all infections. The principle of Universal Infection Control always stays the same regardless of the setting.

The aims of infection control procedures are:

* to prevent contact with blood and blood products, semen, pus, vaginal fluid and breast milk which may be contaminated with infectious microorganisms including HIV, Hepatitis B or Hepatitis C.

Infection control procedures should be applied to ALL body fluids.

HIV is a fragile virus and does not easily survive outside human body fluids. Therefore it is not easily transmitted from one person to another, without an exchange of body fluids.

---

<table>
<thead>
<tr>
<th>PRINCIPLES OF UNIVERSAL CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. INFECTION CONTROL SHOULD BE UNIVERSAL.</strong></td>
</tr>
<tr>
<td>THIS MEANS THAT THE SAME PRECAUTIONS ARE APPLIED TO:</td>
</tr>
<tr>
<td>a. all infectious micro-organisms</td>
</tr>
<tr>
<td>b. all body fluids that may carry micro-organisms</td>
</tr>
<tr>
<td>c. all staff and clients</td>
</tr>
<tr>
<td>2. THE AIMS OF INFECTION CONTROL ARE:</td>
</tr>
<tr>
<td>a. to prevent contact with body fluids that carry micro-organisms</td>
</tr>
<tr>
<td>b. to minimise exposure when accidental contact occurs</td>
</tr>
</tbody>
</table>

---

OVERHEAD 17
Only the following body fluids can contain sufficient concentrations of HIV to allow infection to occur:

- blood and blood products, including menstrual blood and pus (white blood cells)
- semen, including pre-ejaculatory (pre-cum)
- vaginal secretions
- breast milk

However, HIV is only one of many infectious microorganisms which may be present in these body fluids.

Others include Hepatitis B virus (HBV); Hepatitis A virus; Hepatitis C; Herpes genitalis (genital Herpes); Neisseria gonorrhoea (gonorrhoea); Treponema pallidum (syphilis); Human Papilloma virus (HPV); Cytomegalovirus (CMV); Chlamydia trachomatis (Chlamydia); and Candida Albicans (thrush, monilia).

Urine contains HIV but in insufficient quantities. If there is blood or pus in the urine, the chance of transmission is increased.

To provide Universal Infection Control it is recommended to use disposable latex gloves when dealing with all body fluids.

All correctional centres in New South Wales are equipped with Occupational Health and Safety cabinets. These contain all the equipment to carry out correct Universal Infection Control procedures. If any inmate is asked or instructed to clean up the spillage of any body fluid, they need to ask the Officer for this equipment to keep themselves safe from infection.

When handling food, soiled laundry, or cleaning out cells, wear gloves for your own protection to avoid infection from thing such as Hepatitis A.
PROCEDURES FOR UNIVERSAL INFECTION CONTROL

1. Skin is an effective defence against infection as long it remains unbroken. Any cuts, abrasions, ulceration or dermatitis can allow infected body fluids to enter the body.

2. Wash hands as a matter of routine:
   * before food preparation
   * before eating
   * after going to the toilet
   * before and after providing first aid
   * after contact with all body fluids.

3. Use handcream after washing hands. This helps prevent the skin from drying and cracking. Cover any cuts, abrasions, ulceration or dermatitis with a plaster.

4. When contact with any body fluids is likely, rinse or wash with soap and water any part of the body which comes in contact with any body fluid as soon as possible. This is especially important for splashes to the eyes. In this case, rinse immediately with water.

5. Using disposable latex gloves, remove the bulk of any spill of body fluids with disposable items such as paper towels, swabs and cotton wool.

6. After the bulk of a spill has been mopped up, wipe down the surfaces with household bleach (1% hypochlorite). This will destroy most micro-organisms, including HIV, hepatitis B and C virus. Don't mix bleach with detergent or soap and water.

7. The disposable items should then be placed in plastic bags and sealed ready for removal.

8. Follow normal laundry procedures using washing powder and cold water. Normal pre-wash soaking for blood stains is adequate. Blood spills should be washed away with cold, not hot water as hot water causes blood to coagulate.

9. Latex gloves should be worn when handling unwashed laundry.

10. Hands should be washed before preparation of food, and cuts, abrasions or dermatitis should be covered with a plaster.

11. In First aid, wipe away body fluids with disposable swabs or cotton wool. Dispose of these in a sealed plastic bag.

12. Wash any body fluids away from skin with soap and water as soon as possible after contact.

13. Any injury, including cuts, wounds or needle pricks should be washed under running water, gently encouraged to bleed, and treated with an antiseptic such as iodine or bleach.
14. Wipe away blood or vomit from the mouth of the patient before resuscitation.

15. If a trained person is available, use a resuscitation kit. If trained people are not available, cover the mouth of the patient with a piece of material such as a handkerchief.

16. Mouth to nose resuscitation may be used as an alternative to the mouth to mouth method. Mouth to mouth resuscitation is not considered to be an HIV transmission risk and no cases of infection have been reported.

17. Avoid needle stick injuries - never recap, break or bend needles or separate needles and syringes.

18. Place needle and syringe directly into a sharpsafe for later removal. If a sharpsafe is not available, a hard unbreakable container with a secure lid can be used instead.

19. When searching for something, never put hands into areas where you cannot clearly see what you are doing. It is safer to search systematically using some implement (e.g. a ruler) to probe an otherwise inaccessible area.
HIV Information for Prison Peer Educators

1. What does HIV stand for?
   Human Immunodeficiency Virus

2. What does AIDS stand for?
   Acquired Immune Deficiency Syndrome

3. What is the difference between HIV and AIDS?
   HIV is the virus, AIDS is a condition which may result from the virus

4. What has to happen for HIV to be transmitted?
   The four principles of transmission are:
   - Exit the body of an infected person
   - Survive in the environment
   - Enter the bloodstream of another person
   - Sufficient quantity to cause infection

5. How can this happen?
   - Blood to blood e.g. needle sharing
   - Unsafe sex
   - Mother to child

6. What is meant by the "window period"?
   This is the period between initial contact with the virus and the point at which antibodies can be detected in the blood. It is usually within three months.

7. What are antibodies?
   These are made by the B cells to defend the body against the antigen

8. What is an antigen?
   Also known as toxin, virus or bacteria

9. Why are antibody tests used to determine whether someone is HIV positive?
   The virus may be hard to find as it can be hidden inside the T4 cells, but the antibodies to the virus can easily be found in the bloodstream.

