HIV/AIDS

TRAIN THE TRAINER

A RESOURCE MANUAL FOR PLANNING HIV/AIDS EDUCATION SESSIONS

TORONTO PUBLIC HEALTH
HEALTH PROMOTION – SEXUAL HEALTH

Dr. Barbara Yaffe, Acting Medical Officer of Health,
Toronto Public Health

HIV/AIDS
TRAIN THE TRAINER

A Resource Manual for Planning HIV/AIDS Education Sessions

Revised
May 2004

This manual is intended for people who will be leading HIV/AIDS Education sessions in the community. The sessions may take place in a school, workplace or community setting. It could be a one-time event or include a series of workshops. Therefore, the manual has a variety of exercises to cover the factual information as well as the attitudes that people may have toward this subject. It also covers program planning.

Other workshops are available in the community, which address topics relevant to HIV/AIDS. These include cultural factors, harm reduction programs, up to date treatment information and caregiver issues. It is not possible to give a listing here as the topics and availability of workshops are always changing. We list the AIDS – Sexual Health Infoline Telephone 416-392-2437 as a resource for ongoing information regarding workshops and suggest you call them for more information.

Toronto Public Health offers a variety of other workshops related to HIV/AIDS. Your workshop facilitator will provide this information. These workshops are offered free to community organizations as part of our ongoing AIDS Education Program.

Toronto Public health acknowledges the authorship of Jann Houston and Allie Lehmann; previous Health Education Consultants, AIDS Prevention Program, Toronto Public Health and the significant contribution of Louise Carberry, Sexual Health Educator, Toronto Public Health, in the ongoing revisions to this manual. The resource manual was originally developed in 1989 and revised in 1995, 2001 and 2004. New information and exercises from a variety of sources have been added in preparing staff to become successful HIV/AIDS facilitators.

This 2 day workshop is offered to new staff members in the community and this manual gives a very basic outline of the issues that needed to be addressed with any population. Other concerns such as culture, language, education level and age need to be taken into consideration when planning workshops.

If you would like to contact us for more information; or if you have suggestions for other effective education strategies, we would like to hear from you.

Louise Carberry
Sexual Health Educator
Toronto Public Health
175 Memorial Park Ave.
Toronto, Ontario
M4J 4Y6
Telephone: 416-338-0917
Fax: 416-338-0921
Email - lcarberr@toronto.ca

SECTION 1:

CLIMATE SETTING

Your Role as a Trainer - Setting the Tone
Talking Sex: Jargon and Hot Topics
Choosing "Icebreaker" Exercises for Climate Setting
Icebreaker Exercises

l. Human Bingo
2. Don't Pass It Along/The Party Game
3. Porcupine

SECTION 2:

TECHNIQUES FOR TEACHING BASIC HIV/AIDS EDUCATION

Tips for Teaching Basic HIV/AIDS
Basic HIV/AIDS Exercises

l. HIV Facts
2. HIV Card Game
3. STD/HIV Integration (Lecture Style Information)

SECTION 3:

ATTITUDES AND VALUES

1. Family of Origin Exercise
2. Attitudes and Values Exercise
3. Human Graph Exercise

SECTION 4:

SEXUALITY

1. Developing Empathy – Looking at our own risk-taking behaviour
2. Titles Exercise
3. Stop Light Exercise
4. Latex Demonstration
5. Prevention Game - Condom Cards

SECTION 5:

HOMOPHOBIA

l. Identification
2. Word Association
3. Guided Fantasy Exercise
4. Changing Homophobic Attitudes

SECTION 6:

INJECTION DRUG USE
HARM REDUCTION

SECTION 7:

BEHAVIOUR CHANGE

1. Stages of Change – Information & Exercise – “Stage Yourself”
2. Stages of Change as Applied to Sexual Behaviours
3. Other Behaviour Change Models

SECTION 8:

IMPACT

1. The impact of HIV/AIDS on Society
2. Using a Speaker or a Videotape

SECTION 9:

PLANNING

Planning an HIV/AIDS Education Program
Tips for Responding to Questions
Using Participatory Exercises
How to Introduce a Video
Dealing with Group Emotions
Microteach Exercise for Trainers
Presentation Feedback Form
Facilitator Checklist
Train the Trainer Microteach Form
HIV/AIDS Workshop Checklist
Sample Needs Assessment
Sample Evaluation

SECTION 10:

DIVERSITY

Canada's Growing Diversity
Program Bias Assessment
Intercultural Communication
Picking the Right Words
Handling Conflicts and Misunderstandings
HIV and Other Oppression: Beyond Homophobia
The Tree of Oppression

SECTION 11:

APPENDICES

Appendix I: Questions & “Answers
Appendix II: HIV Transmission Guideline for Assessing Risk
Appendix III: The Lecture
Appendix IV: Evaluation

THE IMPACT OF HIV/AIDS

The number of people living with HIV/AIDS world- wide is estimated at 40 million, with approximately 6% being children under 15 years. The number of new infections for 2003 is estimated at 5 million and 14% of these are children. Sub-Saharan Africa accounts for 64% of these infections, South & South-East Asia 17%, Eastern Europe and Central Asia 5% and North America 1%.

The progression of HIV to AIDS diagnosis has decreased dramatically in the developed countries since 1996, at which time antiretroviral treatments became available to people infected with HIV. This decrease in AIDS diagnoses is not true of the developing countries, as they continue to lack access to effective drugs, which can significantly slow the progression of the disease

In Canada the proportion of HIV rates have increased for all females who represent approximately 20% of those infected in recent years. Increased rates are seen in men aged 40+, in heterosexual men and women who have been exposed through sexual intercourse, in women who are pregnant (because of the increase in screening for this population), for members of the Black population and Aboriginal people. HIV rates have declined for injection drug users from a high of 33% in 1996, dropping gradually to 25% in 2001 and 23% in 2002.

In Ontario there were 1,143 new HIV cases reported in 2002 which accounts for 44% of the new infections in Canada. However, only 122 new AIDS cases were reported in the same year, which could demonstrate the effectiveness of the new drugs.

Of the 535 new HIV infections diagnosed in Toronto in 2003, 117 were women primarily in the age range of 24 to 35 years. 416 new HIV cases were men, mostly in the age range of 35 to 44 years. The most prominent exposure categories for men are Men who have Sex with Men (MSM) - 57%; and those from endemic countries - 27%. Since many new immigrants and refugees from HIV endemic areas settle in Toronto, it is estimated that 15 to 25% of new infections will occur among people coming from these regions.

There are a number of recent trends that impact HIV/AIDS. The new Canada Youth, Sexual Health and HIV/AIDS Study demonstrates that youth have less knowledge now, compared to when the original study was completed in 1989, in regard to accurate HIV/AIDS information and prevention strategies. In Canada there has been a significant increase in Chlamydia and Gonorrhea infections, especially in the age group 15 to 24 years which will have the potential of making this age group more susceptible to HIV infection, if they are exposed to the virus.

Toronto is also experiencing an increase in infectious syphilis, primarily among men who have sex with men. This increase is consistent with similar outbreaks in other parts of North America and Europe. In 1998 there were 19 diagnosed cases in Toronto and by 2003 this number reached 279.

Screening of pregnant women has increased in Ontario from 40% in 1999, to 82% in 2003. It is thought that the women not accessing HIV testing are probably those most at risk of HIV. Studies among pregnant women can provide an important source of information on the prevalence rate of HIV in the general heterosexual population. Prenatal sero-prevalence studies in Canada report an estimated national rate of HIV infection among pregnant women of 3-4/l0,000 population.

All of these factors indicate that we cannot be complacent in continuing our efforts to prevent HIV infection especially among new immigrants and refugees to Canada and men who have sex with men. New strategies will need to be developed to reach those most at risk.

BENEFITS OF HIV/AIDS EDUCATION

There are people around you right now who have HIV/AIDS. Maybe a friend, someone you work with or even members of your own family. You may not be aware of them, but they are there.

HIV/AIDS education is important to help prevent the spread of infection and to help prevent fear and panic, as well as to prevent discrimination toward people with HIV/AIDS. HIV/AIDS education can help people learn how the virus is contracted, how it is not contracted, and how to protect against it. HIV/AIDS education can also help people develop compassion and understanding for individuals affected by this illness.

Our Train the Trainer program enables educators to develop skills through our Train the Trainer workshop, and then, with the help of this manual and other resources, to educate others about HIV/AIDS. It is an efficient way to reach a large number of people, by providing organizations with several employees who have a good basic knowledge of HIV/AIDS.

The goals of an HIV/AIDS Education program are to:

Increase participants knowledge about HIV/AIDS and how to protect themselves;

- in the workplace;
- in their personal lives;

Increase awareness of personal risk;

Decrease irrational fears;

Encourage greater compassion and understanding for those living with or affected by HIV/AIDS.

NOTE TO NEW TRAINERS:

Our Train the Trainer HIV/AIDS Education Program aims to provide you with information and teaching strategies to help you successfully achieve the above goals. Train the Trainer is a proven approach to HIV/AIDS education, used in such places as California, Atlanta and Washington. The development of the program (and this accompanying manual) owes much to our consultations and work with other agencies. Therefore, many exercises used in this text have been derived from other programs or modified for our purposes.

<u>The Objectives of this Train the Trainer Program are:</u>

1. To increase knowledge about HIV/AIDS issues and its' impact on communities and society.

2. To examine principles of adult learning and behaviour change as they relate to HIV/AIDS education.

3. To learn HIV/AIDS teaching principles by developing, presenting and evaluating a micro-presentation.

4. To learn how cultural factors, attitudes and values influence the teaching and learning about HIV/AIDS.

5. To increase awareness about educational resources in your community.

Remember that you are both a learner and a trainer in this workshop. You will be given an opportunity to experience "learning activities" firsthand and then consider how you might use these activities as teaching strategies to conduct a program for your community. While you are not required to be an expert on HIV/AIDS, you need to know the resources that are available to answer any questions that may arise.

RESOURCES A PHONE CALL AWAY

In your role of presenting HIV/AIDS education, you will be identified as the resource person with the answers to participant's questions. You will need to take the time to learn the facts about HIV/AIDS so that you can provide responsible, rational, clear and accurate information. To do so, it is important that you establish communication with HIV/AIDS information resources in your area so that your knowledge remains current.

Remember **HELP** is only a phone call away. Call the:

AIDS & SEXUAL HEALTH INFOLINE – 416-392-2437 OR 1-800-668-2437
TORONTO HEALTH CONNECTION – 416-338-7600 OR YOUR LOCAL PUBLIC HEALTH OFFICE OR YOUR LOCAL AIDS COMMITTEE

CLIMATE SETTING

YOUR ROLE AS A TRAINER - SETTING THE TONE

Organizations that have developed and implemented HIV/AIDS education programs have found that preventive education goes a long way toward:

- reducing fears
- improving responses to clients and co-workers
- heightening awareness of infection control practices
- opening communication in work groups

The style, which you adopt as a trainer, will have a great impact on the effectiveness of your program. It is important to remember that:

1. **FEARS OF THE UNKNOWN ARE COMMON**. Some people in your audience won't be able to even hear your information until their fears and anxieties are addressed (see Climate Setting Exercises).

2. **THE CHANCE TO ASK QUESTIONS IS IMPORTANT** for an audience. Think about how to handle questions in a way to make your audience comfortable in asking them. If people at different organizational levels are mixed together in your workshops, some staff may feel uncomfortable asking questions in front of supervisors or managers.

   As you plan your program, think of the format, which would make **you** feel comfortable if **you** had to ask a question. (Refer to: Tips For Responding To Questions, in the Planning section of this manual).

   Techniques that may work:
   - Have participants write questions anonymously on cards and hand them to you or place them in a question box.
   - Have small groups brainstorm their questions.
   - Ask participants for their questions at the beginning of the program.

3. **IF YOU ARE WORKING AS A TEAM**, meet ahead of time to assign roles. Agree not to interrupt each other. Discuss and choose who will answer the questions; each person can be assigned to answer specific types of questions. **Freely repeat factual information. Education research demonstrates that people need to hear information several times in different ways to internalize it.**

4. **DO NOT CONDONE DISCRIMINATION**. Be aware that your group is composed of individuals from diverse backgrounds. This may include racial, ethnic and religious minorities, heterosexuals, homosexuals, drug users, sex trade workers, etc. Stress a non-judgmental approach and model your educational sessions in a way that does not impose your cultural biases and personal views on others. Display sensitivity towards people, remembering that language can often be judgmental. Terms such as "abnormal" and "abuser" in relation to drug use or sexual orientation are not helpful in your presentations. Trainers should respect individual differences in values among staff and clients.

5. **DEVELOP A POLICY OF CONFIDENTIALITY**. People in the workshops need to know that, if they disclose material to you that is personal, it will remain confidential. However, if someone discloses personal information to the group, you cannot guarantee that the group will maintain confidentiality. Let workshop participants know this and ask them, at the beginning of the session, to maintain such confidentiality. This can help to protect peoples' rights and dignity.

6. **NEVER THEORIZE WHEN YOU DON'T KNOW!!** There are lots of inaccurate theories and interpretations about HIV/AIDS out there...who has it, who certainly doesn't, and "how you can always tell...**Say "I don't know" anytime that you are in doubt about an answer. But offer to get back to the person at a later time with the information.**

7. **RELAX!** You are an "expert" relative to your audience, and you are doing an important job. One reason that Train the Trainer is effective is because participants receive education from trainers they already know, trust and respect and who are aware of policies, politics and problems.

START UP: TAKING CARE OF BUSINESS

Teaching people about HIV/AIDS needs to be done with sensitivity. You are asking people to examine their feelings about sexuality, drug use, chronic illness, life and death; - topics people in our society often have difficulty addressing. It is important therefore to establish a climate that will enable people to begin to feel comfortable discussing these issues, particularly in a group setting.

Since your adult learners need to feel safe and comfortable, taking care of the following issues at the very beginning of your program are essential:

- "BE THERE" for your group. Arrive early and stay until the last person leaves.
- Put up articles or posters to create a learning environment within the room.
- Arrange seating in a way appropriate for group interaction.
- Set up A/V equipment so that everyone can see it clearly.
- Always negotiate break times.
- Identify the bathroom locations.
- Make it clear that people will not leave the session with unanswered questions. If you do not know the answer, refer them to the appropriate resource.
- Post numbers where they can get more information - AIDS - Sexual Health Infoline – 1-800-668-2437 or (416)392-2437

- Post work that is completed by the group in the room, so that they can visualize all they have achieved during the session.
- Serve refreshments.

Tip: Be there for the group – from the beginning to the end.

TALKING SEX: JARGON AND HOT TOPICS

One of the ways to introduce the topic of HIV/AIDS is to discuss HIV related "jargon" and terms. They give participants some common language and a framework for asking questions and raising issues. This also contributes to setting the climate.

The language or words we use have a big impact. They influence what we hear and how we are able to hear it. It's helpful if the language used in teaching about HIV/AIDS is as **clear** as possible and as **inclusive** as possible. The following acronyms and topics may be used when we talk about HIV disease and AIDS.

STIs	Stands for sexually transmitted infections. HIV is an STI. It is important to talk about HIV in the context of STIs. The term STD (sexually transmitted disease) may also be heard.
HIV/AIDS	Talking about HIV disease (or infection) instead of just talking about AIDS reflects the chronicity of the disease and implies/nurtures hope.
PHA	Person living with HIV or AIDS.

The emphasis over the past years has gone from "having" AIDS, to living with AIDS, to living with HIV, to living with the disease regardless of the stage. Generally, people who have HIV disease do not like to be known as victims (which implies a lack of control).

OTHER USEFUL TERMS

SEXUAL ORIENTATION

refers to a person's predisposition to experience physical and affectional attraction to members of the same, the other, or both sexes. It is the result of a complex set of genetic, biological and environmental factors.

Talking about a "partner" is more inclusive than "spouse, girlfriend, boyfriend, husband, wife, etc." as this does not make an assumption about a person's sexual orientation.

Other words that are often associated with sexual orientation are: homosexual, heterosexual, bisexual, gay, straight, lesbian, homophobia, heterosexism, and oppression.

IDU

Stands for injection drug use/r. It is a less judgemental term than "drug addict" or "drug abuser". IDU includes a variety of injecting needle use (such as for steroids) where sharing needles and equipment can put someone at risk for acquiring HIV.

BODILY FLUIDS

This is a "polite" term used to refer to body fluids in general, including semen, vaginal fluids, saliva, blood and breast milk. Refer to specific body fluids to avoid misunderstandings. Remember that not all body fluids contain sufficient concentrations of HIV for transmission.

HIV TEST

Not an AIDS test. This is a test for HIV antibodies.
Who should be tested? When? Where? Why?
What needs to happen for an HIV test to be useful to the client?
What does the test tell you? What does it not tell you?