10. Do the following body fluids contain enough HIV to cause infection?
    - YES
      - Blood and blood products
      - Pus, Semen, Vaginal fluid
    - NO
      - Saliva, tears, vomit
      - Urine, Faeces

11. What are the categories of HIV infection?
    - Acute
    - Asymptomatic
    - Persistent Generalised Lymphadenopathy (PGL)
    - Severe HIV infection including AIDS and ARC
12. What is "safe drug use"? (in terms of HIV)
   New, clean needles and syringes that have not been shared.

What is "safer drug use"? (in terms of HIV)
   Clean needles and syringes using the 2 x 2 x 2 procedure. Wash twice with water, twice with bleach and then twice with water again. If bleach is not available, flush several times with cold, soapy water, followed by flushing twice with clean cold water. Do not use hot water.

13. What is "safe sex"? (in terms of HIV)
   An example of safe sex is when two people who are not HIV infected and aren't involved in any risk activities have sex.

What is "safer sex"? (in terms of HIV)
   Sex that does not involve penetration - Sex with condoms

14. What are the treatment options for someone with HIV/AIDS?
   Lifestyle changes, including:
   * diet/exercise/stress
   * alcohol and tobacco intake
   Alternative therapies, including:
   * acupuncture/homeopathy/herbalism
   Conventional medicine, including:
   * AZT, DDI, DDC
   * Treatments for opportunistic infections

15. What is happening to the immune system?
   * The immune system consists of two types of lymphocytes (white blood cells)
   * B cells produce antibodies which are tailored to fight the invaders (antigens)
   * There are two types of T cells. T4 (helpers) and T8 (suppressors) which keep the immune system balanced
   * T4 cells recognise malignant cells and invaders and stimulate the B cells to produce antibodies
   * T8 cells or "turn off" the B cells when they think the job has been done
   * In a healthy person the T4 (CD4) cell count ranges from 500 - 1800
   * HIV weakens the immune system in two ways:
     * T4 cells are less able to recognise invaders and stimulate the production of antibodies
     * T4 cells are reduced in number and start to become outnumbered by the T8 cells. This suppresses the immune system even further.

16. What approaches would be most effective in education?
   * relax (self and Peer)
   * talk on the same level, don’t be judgmental
   * be honest, patient and tolerant
   * listen, show interest/empathy
   * avoid giving opinions and making decisions
   * refer if necessary
### TRUE OR FALSE QUIZ

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. HIV infection will always cause death</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. HIV infection can cause cancer</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. AIDS is a disease only gay men have</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. HIV affects the body’s immune system</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Many people who are infected with HIV have no symptoms</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. You can tell by the way a person looks if they are infected with HIV</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. HIV is a problem in Africa and the US but not in Australia</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Heterosexual people who don’t have anal sex won’t get infected with HIV</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i. People who share fits are at risk of HIV infection</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>j. Condoms used properly are the best protection against spreading HIV via sexual transmission</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>k. You can clean a fit by washing it twice with water, twice with bleach, twice with water (2x2x2)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>l. Non-penetrative sexual activity, (eg. whole body massage) is safe from HIV infection</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>m. People with AIDS all die within six months</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>n. Menstrual Blood is a possible HIV infection source</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>o. Pus carries the virus</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>p. The only way to stop HIV transmission is for everyone to stop having sex and stop taking drugs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>q. Mosquitos spread HIV</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>r. You can get HIV by sharing eating utensils with an infected person</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>s. All babies born to HIV infected mothers will be born HIV infected</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
SESSION 3
ASSESSMENT OF RISK

OBJECTIVES

Participants will be able to:

* list all HIV risk behaviours
* rank all HIV risk behaviours on a safe/safer/unsafe continuum
* explain why each HIV risk behaviour is safe/safer/unsafe according to the four transmission principles
* describe some of the key communication skills needed in assisting somebody assess their level of risk
* describe four common types of responses to risk assessment
* describe at least 3 approaches to each of these four common types of responses.

STRATEGIES

1. INTRODUCTION

Ask if there are any questions or comments about the previous sessions. Explain the link between the bio-medical aspects of HIV and Universal Infection Control to this session on risk behaviours.

2. HANDSHAKE GAME

2.1 Ask for 2 volunteers in the group to shake hands with 2 other people in the group, who shake hands with 2 other people in the group etc.
Tell the group that one person was HIV positive and each handshake was a high risk behaviour.
Ask everybody who was in contact with the virus to stand up (this should be everybody)

2.2 Discuss what happened. Focus on two issues:
* a revision of concepts of epidemiology - that the virus does not discriminate who it goes to.
* the risk behaviour is crucial, not the "type" of person. Serial monogamy is no different to promiscuity if both involve unsafe sex.

2.3 Debrief the group using the poster or overhead "HIV is not transmitted by .......

Emphasise that shaking hands is not a risk activity.
3. BALL GAME

3.1 Think of a subject - it could be music; weather; or something which is non-threatening. Throw the ball to a participant asking them to say the first thing they think of regarding that subject. They then throw it to another and it continues for a few minutes.

3.2 Change the subject to risk practices for HIV/AIDS and ask participants to think of something regarding this subject each time they catch the ball. Continue for a few minutes or until they start to run out of things to say.

3. "CONTINUUM GAME" or "WHAT DO WE KNOW?"

3.1 Describe a continuum across the floor. Mark positions on the floor with large cards as:

<table>
<thead>
<tr>
<th>high risk</th>
<th>low risk</th>
<th>no risk</th>
</tr>
</thead>
</table>
| Mark another position with a large card "Do not know"

3.2 Distribute a set of prepared statement cards (one behaviour per card - approximately 40 cards). Each participant gets 3-4 cards each. Explain that:
- each card describes a sexual, drug use or other behaviour which may entail some degree of risk of infection with HIV.
- in all cases the behaviour assumes that the activity involves an infected person.

3.3 Ask the group to recall the four transmission principles. Emphasise that answers should be based on these principles:
- EXIT the body of an infected person
- SURVIVE in the environment
- ENTER the BLOODSTREAM of another person
- SUFFICIENT quantity to cause infection

3.4 Ask each person to take a turn:
* to read out their card and then placing it on the continuum or on the "Do not know" position
* to explain why they have chosen that position according to the four transmission principles
Others can challenge with additional information and suggestions. Participants then have the option of moving their cards.

3.5 The whole group discusses the results of the game with the trainer adding information where there are questions or disagreements.

4. RISK ASSESSMENT SKILLS

4.1 Introduce the principles of how to help someone assess whether they are at risk of becoming infected with HIV as shown in Handout 1.
4.2 Draw up the chart below on whiteboard/butchers paper. Explain how the classification describes:
* the different levels of anxiety that people have about the risk of becoming infected with HIV, and
* the different levels of risk people take.
Highlight the fact that being anxious about infection does not necessarily lead to low risk behaviour.