WHAT YOU NEED TO KNOW / versus WHAT IS NICE TO KNOW

When planning a program about HIV/AIDS it is helpful to be clear on what participants need to know, and to cover this information thoroughly. Covering the "nice to know" material may be done if time permits. Otherwise, refer people to other resources. (see also the section on teaching Basic AIDS in this manual)

Endemic

HIV-endemic classification includes northern regions of South America, the Caribbean and sub-Saharan Africa according to recent international estimates of adult HIV prevalence (WHO, 1994)

RISK GROUPS

This epidemiological term has been used throughout the AIDS epidemic to classify people who are at increased risk for HIV infection based on disease surveillance data. Unfortunately, people who do not fit neatly into, or identify with a specific risk group may feel they are immune to HIV. (refer to: Risk Behavior below)

RISK BEHAVIOURS

Risk behaviours refer to activities that may expose people to HIV infection. One example of risk behaviour is unprotected intercourse. It is important to refer to risk behaviours e.g. sex without condoms, rather than risk groups e.g. gay males. Sometimes people justify engaging in high risk activities because they do not feel that they are a part of certain group. People's behaviour places them at risk.

RISK ENVIRONMENT

Someone can be in an environment that may be risky because of the increased opportunity for risk behaviour or because condoms or clean needles are not available. For instance, partying can lead to drinking and unsafe sex. Or a prison may not supply condoms or clean needles. Poverty may limit a person's ability to purchase protection. A discussion of risk environment might be a time to explore the concept of risk or harm reduction.

SEX/DRUGS

Speaking about sex and drugs in a public setting may be embarrassing and uncomfortable for some people. However, such a discussion is necessary in an HIV/AIDS education program because the risk of HIV transmission involves identifying personal behaviours, including sex and drug use.

HARM REDUCTION

Refers to a policy or programme directed towards decreasing adverse health, social and economic consequences of drug use - even though the user continues to use drugs. According to this definition, abstinence oriented programs and the use of criminal law to deter any drug use would not be considered " harm reduction" measures.

Source: Single, Eric. Towards a More Conceptually Distinct Definition of Harm Reduction: An Emerging Public Health Perspective, paper presentation at the Conference on Harm Reduction, 1994.

NOTE TO TRAINERS: This list of terms is not meant to be exhaustive but rather a sampling of some common HIV related jargon. These terms can be tailored to meet the needs of participants in diverse communities and settings.

TIP: Discuss jargon early in the program so participants have a common vocabulary for the rest of the training.

For more information: Dobko, Theresa. AIDS Words And Meanings, produced by the AIDS Committee of Toronto (ACT),1990.

STATISTICS AND TRENDS

Epidemiology studies the spread of disease in human populations and the factors influencing that spread. It is concerned with groups of people, not individuals and is an important component of disease prevention work. The statistical analysis of data allows us to chart the spread of HIV, plan interventions and evaluate strategies. Local, provincial, and federal governments spend money on research, education, and support services based on statistical data. As well, some target groups will find statistics very important and may use them as a selling point in order to justify HIV preventative education. However, the collection of statistics may lag behind new trends being identified, which can hamper people from obtaining programs or funding.

Statistics may be useful in helping people create a framework in which they can better understand the HIV/AIDS epidemic. AIDS is now viewed as a long term, chronic, manageable disease and this was facilitated in part by providing statistics that show, on average, an increase in the life span of PHA's due to better treatment options. That is, people now have a statistically better chance of living longer with HIV than previously. As well, statistics may give us a sense of the local, national and worldwide impact of HIV/AIDS.

Statistics can also needlessly alarm people and must be used carefully. Therefore, it is important to recognize that certain statistical information may frighten people. For instance, people may respond to an article claiming " youth are at high risk for HIV" that translates into a message "if you are going to have unprotected sex you will die." Research has shown that such scare tactic messages influence behaviour change in the short term, but these behaviours can't be sustained over the longer term.

The use of statistics often presents problems for an educator. An inherent problem with statistics is that they will vary depending on one's source. A participant in your group for example may present statistics, which in fact conflict with yours. The time lag with data is also problematic; that is, you will not often be able to access up-to-date statistics. Also, anecdotal information may not reflect the most current statistics. Another difficulty of using statistics is that we run the risk of becoming focused on groups and we may lose sight of individuals.

A strategy which effectively uses both * qualitative and * quantitative studies, focuses on trends. For example, the number of youth (Canadian) with HIV is relatively low. However, statistical information on other sexually transmitted diseases, as well as pregnancy rates, demonstrates that these rates are high amongst youth. This information suggests there is a trend towards unprotected sexual intercourse amongst youth, which ultimately creates a risk for HIV infection.

In the late 1970's and early 1980's, it appeared that in North America only gay white males were infected and affected by HIV. Hemophiliacs, and injection drug users who shared needles followed close behind with large and growing infection rates. In the 1990's the face of AIDS has changed and will continue to do so; the trend now is that women, youth, injection drug users and people from endemic countries are becoming infected and affected by HIV.

It is important for facilitators to be aware of the changing trends in their community, as well as the national and/or global picture. An awareness of these changing trends will enable a facilitator to address specific social and environmental factors in an educational session. These factors are dependant on one's gender, race, age, class and a number of other determinants. In the early 90's, qualitative and quantitative studies revealed that young gay men thought they were immune to HIV by virtue of being young. As a result, many exciting campaigns focusing on gay youth were initiated. In the mid 1990's, studies revealed that men in prison who share needles to inject drugs and also have sex with other men are at increased risk for HIV. Strategies need to be in place to focus on this risk behaviour. In some countries, clean needles have been made available to people in prisons.

For additional learning activities see: A Resource Manual for AIDS Educators - "Making Meaning out of Numbers " produced by the Canadian Public Health Association, 1991 ISBN 0-919245-50-1

A CASE IN POINT - STATS CAN BE MISLEADING

In March, 1995, an orthopedic surgeon published an article in the Canadian Medical Association Journal surveying surgeons use of preventive behaviour during surgery. The journal article also presented statistics on the lifetime or cumulative risk of HIV infection to surgeons.

The local paper and radio station picked up the statistic, misinterpreted it, and referred to it in a headline as " 1 in 50 people get AIDS from cuts." Since most people don't track down the original article to see how the statistic was originally used, the public thinks, that if they come in contact with blood, they will have a 1 in 50 chance of getting HIV - which is incorrect. In order for people to better understand HIV transmission when exposed to blood, educators need to explain that the:

- the journal article refers to a lifetime/cumulative risk and is only mathematical.
- the actual risk of HIV infection from one needle stick exposure with blood, known to be HIV positive, ranges from 0.29 - 0.4 percent. This is much less than a 1 in 50 risk and;
- there is a negligible risk of HIV transmission from doctor to patient.

It is also useful to discuss the risks of exposure to HIV and Hepatitis through cuts and bites, and how infection control guidelines address these risks. Please see Appendices for more information on HIV transmission.

* Qualitative Research: Any kind of research that produces findings not arrived at by means of statistical procedures or any other kind of quantification. Qualitative methods explore the context, meaning, variation and perceptual experiences of phenomena.

* Quantitative Research: Research that obtains answers from large numbers of people. It is based in descriptive statistics and refers to the distribution, frequency, prevalence, incidence and size of one or more phenomena.

Source: Strauss, A. and Corbin,J.(1990). Basics of Qualitative Research. Grounded Theory Procedures and Techniques. Newbury Park CA: Sage Publications Inc.

CHOOSING "ICEBREAKER" EXERCISES FOR CLIMATE SETTING

The beginning of your educational session should "hook" the group by getting them interested, involved, and focused early. Examples of "hooks" include starting with interesting news items and facts, telling stories, anecdotes, or even jokes that have relevance to the topic. Icebreaker exercises are one form of "hook".

Besides keeping interest, another goal of icebreakers is to help reduce anxiety by increasing the level of trust and degree of belonging to the group. Icebreaking or introductory activities should move gradually from non-threatening to more personal levels. Personal sharing of information by the facilitator at the beginning of the session can help model and initiate sharing by the group.

In a group that does not know each other and may feel uncomfortable in the setting, icebreakers help members of a group to:

- feel a sense of belonging
- get to know who the other participants are
- let others know who they are
- get some of their basic questions answered

Always be sensitive to the different perspectives of the members of your group when choosing an icebreaker. This means being aware of the diverse cultural, social, and educational experiences and needs of each individual. Other issues to consider when choosing and icebreaker:

- Is this exercise building barriers rather than creating rapport?
- Could participants fail at what they are supposed to do?
- Could this activity embarrass some people?
- Should there be more trust in the group before people risk participation?
- Could the objective be met using less threatening activities?
- Does this exercise accommodate the learning styles or personalities of people in the group?

If you answer "yes" to any of the above questions, you may wish to change or replace the icebreaker.

NOTE: participants can always "pass" and opt out of any activity.