If you are find the chart difficult, you may use the case studies attached.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Anxiety level</th>
</tr>
</thead>
<tbody>
<tr>
<td>*High risk +</td>
<td>High anxiety</td>
</tr>
<tr>
<td>Low anxiety</td>
<td></td>
</tr>
<tr>
<td>*Low risk +</td>
<td>High anxiety</td>
</tr>
<tr>
<td>Low anxiety</td>
<td></td>
</tr>
</tbody>
</table>

Explain that the purpose of the exercise is to explore how a Peer Educator might help a person from each of these different classifications to assess their level of risk of HIV infection.

4.3 Divide the group into four and allocate each small group one "type". Ask each small group to brainstorm:
* all the things that might be going on for that person
* ways of approaching this person so you can in fact assess their level of risk.

Each group appoints someone who will record the groups ideas on butchers paper (whiteboard) and someone else who will present the group’s findings to the large group.

4.4 Groups then in turn present their findings to the large group. Encourage feedback.

4.5 Provide participants with feedback on their skills, and debrief the people who made the presentations by asking them how they felt about the activity and their part in it.

5. REVIEW AND LINK

Recap the main points raised and ask participants to consider:
* How would you feel as a Peer Educator helping a person from each of the categories?
* Would you find some people easy to help and some hard to help?
* What do you consider to be your natural strengths and weaknesses in this assessment situation?
* What could you do to improve your ability to help people to assess their risk behaviours?
CASE STUDY 1:

HIGH RISK/HIGH ANXIETY - Bill has been in gaol now for 2 years. On the outside, he used to get stoned and get laid on a regular basis. He doesn't know the first thing about cleaning needles and never has. He reckons wearing a condom is like eating a Mars Bar with the wrapper on. Since he's been in, he uses less but shares more. He's also been having unsafe sex with half the wing. He recently heard some guys talking about AIDS and is terrified that he might have it.

HIGH RISK/LOW ANXIETY - George has a large sentence. He's looking at another ten or so years on top of the ten he's already done. Being in gaol so long, George has found different ways of getting his rocks off. He's doing things that definitely are not safe. Many people have suggested to George that he is at quite a high risk but he's not particularly concerned. He reckons he only has sex with guys who wouldn't be caught dead with something like AIDS, so he's safe.

LOW RISK/HIGH ANXIETY - Lance is a short term inmate. He's been in gaol only a few short months. He's two out with a well known HIV +ve guy. They're good mates. Neither of them do drugs or engage in sex. They both practise solo masturbation from time to time. Lance is really anxious about AIDS, because people have been suggesting that he's got to have it.

LOW RISK/LOW ANXIETY - Tony has been in gaol for about three and a half years. He's looking forward to getting out in 3 weeks. He really can’t wait to see his girlfriend again. He's been faithful, (except for the one time) since he's been inside and he's convinced she has been as well. He's never done drugs but he thinks she might have been playing a little lately. He has no concerns about HIV as he doesn't consider himself to be at risk.
THE PRINCIPLES OF RISK ASSESSMENT

* deal with feelings first
* establish trust, openness as quickly as possible
* be non-judgemental
* be empathetic
* listen actively and carefully
* use appropriate language
* stick with the "here and now" rather than the "there and then"
* try to work with the person at a reasonable pace, and take it easy
* don’t give personal advice
* don’t get caught up in their anxiety
* don’t ask questions that begin with "why" as they cause a person to be defensive
* work towards getting the facts of what risk behaviours this person has engaged in
* feedback whether or not these behaviours are in fact high risk
* don’t take responsibility for the other person’s problem.
SESSION 4

SAFE AND SAFER DRUG USE

OBJECTIVES

Participants will be able to:

* explain the term "harm reduction"
* differentiate between "safe" and "safer" drug use
* list the possibilities for safe and safer drug use
* list the options available to a person who wants to stop using whilst in the correctional centre
* describe how to access needle exchanges, treatment and support services for pre-release inmates
* explain the procedure of "having a hit"
* describe the 2x2x2 cleaning technique
* list recommended cleaning agents available both within the correctional centre and in the community
* identify common feelings/attitudes/beliefs that maintain unsafe drug use behaviours
* identify strategies for helping others to practice safe/safer drug use

STRATEGIES

1. INTRODUCTION

Provide an overview of the objectives of this session and link these to the previous session on risk behaviours.

2. HARM REDUCTION

2.1 Ask the group what they think "harm reduction" might mean. Explain the goals of harm reduction:

* to help users to use more safely, reducing their risk of becoming infected and reducing the risk of them infecting other users and sexual contacts.

* to help people to reduce the risk of being infected or infecting others through their sexual activities.
2.2 Describe what harm reduction entails:

It involves giving people the knowledge and skills necessary to make informed choices about risk behaviours. This can be done in a number of ways, including:

* peer education
* needle and syringe exchange programs
* mass media campaigns
* methadone programs
* client education programs

2.3 List some key aspects of successful harm reduction programs:

* peers/learners/clients accept that HIV is a real risk which can be prevented
* information about self-protection must be simple, straightforward and easily available
* educators must realise that although breaking the using habit may be the user’s long term goal, they are likely to have set-backs and harm reduction must occur in the meantime
* safer sex and drug use equipment must be available

2.4 Lead a brainstorm to identify what implications this has for the Peer Educator. Ensure that these aspects of the Peer Educator’s role are raised and discussed:

* the primary goal is HIV/AIDS prevention not drug use prevention
* the primary goal is HIV/AIDS education not drug use education
* the Peer Educator may find that their values and attitudes towards drug use and sexuality are in conflict with the basic principles of harm reduction. They may have to evaluate whether expressing their values actually helps or hinders harm reduction.
* if the Peer Educator is seen as an “anti-drugs” crusader they will probably lose effectiveness as an HIV/AIDS educator. They could also damage the credibility of fellow Peer Educators.
* even though safe/r drug use and safe/r sex equipment are not available within the correctional centre system, it is still necessary to find other ways to reduce harm.
3. USING PRACTICES

It is important for Peer Educators to know the common using procedure so that they will be able to accurately explain effective cleaning procedures if required.

3.1 Demonstrate common using practice. Ask a participant to explain what equipment is needed and why:

- spoon
- water, lemon juice, vinegar etc.
- flame - cigarette lighter, match
- filter
- mixing water
- needle and syringe

Explain the terminology often used. Ask participants what terms they have heard (eg Pick, jack back)

4. SAFE AND SAFER PRACTICES

4.1 Define safe practices in terms of HIV transmission: practices that CANNOT result in a person giving or receiving HIV. "Safe" is an absolute term.

* safe drug use - someone using a brand new needle and syringe that they do not share cannot get nor give HIV.