Source: Adapted from Planning Effective Teaching, Simcoe County District Health Unit, January 1990 and Dahmer, B. Kinder, Gentler,Icebreakers.Training & Development, 1992, August pp. 47-49

ICEBREAKER EXERCISES

I. HUMAN BINGO

PURPOSE:
An ice breaker suitable to people who don't know one another or who need to learn more about one another to facilitate group work. The bingo squares can be changed to reflect a variety of facts and activities depending on the group you are working with.

MATERIALS:
A pencil/pen and bingo sheet as below for each participant.

METHOD:
Tell participants that each bingo space identifies something about the people in this program. Ask people to seek out their fellow participants and if one of the listed items pertains to them, ask them to sign their names in the space provided on your Bingo Card. Even though more than one item may be relevant to any person, only one space should be signed by each person. The first person to yell "Bingo" is given a small gift. (e.g. safe sex pack)

Works with youth	Is experiencing resistance at work around HIV education	Knows someone HIV positive	Is looking for new teaching strategies
Has participated in the "walk for life" to raise money	Has published an article or book	In job/role less than 3 months	Sits on a community board
Needs someone to have lunch with	Has been in the job/role 2-4 years	Has attended an AIDS Conference	Speaks more than one language
Is able to access web sites for AIDS information	Works within a multicultural setting	Is looking for new meaning in their life	Can demonstrate condom use in a fun way

Other items that could be inserted:

1. Knows the AIDS and Sexual Health Infoline phone number.
2. Has a copy of the HIV Transmission Guidelines for Assessing Risk
3. Has seen the movie (Whatever is topical).
4. Has knowledge of community resources.

* Check This Out: Excellent icebreaker and other adult learning resources are available for training - see for example The Encyclopedia of Icebreakers from Pfeiffer & Company, 4190 Fairview St. Burlington, Ontario L7L 4Y8, 905-632-5832.

A debriefing of the Bingo Game will assist the group in understanding what some of the common elements are in the group. For instance – ask how many in the group are working with Youth, give details on the AIDS Conference – how many have attended etc. Also, remind participants that they can share resources they have with the group.

Follow with introductions of the participants.

2. DON'T PASS IT ALONG/PARTY GAME/COASTER GAME

PURPOSE:
Participants will become aware of how rapidly a sexually transmitted disease can spread with unprotected intercourse. One of the greatest deterrents to the practice of safer sex is the mindset, "it can't happen to me". Statistics show that 50% of the population contracts an STI by the time they are twenty-four. This lesson dramatizes the rapid geometric progression possible in the spread of an STI and provokes participants to think about the reasons why so many people do not protect themselves. Finally, the lesson encourages participants to "solve the problem" by creating plans that would change people's behaviour so as to stem the spread of STIs. In creating and evaluating the potential effectiveness of these plans, participants are required to think about how to change their own risky personal behaviours.

TARGET GROUP:

This exercise works especially well with teenagers but can be used with any group of approximately 20 to 25 people.

MATERIALS:

A small index card is required for each participant. Two cards have a small "d" on the back; twenty percent have a "C" on the back; twenty-five percent have an "O" on the back; twenty - five percent have an "S" on the back. The remainder can have a combination of Cb and N.

"d" - stands for sexually transmitted disease (possibly HIV/AIDS)

"C" - stands for using a Condom all the time

"O" - stands for Outercourse – touching, kissing, hugging – activities which do not pass on HIV infection

"S" - stands for Single, not in a relationship – not having sexual intercourse

"Cb" - stands for Condom breakage – leaking or tearing during intercourse

"N" - stands for Needle User – injecting drugs, unsafe piercing or tattooing

NOTE TO TRAINERS:

a. This exercise works best with a group that will readily talk with each other and feels safe to do so.
b. Questions to be discussed can be designed to enhance the objectives and tailored to the needs of the group. For example, use the three basic AIDS questions; how you get HIV; three body fluids that transmit the virus; three ways I can protect myself.

METHOD:

1. Explain that this lesson is designed to teach participants how to avoid getting sexually transmitted infections. For a warm-up exercise, they'll have a chance to talk with 3 different people on topics you will suggest. Ask participants to imagine they are mingling at a party.

2. Distribute a card to each participant; explain that after each discussion, they should sign the other persons' card.

3. Ask them to stand, mingle and discuss the first question. “How do you get HIV?”

4. After 2 minutes, ask them to sign each other's cards, find another person and discuss the second question. “Name 3 body fluids with sufficient quantities of HIV to transmit the virus?”

5. After 2 minutes, ask them to sign each other's cards, find a different person and discuss the third question. “How do you protect yourself from HIV?”

6. After 2 minutes, ask them to sign each other's cards and return to their seats. Each participant will have 3 different signatures on their card.

7. Now ask the persons whose cards have a "d" on the back to stand. For the purpose of this exercise, these people have an STI, possibly HIV. Ask how they might feel if they were given this information by a doctor or nurse?
(some responses might be anger/ fear/ disbelief)

8. Ask them read out the names they have on their cards, and those people must stand; or the people sitting who have the names of the two people with the “d” must stand.

. - discuss feelings of people standing (possible responses - surprised, angry, caught)
- discuss feelings of people sitting (possible responses - lucky, happy)

9. Next, everyone with the names of those standing must also stand - they too may be infected. And so on... until the entire class is standing.
   - note how rapidly a disease can spread with unprotected intercourse.
   - STI rates are highest in young people 15 - 24 years of age.
   - HIV infection increasing in teens and women.

   The next part of the exercise demonstrates that not everyone is at risk! They all engaged in different behavious with the two people who had the “d” on their cards.

10. Standing people who have a "C" may sit because if they had intercourse, they used a condom.
    - point out that only about 30% of teens use a condom all the time

11. Standing people with "Cb" have to remain standing. Their condom broke.
    - review condom use at the end of the exercise

12. Next, indicate that standing people with an "O" on their cards may sit. They are in a relationship but did <u>not</u> have intercourse, but outercourse! (intimate relationship without oral, vaginal or anal penetration)
    - women who postpone sexual intercourse until age 18/19 reduce their chance of developing cancer of the cervix as the cervix is more mature and protective by this age. Exposure to a type of Human Papilloma Virus (HPV) is related to cancer of the cervix. A regular pap test can detect the presence of this virus.
    -

13. Standing people with an "S" on their cards may sit. They are single, happy and are not having any sexual contact with anyone at the present time.
    - note that about 50% of l6 year olds have not had intercourse.

14. Standing people with an "N" have used needles for injection drug use and have shared these needles with others, which puts them at risk.
    - discuss how one can reduce their risk by cleaning needles or by using a new needle every time they inject drugs

-

15. Thank the students for participating. If possible have some small gift to give to the participants still standing at the end of the exercise. Condoms are appropriate to give out.

16. Debrief the three questions from the game.

Source: adapted from Teaching Safer Sex, by Peggy Brick, l989
Planned Parenthood of Greater Northern New Jersey.

Examples of other questions, which could stimulate discussion:

1. How do people learn about sex?
2. Name a clinic where a person could get tested for an STI?
3. Name three places where condoms can be bought or given for free?

3. PORCUPINE (40 minutes)

PURPOSE:

To determine what a group has heard about HIV/AIDS.

MATERIALS:

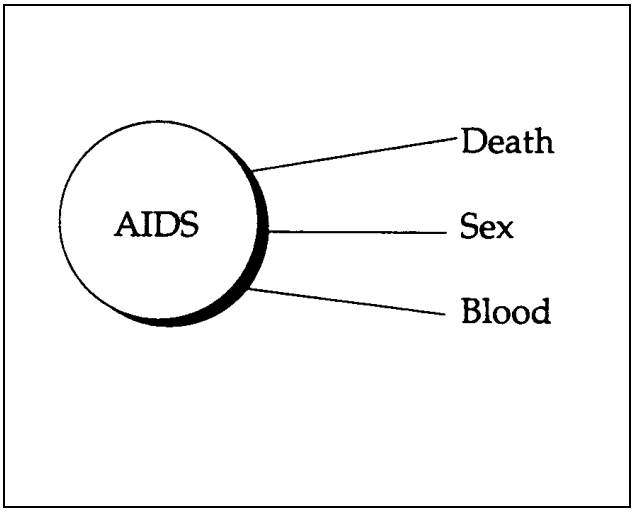
- Flipchart
- Marker pens
- Masking tape

METHOD:

Draw a circle on a blackboard, flipchart or overhead with HIV/AIDS in the middle. Have people call the words they think of when they hear HIV/AIDS. Draw a line from the circle for each word that is called out and write the word beside the line i.e.,

You can use the exercise to structure will better language of your concerns, and sense of their

Refer to each word discuss with the it is related to any



responses from this your session. You understand the group, their initial generally have a knowledge base.

called out and group how and why HIV/AIDS, clarifying misconceptions.