* safe sex - two people who are not HIV infected, who only engage in sexual practices with each other and do not engage in any other risk practices.

4.2 Define safer practices:

Practices that reduce the likelihood of giving or receiving HIV are safer. "Safer" is a qualified term. It is less than completely safe.

* safer drug use - people share a needle and syringe BUT clean both the needle and syringe before and after each person uses it. It is safer to clean than not to clean, but the practice is not 100% safe in terms of HIV prevention.

* safer sex - is where a person has casual sex with new partners but uses condoms. It is safer to use condoms than not to use them, but the practice is not 100% safe in terms of HIV prevention.

5. OPTIONS FOR SAFE AND SAFER DRUG USE

Ask the group what options injecting drug users have both within the correctional centre and in the general community. Use the following information as a prompt.
5.1 Option 1: Stop Using

Within the Correctional Centre
- cold turkey
- detoxification
- methadone
- counselling
- Narcotics Anonymous
- other

Divide into 2 groups. Ask one small group to briefly list the advantages of 2 of these options and the other group to list the disadvantages of 2 of these options. The small groups report back their findings to the large group where the suitability, credibility and availability of these services can be considered.

In the community
Briefly describe the range of drug treatment alternatives:
- assessment and referral services
- detoxification
- residential and non-residential rehabilitation
- methadone
- self help - Narcotics Anonymous

5.2 Option 2: Don’t share

In the community
Describe the purpose of the Needle and Syringe Exchange Program shown in the leaflets in the participants’ kits. Explain what the services offer.

- New needles and syringes
- sterile water, swabs and spoons
- fitpacks and bins for disposal
- condoms, lube, dams
- advice on safe injecting
- referral and support

5.3 Option 3: If you share, use bleach and clean 2x2x2

Explain that bleach is the preferred cleaning agent as it is generally available, cheap and it kills HIV and Hepatitis B.

Demonstrate the 2x2x2 cleaning method.
Within the Correctional Centre

Explain the current policy for access to bleach in your State.

In the community

Discuss how the use of bleach is becoming widespread amongst injecting drug users. Show a video (It Only Takes a Minute - One Off Shot)

5.4 Option 4: If you cannot get bleach

Within the Correctional Centre

Ask the group for information about what else is used within the correctional centre in the absence of bleach. If possible, discuss the effectiveness of the options being used. If a product has an alcohol concentration of 70% (or higher) and is thoroughly flushed with water after it is used, it may be an effective substitute for bleach.

If you don’t know about the particular product being used in the correctional centre, find out for the next session.

When bleach is not available, flush with lots of cold soapy water followed by clean cold water. Emphasise that hot water is not to be used as it causes the blood to coagulate or clot.

When bleach is not available, people outside of the correctional centre system commonly clean fits by flushing with alcohol as long as the content is more than 70% (eg. methylated spirits) followed by flushing with water.
6. CONSTRAINTS TO CHANGING BEHAVIOUR

This is an exercise where people can close their eyes if they feel comfortable with that.

6.1 Ask each person to close their eyes and think of something that they do that they already know in their rational selves is not good for them. It could be smoking cigarettes, over-eating, losing their temper, allowing other people to walk over them, injecting drugs, being unfit, avoiding contact with their family etc.

Ask them to imagine that there are two voices inside their heads. One voice is the rational parent part of themselves, saying:

"You're just going to have to shape up! This is not good enough - you will damage yourself if you don't ... (whatever applies to them personally). Now from tomorrow onwards, there should be some changes around here! It'll be for your own good."

The other voice is the emotional child part of them and it is saying:

"BORING. Just leave me alone. I NEED to do it (smoke, fight, eat etc). It's easy for YOU to talk about change, you don't know what it's like for me."

Still with their eyes closed, ask each person to continue to make up a conversation between these two parts of themselves. Try to get in touch with what the child part is feeling.

6.2 Ask participants to open their eyes and take a couple of minutes to privately write down:

* how does the child part of themselves feel about being pressured to change?

* what is needed for them to be able to actually change that self destructive behaviour?

6.3 Divide the group into 3 or 4 small groups, brainstorm and record on butcher's paper or whiteboard:

* a list of the barriers that stop people from changing their risky behaviour.

A representative of each small group presents their group's ideas to the whole group. Encourage the rest of the group to provide feedback.

6.4 As a large group, discuss the implications of these findings for the Peer Educator.

7. ASSESSING WHAT CHOICES PEOPLE REALLY HAVE

Use the following scenarios with participants to assess using practices and to identify options for HIV prevention.
7.1 Divide the group into 3's or 4's. Give each group a scenario card and a sheet of butcher's paper.

Ask the groups to:

* identify and record all the possible choices available to the people in the scenarios
* discuss the implications of each choice, and
* decide why some choices are better than others as a way of preventing HIV/AIDS.

7.2 If time permits, assign another card to groups, or have groups swap their cards.

7.3 When the activity is complete, have each group stick their butcher's paper to the wall and take turns to present their findings to the group. Encourage the other groups to comment on the findings and/or suggest alternatives.

8. REVIEW AND LINK

Summarise some of the issues that were raised and ask participants to consider the implications for their roles as Peer Educators. Emphasise the importance of helping people to recognise that they do have the power to make certain choices. It is easy to be fooled into a belief that we have less control than we really do. If someone feels powerless how can they be expected to become motivated to change?

Link this session to the next session on safe/safer sex.
SESSION 5
SAFE AND SAFER SEX

OBJECTIVES

Participants will be able to:

* recognise the significance of their own sexual learning experiences to their role as Peer Educators
* list sexual practices to be encouraged in relation to HIV prevention
* differentiate between safe and safer sex
* list and discuss three types of sexual activity which occur in prison
* differentiate between sexual activity in prisons and sexual preference
* differentiate between sexuality and sensuality
* list the options for safe/safer sex for people in prisons
* explain the correct instructions for proper use of condoms
* explain the correct instructions for proper use of dental dams
* demonstrate an ability to discuss other safe/safer sex practices

STRATEGIES

1. INTRODUCTION

Refer to the "homework". Find out whether people thought about how someone else could help them to change a self-destructive behaviour. Link these ideas to the issues of safe/safer sex.

Provide an overview of the objectives of the session.

2. WHERE AND WHAT DID YOU LEARN ABOUT SEX?

2.1 Explain the purpose of this exercise, which is to help people feel more relaxed about talking about sex and to recognise the wide range of "normal" sexuality.

Discuss the fact that each person's sexuality is different from another person's sexuality. It is more than sexual "preference" and it was not stamped on us when we were born. In fact the way in which we view our sexuality now, will probably change in the future. Our current view of sexuality is generally shaped by significant experiences and influences since our childhood.