TIP: Some facilitators extend this exercise in the following way: Replace the word cancer for HIV/AIDS. Ask the group what words still apply to cancer ie., sickness, fear, grief. The words that remain are often judgement laden terms such as drugs, sex, etc... This helps people understand why learning about HIV/AIDS can not be handled in the same way that you learn about other diseases. Ask participants which diagnosis they could more easily tell a partner or parent? This clarifies why teaching about HIV/AIDS is so challenging as one must address fears, myths and judgements.

SECTION 2:

TECHNIQUES FOR TEACHING BASIC HIV/AIDS EDUCATION

This section provides you with exercises to use when conducting your HIV/AIDS education sessions, and tips for teaching the BASIC HIV/AIDS information, as found in APPENDIX I.

Reading the preparatory material ahead of time will give you a good knowledge base to teach a Basic HIV/AIDS session. Review print resources available in your community to give as handouts that are specific to the group you are trying to reach. For instance, if you are working with women or gay men, determine what resources would be useful for their needs. There may be videos available through your local AIDS Committee or Public Health Office that can supplement the information you will be presenting.

To review Basic HIV/AIDS information, turn to the Appendix.

> **NOTE TO TRAINERS:** This manual was designed as a resource to be used in conjunction with our Train the Trainer approach to HIV/AIDS education. It is expected that participants have the basic knowledge of HIV/AIDS. Answers to some basic questions are in the Appendix.

TIPS FOR TEACHING BASIC HIV/AIDS

There are many different ways to teach Basic HIV/AIDS information. Some approaches are based on an **Information Giving Model.** This includes:

- pretest on Basic HIV/AIDS information
- short lecture (20 min-1 hour) - see appendix
- video
- question and answer session

Other approaches are based on a **Participatory Model**, which includes small group exercises to determine what people know or have heard about HIV/AIDS, followed by large group processing. There are pros and cons to each approach. Therefore, keep in mind the following Adult Learning Principles:

- Adult learners build on knowledge they already have.
- Lectures often focus on factual details that may be interesting to know but don't help to change behaviour. (see the behaviour change section of this manual.)
- Participatory exercises require processing time in the large group.
- Participatory exercises require clear instructions.
- Exercises should be rehearsed, preferably with a pilot group.
- Material from abroad may not fit the Canadian context.
- Often a blend of both approaches is best to meet a variety of learning styles.

Incorporate these facts into your program by doing such things as:

- have small group discussions and/or problem-solving exercises

- have the group share their discussion/solutions with the large group

- have the group practice skills (teaching, counseling)

- use a variety of A/V materials

- provide resources (human, print, phone numbers...)

- circulate during small group work to ensure that group members understand the directions and to give the groups guidance.

Decide on Content:

When teaching BASIC HIV/AIDS, there is information that people **NEED** to know and information that is **NICE** to know. Regardless of the method you use, there are three essential topic areas that must be covered:

1. What is HIV/AIDS?
2. How you get HIV/AIDS?
3. How to protect yourself from HIV?

These are the critical elements necessary to help people change their behaviour in their personal as well as work life. Remember, you don't have to be a microbioligist to teach BASIC HIV/AIDS. Refer people to other sources if you don't know the answer.

BASIC HIV/AIDS EXERCISES

I. HIV FACTS (40 minutes)

PURPOSE:

This exercise will focus on the basic information of HIV/AIDS. Many people have read newspapers, seen television programs or generally heard about HIV/AIDS. This exercise presupposes that the individuals attending the session have some of this knowledge. The need to know information is emphasized.

MATERIALS:

- Flip chart
- Masking tape
- Marker pen

METHOD:

Post sheets of flipchart paper on the walls. Each sheet has a different title. Number the participants to create 3 groups. Each group will be given a marker in order to record their responses.

The titles of the sheets are:

1. WHAT IS HIV/AIDS?
2. HOW DO YOU GET HIV/AIDS?
3. HOW DO YOU PROTECT YOURSELF?

WRITING SEGMENT: (10 minutes)
Have each group list the information they know about the topic they are assigned to.

> **NOTE TO TRAINER:** For groups that have a limited knowledge about HIV/AIDS and may feel uncomfortable about discussing what they "know" you can ask them to: "List the information that you have heard."

DISCUSSION: (30 minutes)

Post the sheets at the front of the room and in the **large group** discuss the responses generated by the written segment of the exercise. The group task is to review the information, correct misinformation, affirm correct information, and fill in missing information.

It is important, therefore to:

- Use large print
- Post the sheets where everyone can see them
- Read out and address each point

NOTE TO TRAINER: You may wish to provide HIV/AIDS fact sheets to participants after they have concluded the brainstorming task. It may facilitate the feedback session. Check the resources available in your community to get the most up to date fact sheets and pamphlets.

As you review how the virus is transmitted during the HIV FACTS exercise, refer to the following list on a flipchart.

PRINCIPLES OF TRANSMISSION

1. A body fluid with enough of the virus.
2. A way for it to get into the bloodstream of another person.

Keep this chart posted, and when people ask questions about whether a particular activity will transmit the virus you can refer back to this chart and have the group determine whether the virus could be transmitted or not.

2. HIV CARD GAME (40 minutes)

PURPOSE:

To review how you get the HIV/AIDS virus and how you don't. For people with a limited knowledge of HIV/AIDS, or who are learning English, this activity may be more acceptable.

MATERIALS:

- Set of activity cards for each group - each card has an activity written on it. Some are high risk, some low risk, and some are no risk activities
- Flip chart
- Marker pen

METHOD:

LARGE GROUP (20 minutes)

On a flipchart record all the activities that the groups feel will or might transmit the virus. Have each group call out one activity at a time. The group will decide if it is High, Low or No Risk. Then review how the virus could be spread with each activity.

> **TIP:** Some trainers have simplified this small group activity by handing out activity cards that are workplace specific, i.e.: changing a diaper in a daycare setting, disposing of sharps in a health care setting. Participants are then asked to rank the activities from high risk to low risk for HIV transmission.
> Be sure to include blank cards for groups to make up their own activities. You can modify these cards to indicate activities within a particular workplace i.e., hospital, police station, factory or school.

Basic HIV/AIDS information is in the Appendix section of the manual.

Once the Basic Information of HIV/AIDS is complete, the following information can be given in the form of a short lecture. It helps answer the question “What are my chances of getting HIV?”

3. STI AND HIV INTEGRATION

Recent research has demonstrated that the relationships between STIs and HIV are multiple and complex. The presence of STIs increases the chances that HIV transmission will occur through sexual contact. This is because STIs result in an inflammatory immune response of the mucous membranes which increases the number of target white blood cells that are present at the surface. These target white blood cells, are able to be directly infected by HIV.

For persons with an STI infection:

- If an STI is present, the risk of HIV transmission is increased 3 – 50 fold.
- The risk of HIV transmission IS INCREASED due to the recruitment of target white blood cells to the surface of the genital mucous membranes.
- Treatment of all STIs reduces HIV transmission significantly in populations with high STI rates.

For persons with HIV infection:

- HIV genital shedding in men and women increases in the presence of an STI.
- The amount of HIV being shed from the genitals may increase seven-fold in men co-infected with HIV and another STI, such as gonorrhea.
- HIV shedding can be reduced to baseline levels in co-infected persons by treating the STI as soon as possible.
- Some STIs, in persons co-infected with HIV, may be harder to diagnose and treat. For example, women with HIV are more likely to develop PID (pelvic inflammatory disease) and may often require hospitalization to receive adequate therapy.

This new information has significant implications for HIV and STI prevention, and behavioral interventions:

- The secondary prevention of STIs (early diagnosis and treatment) is an important new strategy for the primary acquisition and primary transmission prevention of HIV.
- HIV treatment may have implications of HIV primary transmission prevention. Antiviral treatment to improve survival may also reduce HIV shedding in genital secretions, thus prevent transmission.
- Integrated HIV and STI prevention programs, should focus on changing sexual and substance use behaviours of clients, as well as their STI health care seeking behaviours.

- Integrated HIV and STI prevention programs should be designed for all levels of prevention; primary acquisition and transmission, secondary, and tertiary.

Reference: St. Louis, Wasserheit, J. and Gayle, H.; "Editorial: Janus Considers the HIV Pandemic – Harnessing Recent Advances to Enhance AIDS Prevention". American Journal of Public Health; Vol.87, No. 1 January 1997, pgs. 10-12.

Understanding the Sexual Transmission of HIV and STDs.

The immunological STI/HIV relationships have been more recently defined and are less well understood. The following clarifies what is currently known about the immunological inter-relationships for persons with HIV who acquire an STI and visa versa.

The probability of transmission from an infected person to an uninfected person after exposure =

$$\frac{\text{Virulence X Exposure}}{\text{Resistance}}$$

Virulence is Viral Dose – how much organism?

This depends on the type of fluid, clinical stage of the person you're exposed to and whether the other person has an STI.

- Viral dose is increased in the primary and symptomatic stages of HIV.
- Viral dose is increased in the person if HIV/STI co-infected.
- Viral dose in increased with cervical ectopy, pregnancy.

Exposure – For how long?

This depends on the type of sexual activities, the number of times a person is exposed and the chance that your partner is infected.

- Type of exposure affects duration – Penile, Vaginal, Rectal, Oral.
- Insertive or Receptive (Women are always receptive partners – men may be receptive or insertive).
- Number of sexual acts/number of partners.
- Chance your partner is infected – geographic location – and social networks.

Resistance – HIV infects White Blood Cells at the Mucous Membrane Sites!
Resistance depends on the state of your mucous membranes: how healthy they are, how intact they are and whether you have an STI or some other source of inflammation.

Mucous Membrane Sites:

- Oral – Mouth and Throat
- Vaginal – Vagina and Cervix
- Urethral – Meatus, Urethra
- Rectal – Anus, Rectum

Squamous Epithelium on the mouth, vagina, meatus and anus is more protective
Columnar Epithelium on the throat, cervix, urethra and rectum is more vulnerable

Inflammation and/or infection increase the number of white blood cells on the mucous membranes. Therefore it increases the number of cells that are vulnerable to HIV infection.

The combination of all three of these factors determines one's changes of getting an STI or HIV every time they have sex. It can explain why one person may have multiple exposures to HIV and not become infected; yet another person may have only one exposure to HIV and become infected.

Reference: Royce, R., Sena, M., Cates Jr., W, and Cohen, M: "Sexual Transmission of HIV", The New England Journal of Medicine; Vol. 336, No. 15. April 10, 1997 pages 1072 – 1078

SECTION 3:

ATTITUES AND VALUES

INTRODUCTION

This section of the manual explores the influence trainers' own values and attitudes about issues related to HIV infection can have on their learners. You will also examine how the trainers' own attitudes and values influence learners' retention and acceptance of HIV/AIDS information.

The content and exercises in this section are designed to help you consider your own values and how they will influence you as an educator. The exercises will also help you to become more aware of factors that will influence the learners you will be educating. **These exercises are not designed to be implemented in a short HIV/AIDS session. They require processing and debriefing time. You may want to use them if you are educating human resource personnel or health care professionals who will be counseling clients about safer sex, HIV testing or caring for PHA's**. Most people need to feel safe and trusting when participating in these exercises.

Values

Consider values as navigators in life. They allow us to create and maintain a sense of who we are and where we belong in the world; our values are our belief system. Values also help us to maintain a sense of what's right and wrong as well as what is important to us. We establish this belief system both consciously and subconsciously throughout our lives.

Developmental experiences (familial, cultural, religious, educational, workplace) offer a great deal toward the formation of our value system. As we grow to adulthood the opportunity to consciously choose and reject specific values increases; this is what we refer to as "values clarification".

When we deal with issues such as HIV/ AIDS we may need to do some values clarification. HIV / AIDS is more than a medical issue. It demands that we deal with issues, which can be difficult and controversial; particularly sexual orientation, drug use, and sexual expression. We may be forced to address these issues which in the past we have managed to avoid. If, for example, our values only accept heterosexuality and condemn homosexuality, the issue of HIV/AIDS will present a challenge because HIV/AIDS and homosexuality are inextricably connected in North America.

Attitudes
The outward expressions of our values are called "attitudes". We form attitudes based on our values system. Therefore, our attitudes toward a particular issue will reflect our values toward the same issue.

What we say to others, and how we say it will reflect our own attitudes and values. It is therefore important to offer participants in an education session an opportunity to clarify their attitudes and values in a safe environment, and to consider their effect upon the work they do with others. As an educator it is important to include processing and debriefing time in your exercise plans. People must not feel forced to engage in these activities, as the audience will need to feel safe and trusting.

The following three exercises aim to begin or continue the process of values clarification. The focus of these exercises is human sexuality and drug use and sexual expression.

1. Family of Origin Exercise

Purpose:

Ask participants how they think people learn about sexuality?
What are the influences?

As adults our sexuality and understanding of human sexuality has been influenced by many early experiences. Early family experience is very powerful. We will learn about the connection between our early learning and the way we respond to sexual issues today.

Many of you are now parents and grandparents. This exercise is relevant to our work and personal life. It is a way to begin to think and talk together about sexual issues in a non-threatening way.

Method

Put participants in 6 groups. Distribute a set of index cards to each group. The following topics are listed – one per card.

1. Language
2. Affection
3. Nudity
4. Sex Play
5. Sexual Orientation
6. Gender Roles

To recall and talk about how some issues were dealt with in the family you grew up in. To remember your early learning about sexuality, from 0 – 8 years of age. (May also include extended family, friends)

Acknowledge possibility of participants having had painful childhood memories. Give permission to pass. These memories are real and need to be acknowledged but this is not the place to share them. Individual counseling is recommended.

Do the first topic in the small groups and then debrief with the large group.

Language
In your group, each person takes a turn to describe (or can pass, or won't remember), what words were used in the home for sexual body parts and for bathroom activities. What questions do you remember asking?

Debrief:
What did you find out in your group about language. Any similarities?
People's experiences often fall into these 3 categories.

First Family	No words – no talking
Second Family	Some words – talked sometimes
Third Family	Could talk about anything, anytime, very open

How many grew up the in the First Family, Second or Third.
How does this help or hinder you in issues that arise in your work.
Acknowledge that how and what we learn will affect our attitudes and behaviours in our work.

Continue with the cards in the small groups until everyone has had a chance to discuss all topics.

Debrief on each subject in the large group. Remind people to share only if they are comfortable to do so.

Discussion Guide

Affection
How was affection shown in your family as you were growing up? Between who? If there were words spoken, what were they?

Did your early family experiences help or hinder you in your personal relationships? How does this experience affect your response to public displays of affection?

Nudity
Who did you see a naked body and under what circumstances? Remember, for some people this might be a painful memory. If it changed as you were growing up – when did this occur?

Sex Play
Who wants to share a remembered experience?
For example: Playing "doctor" – You show me yours and I'll show you mine:
If an adult caught you – what happened?

Is playing doctor an OK expression these days? (issues of coercion and abuse to be included here)

If we've had a particularly negative experience where sexuality is concerned, our response to sexual issues will be different from someone whose experience was positive or neutral.

Sexual Orientation
Refer to the 3 categories of families – Not talked about – talked about in a negative way or talked about positively. Speculate on how this has affected your present attitude.
How can we learn more about Sexual Orientation?

Gender Roles
Were there strict roles? What behaviour was expected of boys, that was different for girls? How was worked shared in the family?
How does this affect your response to changes in public roles for men and women?

Wrap up – were there any surprises in doing this exercise? Will it change how you view responses to certain issues when you are doing presentations in the future? How has your early learning experiences affected your parenting today (if you are a parent)?

2. Attitudes and Values Exercise

PURPOSE:

To identify participant's attitudes and values in relation to common behaviours or characteristics of people at risk for HIV/AIDS. Attitudes and values are influenced by our culture, family background and experience. In situations where the facilitator communicates a strong belief, which significantly differs from the participants, there may be a negative impact. Attitudes and values are not right or wrong. We have all experienced situations that may "push our buttons". This is usually due to a conflict between attitudes. These situations are often challenging to deal with in an effective manner.

In order to provide non-judgmental sessions, it is important to gain insight into our own attitudes and values toward common behaviours and characteristics.

METHOD:

Break into groups as designated by the facilitator.

In a round robin sequence, each participant will pick one statement from "the hat".

Read the statement aloud and share your reaction to the statement. Do you agree or disagree and why.

Other group members can then respond and share their reaction to the same statement. It is important to state only your point of view, not whether you think someone else is right or wrong in their reaction.

Continue the sequence until all the statements have been discussed.

Facilitators:

Process the discussion and using newsprint identify specific attitudes or values.