Talk about the differences between women and men and how it is traditional that women are less able to display their sexuality. Discuss socialisation and how society is changing to allow women more sexual freedom. Or is it? How has the onset of HIV/AIDS affected women and their choices?
2.2 Ask the group to get comfortable, perhaps close their eyes, and think back to the first
time they heard about/may have seen/experienced:
masturbation
intercourse
women’s bodies, period, sexual response
homosexuality
how men/women are supposed to behave intimately

As participants begin to reflect, encourage them to think about how these
experiences/influences have shaped their sexuality.

In 3 or 4 small groups, ask people to discuss their recollections and then make some
generalisations about where and what they learned. A representative from each small group
summarises these points for the large group.

2.3 Highlight with the group, the dangers of:

* lack of correct information
* no-one to talk sensibly to
* guilt and shame in our society
* double standards
* stereotypes
* denial and fear of knowing oneself
* growth of self-awareness/self acceptance as a lifelong process

2.4 Ask the group to think about the difference between sexuality and sensuality. Their ideas
about sensuality should include:
body awareness
body image
willingness to explore
using the senses - touch; taste; smell; sight and hearing
being honest about feelings
being unafraid to feel

2.6 Debrief by asking participants to share how they felt about discussing their
sexuality/sensuality.

Emphasise the benefits of self awareness and self acceptance for Peer Educators. Explain that
this will increase the quality of their communication with other inmates about risk
behaviours.

2.7 Discuss the implications of making judgments about another person’s sexuality. Explain
that a successful Peer Educator challenges narrow and judgmental views of sexuality and
recognises that it is counter-productive to express any personal prejudices or try to
indoctrinate others into a particular slant.
So even if a Peer Educator has a particular bias, this should not be expressed if they are to be effective and credible in their goal of HIV/AIDS prevention in the correctional centre loses credibility in this way, may also damage the credibility of other Peer Educators.

2.8 Ask participants to try to think about the sexual behaviours that they personally cannot accept. Ask them to imagine that they are faced with the task of helping/educating someone who engages in this behaviour. What are they going to do?

Reinforce that if they feel that they cannot sensitively and in a non-judgmental way deal with a person, then they should carefully refer that person to another Peer Educator.

3. REASONS WHY PEOPLE HAVE SEX IN CORRECTIONAL CENTRES

3.1 Ask for a volunteer to record a brainstorm of why people have sex in correctional centres include:
* affection
* sexual release
* sexual preference
* relationship approximating emotional normalcy - what is that?
* power/favours

3.2 List the three different types of sexual activity in correctional centres:
* free choice to have sex - consensual sex
* obligation to have sex in exchange for protection or favours - semi-consensual sex
* sexual assault - non-consensual sex

4. IMPLICATIONS OF SEX IN CORRECTIONAL CENTRES

Ask participants to consider the impact that sexual relationships in correctional centres have on people:
* if a person who sees themself as heterosexual has sex with someone of the same sex while they are in the correctional centre, what effects might this have on them? (guilt, shame, confusion)
* what happens to the victims of violent sex? (sexual assault may not be overtly violent and that most sexual assaults rely on fear and reputation than overt violence.)
* what happens to the perpetrator of violent sex?

5. SAFE/SAFER SEX PRACTICES

5.1 Ask who can recall the definitions of safe sex and safer sex in terms of HIV. Have them write it on the board and ask for examples of each.

Safe practices CANNOT result in a person giving or receiving HIV. "Safe" is an absolute term.
eg. two people who are not HIV infected, who only engage in sexual practices with each other and do not engage in any other risk practices.

Safer practices reduce the likelihood of giving or receiving HIV. "Safer" is a qualified term. It is less than completely safe.

eg. a person has casual sex with new partners but uses condoms. It is far safer to use condoms than not to use them, but the practice is not 100% safe in terms of HIV prevention.

5.2 Safe sexual activities:
Ask the members of the group to brainstorm what activities they believe would be safe.

Explain what sexual activities are safe. Any activity which does not allow any body fluid to pass from one infected person into the body of another person is safe:

Safe:
* solo masturbation
* kissing
* massage
* hugging

Safer:
* mutual masturbation
* oral sex - certainly low risk
* s&m where no bodily fluids are exchanged
* anal and vaginal intercourse with a condom and lubricant properly used.

Unsafe sexual activities:
* unprotected vaginal intercourse (unsafe for both partners)
* unprotected anal intercourse (unsafe for both partners)
* withdrawal before ejaculation

Ask the group to think of the words commonly used to describe different sexual activities. Make the list as large as possible and emphasise the importance of using appropriate language with their peers. Use the "Summary of Sexual Behaviours" in the Peer Educator packs.

6. ASSESSING THE CHOICES THAT PEOPLE REALLY HAVE

Use the following scenarios with participants to enhance their skills in identifying options for HIV prevention.

6.1 Divide participants into small groups. Give to each group a scenario card and ask them to consider the questions and answer them.
6.2 Allow 20 minutes for the roles to develop then call back into large group. Ask the group to talk about the scenarios and what suggestions they could make. Identify with the group, common problems faced by peer educators. Fill in the gaps.

If time exists, negotiate with the group to do another.

7. CONDOM DEMONSTRATION

Use the dildo to demonstrate the correct use of condoms.
* use "Australian Standard" condoms only - explain difference in standards.
* remember that glow in the dark and other such condoms will be for novelty use only and will not provide a barrier
* store condoms in a cool dry place, away from direct sunlight
* check the use by date (expiry date)
* use water-based lubricants only, eg. KY and Wetstuff - do not use grease or oils
  * before removing the condom from the plastic cover, inspect for holes or other damage
  * remove the condom by carefully tearing off the corner of the plastic cover at the serrated edge
  * inspect the condom to determine which way it will roll down. Note: condoms will only unroll in one direction
  * squeeze the teat of the condom between thumb and forefinger in order to expel air from the condom teat - this will allow room for the semen to deposit
  * roll the condom on to the erect penis - be careful not to scratch the condom with fingernails
  * smooth on water based lubricant
  * grip penis at the rim (base) of the condom and withdraw quickly after ejaculation
  * use each condom once only
  * dispose of condom thoughtfully - don’t flush them down toilets, wrap them up, place in a plastic bag and tie a knot to seal the bag, then throw the bag in with the rubbish.

7.1 Explain what is a dental dam. Historically used by dentists to protect themselves while working in peoples mouths, this thin latex square are now used for oral (male-female; oral anal) sex. They are held across the vagina or anus to provide a barrier against body fluids. Like the condom, it does not restrict sensation.