Attitudes & Values Identification

1. A pregnant woman who is HIV positive should be encouraged to terminate.

2. Injection drug users are not capable of any behaviour change as long as they are actively using.

3. Anal intercourse is not normal.

4. A person who has unprotected sex and gets an STI is irresponsible.

5. People with an STI have no right to be angry or demanding because they're getting free service.

6. Bisexual men who don't tell their female partner are selfish.

7. A gay male should never count on monogamy to protect himself from HIV.

8. Older men who develop sexual relationships with teenage girls are taking advantage of them.

9. Cocaine addicted women don't listen to anything you say because they'll do anything to get high.

10. STI clients usually lie about their sexual behaviour.

11. Lesbians are not at risk for STIs or HIV.

12. Day care staff or school staff need to know a child is HIV or has AIDS

13. People are sometimes still afraid of catching HIV from hugging or shaking hands.

14. People who start a new relationship should have an HIV test before they have sex.

15. All pregnant women should have an HIV test automatically as part of their prenatal screening.

16. Universal precautions are all that is needed to protect oneself from HIV.

3. VALUES CLARIFICATION EXERCISE (45 minutes)

PURPOSE:

This exercise provides a structured opportunity to explore the range of values and attitudes about HIV/AIDS that exist in any group. This exercise helps increase understanding about why people hold the attitudes and values they do.

METHOD:

1. Facilitator begins by examining the different ways people look at values.

a) **Values Push**
One person tries to push their values on another. The person can only see an issue one way and believes there is no room for difference.

b) **Values Vacuum**

One person denies another's values. There is a risk that when people engage in discussion, one or both will have to give up some part of the argument, therefore losing ground. Avoidance of discussion of either point of view is the result.

c) **Values Exchange**

Both persons listening with no attacking or avoiding. This is what we strive for. This is demonstrated by saying "Why do you feel that way?" or "Tell me more".

2. Facilitator then tells the group that she/he will read a statement. Participants are instructed to go to parts of the room designated to reflect their response to this statement.

AGREE **UNDECIDED** **DISAGREE**

NOTE TO TRAINER: Always let participants know they can pass if they wish, and remain in the middle of the room.

3. Advise participants that they can change their position during the course of the exercise.

4. Facilitator then reads a statement. Participants move accordingly.

5. If a statement is controversial to the group, participants will want answers or clarification from the facilitator.

TIP: It is important that the facilitator not clarify the statement in any way or acknowledge one person's point of view by body language, etc. Other than repeating the statement, the facilitator should remain neutral.

TIP: It is important to state only your views – not disagree about another's viewpoint.

6. Facilitator gives each group equal opportunity to express views, and reminds participants they can change their position.

7. Participants, in absence of clarification from facilitator, may look to each other and discussion may bring about examples of attitude push, vacuum and exchange.

8. Usually 3 – 4 statements provide enough variety to demonstrate the range of attitudes in the group.

Points for discussion:

1. How did it feel **not** to get answers from the facilitator?

2. What were the feelings generated by the statements, and by others' points of view?

3. How did it feel to participants to be in the minority if, for example, they were the only one of the group to initially agree or disagree with a statement?

4. If the statement had been worded in a different way, would it have minimized disagreement?

> **TIP:** People may first appear to have very different feelings or opinions on certain matters because of the words they have chosen to express themselves. Make sure that what a participant says is clear to everyone. Often people's feelings are more in agreement after some discussion and clarification.

This exercise points out the difficulties that can arise when discussions about HIV/AIDS involve values.

If feelings of anger were apparent during the exercise, take time to process.

Discuss strategies with group for dealing with persons who have strong values.

Discuss why HIV/AIDS prevention creates a challenge to long held values.

This exercise often illustrates that if people really listen to each other they may be closer in agreement than they had previously thought.

EXAMPLES OF CONTROVERSIAL STATEMENTS TO USE IN THIS EXERCISE:

1. HIV/AIDS educators should practice what they preach.

2. Any sexual behaviour between consenting adults is OK.

3. The sole purpose of having sex is to express intimacy.

4. Sex is part of all human interaction; if someone can't ask their partner to practice safer sex, they should not have sex.

5. Persons at risk for HIV/AIDS should not have unsafe sex.

6. Ultimately the person with HIV/AIDS is responsible for practicing safer sex.

7. Pregnant women who are HIV/AIDS positive should have an abortion.

8. Bisexual men have acted as a bridge for HIV/AIDS transmission between gays and the heterosexual population.

9. Blood transfusion recipients are the only innocent victims of this disease.

Alternately you may create your own controversial statements that will generate discussions.

LARGE GROUP DISCUSSION:

How did it feel to listen to the opinions of others?

How did it feel exposing your values to other participants?

Did you surprise yourself in any way?

Did you move as you heard the explanations of other participants?

Can opposing positions or attitudes have at their core similar values?

SECTION 4: SEXUALITY

INTRODUCTION

Discussing sexuality is a very important aspect of HIV/AIDS education. How we feel about our own sexuality, about other's sexuality, and how we communicate information about sexuality is very important when we talk and teach about HIV/AIDS.

An impressive amount of data has been collected about human sexual development, but its analysis and interpretation has generated significant differences of opinion. What is considered as fact at one time in history, may change, as more information becomes available. And as facts and attitudes change, so can public policy. For instance, masturbation is no longer considered harmful, but a normal expression of sexuality, from infancy to old age. Abortion, once considered criminal, is now covered under our health plan. Under former Prime Minister Pierre Trudeau (who said the state has no business in the bedrooms of the nation), the government removed homosexuality from the Criminal Code. Another significant change occurred when homosexuality was removed from the Diagnostic Statistics Manual (DSM) in 1975. The DSM is the professional classification of mental illnesses.

There have also been changes in the messages about sexuality, as sexuality is no longer spoken of only in the context of religion, illness, social class, culture and gender. Discussions now may include issues related to pleasure, freedom and experimentation. Since one mode of transmission of HIV infection is sexual, educators are continually re-examining the messages given about sex, sexuality and sexual activities in all these realms. And because values about sexuality remain tangled up with religion and morality, it is important for educators to distinguish between their (or their learners') own values, opinions and facts.

Although HIV/AIDS education is not solely about sexuality, discussing sexuality remains an essential component. Many HIV/AIDS educators are learning more and more about sexuality as they confront problems, difficulties and complexities related to sexual behaviour and change. It is useful to study human sexuality, and to think carefully about the controversial issues which such scrutiny and study elicits. Few topics have as much potential for eliciting strong, often conflicting or controversial opinions. Yet talking about sexuality is an integral component of HIV/AIDS education, as they are inextricably linked.

Parents, teachers, counselors and health advocates involved in health education need to be comfortable with their sexuality, and comfortable talking about sexuality to others, in order to help them achieve their goals of disease prevention. Silence, both public and private does not help to achieve disease prevention.

Children learn their messages about sexuality from a wide variety of sources. Not all of them are factual. Besides getting messages from their parents, they read newspapers and magazines, watch television and talk to their friends. Often, the media presents a distorted picture of sexuality, focusing on violence or freedom from unwanted consequences. Rarely are the positive aspects of sexual expression discussed in a helpful way.

The research overwhelmingly supports broad-based sexual education in helping youth delay intercourse, and to use contraception and/or disease prevention tools. Abstinence messages of NO! DON'T! WAIT! have been shown to simply not work on their own. Therefore, conversations about sexuality have to take place, using language that all persons understand and can "hear". When talking to youth, we therefore need to clarify our own values and feelings about sexuality and to provide information in a manner that is acceptable and understandable.

Source: Research Supports Broadly-Based Sex Education, "Canadian Journal of Human Sexuality, Vol.2(2) Summer 1993, Toronto, p.89.

1. DEVELOPING EMPATHY - LOOKING AT OUR OWN RISK-TAKING BEHAVIOUR (30 Minutes)

PURPOSE:

The concept of risk is a useful prelude to discussing safer sex. Educators are often frustrated by people who want to know precisely how risky an activity is. Similarly, educators frequently encounter people who judge others harshly for taking any sexual risks.

One way to put risk in perspective is to show how it permeates daily life. One way to help people make informed choices about sexual activity is to help them see how many risks they take in other areas of their lives.

The following exercise helps people to examine the risks they take and develop empathy for others who take risks.

METHOD:

- It is important to understand different types of risk – physical, social, emotional and career risks.
- There is a dual nature to risk taking – it may be associated with harmful outcomes, but also has many positive benefits – it promotes learning and skill development
- We need to think through choices and make decisions that minimize the harm associated with risk taking.

Facilitator makes the point that **PEOPLE TAKE RISKS**.
Designate different corners of the room for each category (on newsprint or cards):

"**ALWAYS" (100% of the time) This means EVERYTIME**
"USUALLY" (80% of the time)
"SOMETIMES" (50-50)
"SELDOM OR NEVER" (below 50% of the time)

Facilitator reads the following statements, asking participants to get up and move to the corner that fits them best, after each statement:

1. "I wear my seatbelt while driving."
2. "I use a birth control method every time I have sex"
3. "I use a crosswalk every time when crossing the street"
4. "I refrain from smoking cigarettes."