Explain how dams are used:
* as they are covered in a fine talc, they should be washed first
* hold across the vagina or anus
* store away from sunlight
* lubricate with water based lubricants only
* use only once
* don’t flush them
* if you cannot get hold of a dam, cut up a condom

Dams reduce the risk of HIV infection through menstrual blood and other body fluids and makes oral sex safe and fun.
Talk about gloves and their part in some of the activities people participate in.
* mutual masturbation
* fisting

9. REVIEW AND LINK

Remind participants that many inmates will be looking for a sexual partner when they are released. Potter and Connelly's study of 158 inmates (NSW Department of Community Services) showed that:

* 42% of men and 25% of women had no regular sex partner and would want to form relationships on release
* half had never used condoms
* a third had only used condoms once or twice
* a quarter had 20 or more sexual partners

Recap on the main issues raised and ask participants to spend time trying to honestly identify their own biases and prejudices about sexuality and how they might deal with these in their role as a Peer Educator.
SESSION 6
HIV PRE TEST EDUCATION

OBJECTIVES

Participants will be able to:

* list the areas to cover in a HIV pre test education for a person who will be in a correctional centre for a while
* list the areas to cover in a HIV pre test education session for a person just about to be released
* demonstrate a HIV pre test education session
* list resources/services within/outside the correctional centre for HIV pre test counselling

There are many situations in which Peer Educators are able to assist their peers during the HIV testing process, by either:

* providing education and support before a test is conducted
* providing support for inmates who are found to be HIV positive
* or by providing those who are HIV negative with information about safe/safer drugs/sex practices.

However it is important to understand that:

1. Peer Educators are not part of any compulsory testing program

In order to maintain the credibility of the Peer Educators and the Prisons Peer Education Program, it is essential that Peer Educators are not seen to be involved in implementing departmental programs such as compulsory testing, particularly given the controversy which surrounds it and any inadequacies which may exist in the provision of both pre and post test counselling.

2. Peer Educators should not be seen to be acting as qualified counsellors.

Peer Educators have valuable knowledge and skills to support and educate inmates who have received a test result however the Prison Peer Education Program provides only basic and limited training in pre and post test education and support - not counselling skills.
The Segregation/Integration of HIV Positive inmates debate:

States differ in their management approach to inmates who are HIV positive. Part 3 of this session deals with the segregation/integration debate. The amount of time which needs to be spent on the integration versus segregation policy will depend on the needs of individual states and the attitudes of the participants.

As of November 1990, inmates in NSW who are identified as being HIV positive are currently integrated with other inmates. Integration is partial in Queensland and Victoria. A segregation policy exists in the Northern Territory, Tasmania and Western Australia. This session addresses the issues relating to the segregation of HIV positive inmates. It gives participants the opportunity to develop an awareness and understanding of the implications of segregation/integration for HIV positive inmates.

STRATEGIES

1. INTRODUCTION

Explain the purpose of this session. Differentiate the role of the Peer Educator from the role of a qualified pre/post test counsellor.

2. THE HIV TEST

Review the information about the test for HIV:

* what it measures
* window period
* how it is done
* how long it takes to get a result

3. SEGREGATION

3.1 Divide the whiteboard into two:

Arguments for arguments against

Ask for two volunteers to record the results of a large group brainstorm. One records the arguments for the segregation of people who are HIV positive and the other records the arguments against segregation.

Some of the commonly expressed arguments for segregation include:

* to protect HIV negative inmates from HIV+ve sexual predators or violent inmates
* to avoid transmission through needle sharing
* allows specific services to be provided to segregated inmates
* to protect HIV +ve inmates from others
* correctional centre staff will know who to act carefully and safely with
Common arguments against segregation:

* imposes a further unreasonable penalty on inmates
* impossible to maintain confidentiality of HIV status
* sexual predators should be removed anyway
* threat of violence to HIV +ve inmates is overstated
* precautions will slacken off in the HIV -ve part of the correctional centre and thus develop a false sense of security and HIV transmission may increase
* undermines education which says that transmission doesn’t occur through casual contact
* puts great psychological stress on those segregated
* is expensive and impractical if and when numbers of HIV positive inmates increase

3.2 Lead a discussion about the emotions attached to the segregation debate. Ask people to suggest how the conflicting positions can be accommodated.

Options for the resolution of the controversy:

* integration should be restricted to single cell accommodation
* daytime integration but separate sleeping/shower facilities
* short term segregation
* segregation when sick only
* determine on the basis of individual cases

4. REASONS FOR PRE TEST EDUCATION

4.1 Divide the board into two:

advantages                                     disadvantages

Ask for a volunteer to record the ideas generated in a group brainstorm about why people need pre test education.

5. WHAT TO COVER IN PRE TEST EDUCATION

Divide the group into two and ask:

Group A: to develop a checklist of areas to cover in a pre test education session for someone who will be in prison for a while

Group B: to develop a checklist of areas to cover in a pre test education session for a person just about to be released

Give each group butchers paper and pens and ask them to select a person to record their ideas and another to present them to the large group.
Group A’s checklist should include:

* assess the persons level of risk
* assess their reasons for taking the test
* educate about the test procedure
* anticipate feelings if the test is positive
* provide support for feelings about the lack of confidentiality of test results
* anticipate feelings about segregation
* anticipate feelings if the test is negative
* educate about safe/safer sex/drug use practices
* consider discussing the decision with family/friends first
* anticipate who/how would they want to tell if result is positive
* list the resources/support within the prison, including inmate support
* include other sexually transmitted diseases

Group B’s checklist should include:

* assess the persons level of risk
* assess their reasons for taking the test
* list the services available on the outside for pre test counselling and the test
* anticipate feelings if the test is positive
* anticipate feelings if the test is negative
* educate about safe/safer sex/drug use practices
* consider discussing the decision with family/friends first
* who/how would they want to tell, if result is positive

After each group has presented their ideas and these have been refined by members of the large group, arrange to have these checklists printed and copied for circulation amongst the group for the next meeting.

6. HOW TO TALK ABOUT TESTING

The previous exercise identified what needs to be discussed, but it is crucial to know how to discuss these issues with peers.

Ask participants to reflect for a couple of minutes on their experiences as clients in a counselling. Encourage them to focus on what they found to be both good and bad aspects of their experiences.

In small groups conduct a brainstorm to identify and record how the helper/counsellor’s behaviour made the experience good or bad. Small groups present their findings. The trainer compiles these into a list of recommendations for how Peer Educators can communicate effectively:

* relax and try to help their peer to relax
* talk on the same level as the peer
* listen with interest to what is being said
* ask open ended questions
be patient; tolerant; empathic and non-judgmental towards peer
* avoid giving opinions and making decisions for peers. Instead help peers to identify options and to carefully examine the options in order to come to her/his own decision
* be honest and open
* don’t take notes
* refer if necessary
* don’t try to force information
* show respect for the peer and his/her attitudes and beliefs.

8. PRACTICE SESSION

Divide the group into 3 or 4’s who select 1 Peer educator, 1 peer and 1 or 2 observers. Explain the purpose of the three roles.

The members of the small groups will rotate their roles so that each person can experience all three roles.

Peer: The peer should read the role card carefully and make a genuine attempt to assume the role described. She/he should not read it out to the Peer Educator or the observer. Information about the peer should unfold naturally during the course of the session.

Peer Educator: The Peer Educator should make a genuine attempt to deal with the peer sensitively and in a non-judgmental way. It is not the role of the Peer Educator to tell the Peer what she/he should do. Instead the Peer Educator should be able to:

* help the peer to identify their options
* help the peer to work through those options in order for them to make their own decisions
* attempt to raise the issues covered in the checklists
* never attempt to force information upon a peer.

Observer: Observers should concentrate on the role-play and mark the "observer checklist" honestly. The observer should not interrupt the role-play. Following the conclusion of the role-play the observer should provide the Peer Educator and peer with critical feedback. This should be done honestly and supportively.

The trainer should move between small groups facilitating the exercise, reinforcing and encouraging appropriate attempts.

9. PEER EDUCATOR NEEDS

Ask each person to consider how they will debrief/unwind after talking to someone about their reasons for testing. Explain that helpers can become "burnt out", their own emotions can become confused with the emotions of their client and that this can be very counter productive for everyone involved unless the situation is managed appropriately.
10. SUMMARISE

Briefly go over what the participants have learnt in this session. Make the connection between this and other issues already discussed. Allow time for questions and make yourself available for any concerns anyone may have.
Observer Checklist

PRE TEST EDUCATION

1. Being relaxed and open.

<table>
<thead>
<tr>
<th>Being relaxed and open</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not relaxed and open</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Listening Skills.

<table>
<thead>
<tr>
<th>Poor Listening</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good listening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Letting the person make their own decision about the test.

<table>
<thead>
<tr>
<th>Making decision for person</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let person make own decision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Giving information about testing procedures.

<table>
<thead>
<tr>
<th>Not so good</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Giving safe/safer sex information.

<table>
<thead>
<tr>
<th>Not so good</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Not so good</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Did the person understand all the information?

<table>
<thead>
<tr>
<th>Not much understanding</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good understanding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Did they seem to feel comfortable and able to talk?

<table>
<thead>
<tr>
<th>Not very comfortable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very comfortable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SESSION 7
HIV POST TEST SUPPORT

OBJECTIVES

Participants will be able to:

* list reasons why people with a positive or negative result need post test support
* list the areas that need to be covered in a post test support session with a positive or negative result
* list a range of possible feelings that may emerge for someone with a positive or negative result
* list resources/services within/outside the correctional centre for post test counselling and support
* list resources/services within/outside the correctional centre for people who are HIV positive including treatment options

There are many situations in which Peer Educators are able to assist their peers during the HIV testing process, by either:

* providing education and support before a test is conducted
* providing support for inmates who are found to be HIV positive
* or by providing those who are HIV negative with information about safe/safer drugs/sex practices.

However it is important to understand that:

1. Peer Educators are not part of any compulsory testing program

In order to maintain the credibility of the Peer Educators and the Prison Peer Education Program, it is essential that Peer Educators are not seen to be involved in implementing departmental programs such as compulsory testing, particularly given the controversy which surrounds it and any inadequacies which may exist in the provision of both pre and post test counselling.

2. Peer Educators should not be seen to be acting as qualified counsellors.

Peer Educators have valuable knowledge and skills to support and educate inmates who have received a test result however the Prison Peer Education Program provides only basic and limited training in pre and post test education and support - not counselling skills.
3. The Lifestyles Unit - Long Bay

The Department of Corrective Services has opened the Lifestyles Unit for HIV Positive inmates at the Special Care Correctional Centre. This unit provides a three month residential course. It is an intensive program where inmates will be given the opportunity to acquire the practical skills to enable them to cope successfully with their HIV positive status and also to optimise their health and well-being. Entry is voluntary and encouraged.

STRATEGIES

1. INTRODUCTION

Explain the purpose of this session. Differentiate the role of the Peer Educator from the role of a qualified pre/post test counsellor.

Review the information from session 2 on the 4 categories of HIV infection and treatment options that are available for people who are HIV positive.

2. REASONS FOR POST TEST SUPPORT

2.2 Divide the board into two:

Positive result                      negative result

Ask for a volunteer to record the ideas generated in a group brainstorm about why people need post test support.

3. WHAT TO COVER IN POST TEST SUPPORT

Divide the group and give them the task of developing checklists as in pre test education. eg.

Group A develop a checklist for someone with a negative result.

Group B for someone with a positive result.

The checklist for the negative result should include:

* acknowledge feelings of luck, omnipotence, bravado etc
* promote behaviour change to safe/safer sex and safe/safer drug use

The checklist for the positive result should include -

In the shorter term:

* acknowledge feelings of shock, fear, grief, acute anxiety, anger, denial etc
* Provide emotional support as they consider what to do in the short term
In the longer term:

* help the person decide who to tell
* help the person decide how to tell
* help decide when to tell
* provide information on lifestyle/treatment options.

3.2 Each group presents their findings to the large group for comment/development.

3.3 Once the checklists are finalised, copies can be printed and circulated to all participants in the next session.

4. PRACTICE

Divide the group into 3 or 4's who select 1 Peer educator, 1 peer and 1 or 2 observers. Explain the purpose of the three roles.

The members of the small groups will rotate their roles so that each person can experience all three roles.

**Peer:** The peer should read the role card carefully and make a genuine attempt to assume the role described. She/he should not read it out to the Peer Educator or the observer. Information about the peer should unfold naturally during the course of the session.

**Peer Educator:** The Peer Educator should make a genuine attempt to deal with the peer sensitively and in a non-judgmental way. It is not the role of the Peer Educator to tell the Peer what she/he should do. Instead the Peer Educator should be able to:

* help the peer to identify their options
* help the peer to work through the implications of those options in order for them to make their own decisions
* attempt to raise the issues covered in the checklists
* never attempt to force information upon a peer.

**Observer:** Observers should concentrate on the role-play and mark the "observer checklist" honestly. The observer should not interrupt the role-play. Following the conclusion of the role-play the observer should provide the Peer Educator and peer with critical feedback. This should be done honestly and supportively.

The trainer should move between small groups facilitating the exercise, reinforcing and encouraging appropriate attempts.

5. PEER EDUCATOR NEEDS

Ask each person to consider how they will debrief/unwind after talking to someone about their result. Explain that helpers can become "burnt out", their own emotions can become confused with the emotions of their client and that this can be very counter productive for everyone involved unless the situation is managed appropriately.
6. REVIEW AND LINK

Make the connection between pre test education and post test support. Discuss the special requirements of each session whilst reminding participants of the qualities needed to deal with people in all of the abovementioned categories.

Move on to talk about putting into practice their knowledge and skills to educate, inform and support the general correctional centre community.
Observer Checklist
POST TEST SUPPORT SKILLS

1. Being relaxed and open.
   
   Not being relaxed and open   1 2 3 4 5  
   Relaxed and open             

2. Listening Skills.
   
   Poor Listening               1 2 3 4 5  
   Good listening               

3. Letting the person make their own decision about the test.
   
   Making decision for person   1 2 3 4 5  
   Let person make own decision 

4. Giving information about testing procedures.
   
   Not so good                  1 2 3 4 5  
   Good                         

5. Giving safe/safer sex information.
   
   Not so good                  1 2 3 4 5  
   Good                         

   
   Not so good                  1 2 3 4 5  
   Good                         

7. Did the person understand all the information?
   
   Not much understanding       1 2 3 4 5  
   Good understanding           

8. Did they seem to feel comfortable and able to talk?
   
   Not very comfortable         1 2 3 4 5  
   Very comfortable             

9. Are they better prepared for the test result now?
   
   Not prepared                 1 2 3 4 5  
   Well prepared                

72
Activity:
* people learn better if they are actively involved - make lots of opportunities for people to make choices, decisions and to answer questions
"what we have to learn to do, we learn by doing" Aristotle

Reinforcement:
* reinforce verbal messages with visual messages and/or through practice
* practice should allow people the opportunity to give and receive feedback
* encourage people to review the implications of what they have learned

Transfer:
* the new materials need to be transferred or applied to the learner’s real situation
* give people the opportunity for reflection both individually and as a group
* avoid "do" and "don’t" statements, but rather ask participants to make up their own minds: ask "what would happen if..." questions

Environment:
* try to choose a comfortable environment with a minimum of distractions

"A PLAN IS A DREAM WITH A DEADLINE"
* be clear about what you want to achieve (your goal)
* check that your goal is clear, concrete, simple and do-able
* break your goal into smaller achievable pieces
* set priorities - do what is most important first
* anticipate what resources will be needed
* set target dates or deadlines for the stages in the process

Explain that by following these guidelines, it will be much easier to conduct peer education in the correctional centres. Describe the Planning sheets and how they can be used to be more efficient in gaining the proper permission. The planning format helps Peer Educators gain permission from Governors to run a project. The Governor can clearly see:
* the nature and purpose of the request
* exactly what is planned
* that the project has been fully thought out
* what impact the project will have on the correctional centre schedule

Explain the meaning of the terms used in the first planning sheet.

Discuss the example of a project plan shown on the second sheet. Reassure participants that not all projects will need this degree of planning detail.

Brainstorm peer education activity ideas and settle on two. Break the group into two and ask them to go through the motions (on paper) of seeking approval for these activities.
Activity:
* people learn better if they are actively involved - make lots of opportunities for people to make choices, decisions and to answer questions
"what we have to learn to do, we learn by doing" Aristotle

Reinforcement:
* reinforce verbal messages with visual messages and/or through practice
* practice should allow people the opportunity to give and receive feedback
* encourage people to review the implications of what they have learned

Transfer:
* the new materials need to be transferred or applied to the learner's real situation
* give people the opportunity for reflection both individually and as a group
* avoid "do" and "don't" statements, but rather ask participants to make up their own minds: ask "what would happen if..." questions

Environment:
* try to choose a comfortable environment with a minimum of distractions

"A PLAN IS A DREAM WITH A DEADLINE"
* be clear about what you want to achieve (your goal)
* check that your goal is clear, concrete, simple and do-able
* break your goal into smaller achievable pieces
* set priorities - do what is most important first
* anticipate what resources will be needed
* set target dates or deadlines for the stages in the process

Explain that by following these guidelines, it will be much easier to conduct peer education in the correctional centres. Describe the Planning sheets and how they can be used to be more efficient in gaining the proper permission. The planning format helps Peer Educators gain permission from Governors to run a project. The Governor can clearly see:

* the nature and purpose of the request
* exactly what is planned
* that the project has been fully thought out
* what impact the project will have on the correctional centre schedule

Explain the meaning of the terms used in the first planning sheet.

Discuss the example of a project plan shown on the second sheet. Reassure participants that not all projects will need this degree of planning detail.

Brainstorm peer education activity ideas and settle on two. Break the group into two and ask them to go through the motions (on paper) of seeking approval for these activities.
**APPROPRIATE HIV/AIDS LANGUAGE**

**THE FOLLOWING TERMS ARE:**

<table>
<thead>
<tr>
<th>INACCURATE</th>
<th>ACCURATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS carrier/sufferer/victim</td>
<td>Person/people infected with HIV or living with HIV/AIDS</td>
</tr>
<tr>
<td>Innocent victims</td>
<td></td>
</tr>
<tr>
<td>Bodily fluids</td>
<td>Blood, semen, vaginal fluid, breast milk</td>
</tr>
<tr>
<td>At risk/High risk groups</td>
<td>At risk/High risk behaviours/practices</td>
</tr>
<tr>
<td>Intravenous drug user/heroin addicts/drug abusers/junkie</td>
<td>User/Injecting drug user</td>
</tr>
<tr>
<td>Dying from AIDS</td>
<td>Living with HIV/AIDS</td>
</tr>
<tr>
<td>AIDS test</td>
<td>HIV antibody test</td>
</tr>
<tr>
<td>Full Blown AIDS</td>
<td>AIDS (Category four)</td>
</tr>
<tr>
<td>Tested for AIDS</td>
<td>Tested for antibodies to HIV</td>
</tr>
<tr>
<td>Active, passive</td>
<td>Insertive, receptive</td>
</tr>
<tr>
<td>Contaminated</td>
<td>Infected</td>
</tr>
<tr>
<td>Normal sex</td>
<td>Vaginal Intercourse</td>
</tr>
<tr>
<td>Indulge in</td>
<td>Engage in/practice</td>
</tr>
<tr>
<td>Plague</td>
<td>Epidemic</td>
</tr>
<tr>
<td>Came into contact with virus</td>
<td>Was exposed to the virus</td>
</tr>
</tbody>
</table>