Let group members comment after each statement. For instance, you might ask, "Why do you think there are so many of us in the "ALWAYS" category for wearing seatbelts, but so few of us are in the "ALWAYS" category for using a crosswalk?" The key is the small amount of effort it takes to put on a seatbelt and seatbelts legislation, and the amount of effort it takes to get to a crosswalk when the store you want is directly opposite. You can equate the hassle of using a crosswalk to putting on a condom.

LARGE GROUP DISCUSSION

Points to put up on flipchart and examine after participants return to their seats:

1. Risk-taking behaviour varies from person to person, depending on their values and priorities (some people would not dream of "polluting" themselves with cigarettes).

   Some people are willing to take chances with their mental health, some with their **teeth, lungs, heart, life,** and **death** - others take chances with their fertility.

2. We all play the odds repeatedly - without really knowing what the odds are!

3. We are all health professionals (if that is the make-up of the group) and if we repeatedly take chances with our mental and physical health and safety, how can we expect others to behave differently?

4. Taking risks is an important aspect of living. We need to learn how to calculate and weigh out the alternatives around risks and risk situations and the potential they may hold for harm to ourselves and to others.

We also need to learn from experience. Harmful or unhealthy choices can help us to learn and grow and support us in deciding not to make that choice again, or to go about it in ways that will prevent or reduce the likelihood of harm. Adolescence is a time when we explore, seek out sensations and excitement. If young people don't take some risks, they will not mature and be able to make decisions for themselves.

Source: Adapted from Annie Baker, " The Hope Clinic for Women Ltd.", Granite City, Ill. U.S.A. 62040,

2. TITLES EXERCISE

You cannot "teach" others about HIV infection without talking candidly about sex, sexuality and sexual activities, specifically as the activity pertains to the personal level of risk for HIV and STD infection. The next three exercises will help you handle frank discussions about sex.

PURPOSE:

To increase comfort level when talking about sex and sexual activities
To share an understanding of a variety of sexual activities
To discuss how our values related to sexuality, influence our teaching and learning about HIV infection.

MATERIALS:

- Flipchart paper - each sheet has a different title

  The titles are:
  a) sexual body parts, areas
  b) sexual activities
  c) sexually transmitted infections

- Markers pens
- Masking tape
- Post-it notes

To demonstrate the range of words that might be used in presentations to describe the body parts, activities or sexually transmitted infections, the following demonstration is helpful.

Write the word Penis on a flipchart and ask the group to list the many variations of words that describe penis. The words usually fall into 4 categories, “baby talk”, “polite words”, “dictionary words” and “slang”. Continue using the word “Breast”. This exercise will provide permission for the group to use a wide range of words.

METHOD:

SMALL GROUPS (10 min.)

Post the flipchart paper to make three stations. Divide participants into three groups. Each group rotates to all three stations. Each group lists all the words they can think of that fit their title in two minutes. The goal is to be as creative as possible in the number of words that are used for each title. The language can reflect proper words, slang etc.

For the Sexual Activities List – have participants write on post it notes – For the Stoplight exercise that follows.

LARGE GROUP (30 min.)

Discuss the responses generated by the written segment of the exercise. Your role as facilitator is to post and review the words on each list with the participants. Before you begin clarifying language, ask the participants:

1. What aspects of this exercise were most/least comfortable for you?

> NOTE TO TRAINERS: If there are no specific responses, think about what was comfortable/uncomfortable for you.

2. What do these words mean? Go over each word. The following ideas are only suggestions:

   Sexually Transmitted Infections: - Elicit from the participants sufficient information that assures you they understand the disease and how (if it is) linked to HIV/AIDS.

   Sexual Body Parts/Areas - Define/describe each word. Associate the body part with men, women, or both. Emphasize that all the body is sexual not just the genital areas.

   Sexual Activities - Go over each activity, define/describe each. The STOPLIGHT EXERCISE following will define the risk level of each activity.

3. How do you believe your personal values, attitudes or beliefs, relevant to sexuality, will impact your teaching about preventing the transmission of the HIV/AIDS virus? For example:

   "I am very uncomfortable talking about anal sex. I may need to work on my discomfort".
   "I don't see why I have to talk about it".

4. How can you become more comfortable discussing sexuality and other sensitive issues? For example:
   Take a Human Sexuality class. Practice saying "loaded" words.

5. What values, attitudes or beliefs do you anticipate your learners will express that might influence their learning about preventing the transmission of HIV infection?

Guelph Sexuality Conference, www.open.uoguelph.ca/sexconf

A once a year conference that provides research, information, trends, skill building workshops and resources to keep up to date on this topic.

3. STOP LIGHT EXERCISE (15 min)

PURPOSE:
To discuss the risk levels of various sexual activities and how those activities can be made safer:

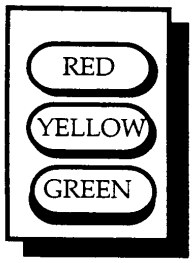
MATERIALS:

- Flipchart with a stoplight drawn on it
- Cards with sexual activities on them, or post-it notes
- Masking tape

METHOD:

LARGE GROUP
Have the group members remove the post it notes from the Sexual Activities List and place them beside **HIGH – LOW** – or **NO RISK**. There is also a category called "Negligible Risk". See the appendix for more details.

Post a piece of flipchart paper with a stoplight drawn on it:



(High Risk)

(Low Risk)

(No Risk)

Have people place their card somewhere on the stoplight according to whether or not they think the activity will put someone at HIGH, LOW or NO RISK of getting HIV.

Go through each activity with the group and explain (or have volunteers from the group explain) what the activity means. Then discuss whether or not it is HIGH, LOW or NO RISK. (Refer back to PRINCIPLES OF TRANSMISSION from BASIC HIV/AIDS to guide you and see answer sheet on the following page). Then review how or if each activity can become safer. When discussing risk for HIV, be sure to include risks for other STI's like Hepatitis A, which can be passed through oral/anal sex.

Here are some specific examples of how some activities can be made safer. Remember that this discussion can be done for all sexual activities.

Making Oral Sex on a Man (Fellatio) Safer:

- put a condom on the man's penis
- don't allow ejaculate to enter your mouth
- lick the shaft or the testicles instead of the head of the penis
- use your hand and lubricant to stimulate the head of the penis
- don't brush or floss before oral sex

Making Vaginal or Anal Sex Safer:

- put a condom on the man's penis before there is any vaginal/anal contact
- use lots of water-based lubrication eg. K-Y Jelly, Astroglide
- make sure that the condom is put on properly (see Basic HIV/AIDS section)
- after ejaculation, remove the penis, holding onto the base of the condom to avoid spillage.

For more information see: Canadian AIDS Society, HIV Transmission – Guidelines for Assessing Risk, Jan. 1999 , 900-130 Albert Street, Ottawa K1P 5G4 – TEL 613-230-3580, FAX 613-563-4998, www.cdnaids.ca

STOPLIGHT EXERCISE - ANSWER SHEET

Sexual Activities	**Risk Level**
Anal sex - no condom	High Risk
Anal Sex - with a condom	Low Risk
Vaginal sex - no condom	High Risk
Vaginal sex - with a condom	Low Risk
Oral Sex on a man - no condom	Low Risk
Oral Sex on a woman - no latex barrier	Low Risk
Oral Sex on a man - with a condom	Neg. Risk
Mutual masturbation	No Risk
Kissing	No Risk
Hugging	No Risk

NOTE TO TRAINER: Activities using condoms may be considered low risk, rather than no risk, due to condom breakage. Condoms should always be used correctly and consistently, everytime.

TIP: Putting other STI's into the picture. Some STI's (other than HIV) can be passed by activities that are low risk for HIV transmission. While oral sex is lower risk for HIV transmission than unprotected anal or vaginal sex, the risk for other STI's is high. For example, oral/anal sex may be high risk for Hepatitis A transition. A pre-existing STI can facilitate transmission of HIV.

4. LATEX DEMONSTRATION (15 min.)

PURPOSE:
To increase group members' comfort level and knowledge about latex barriers and their correct use.

MATERIALS:

- Condoms (lubricated and unlubricated)
- Latex gloves
- Female condoms
- Water based lubricants
- Damz (latex squares)

METHOD:

This exercise can be done in one of two ways.

1. Trainer discusses key points about buying, storing, putting on and disposing of latex barriers (see below). Trainer can pose questions to the group such as "where can you get these products or "what should you look for when buying these items".

2. Trainer demonstrates the actual steps of using the latex barrier.

Important points to remember are:

- use latex condoms not natural skin condoms before opening package, make sure it hasn't been punctured in any way; if package is not intact, use another condom
- check the expiry date on condoms
- proper storage - not in a hot place i.e., glove compartment or back pocket
- put latex barrier on before any genital contact
- pinch end of condom to remove any air before unrolling
- unroll condom to the base of the penis
- after ejaculation, hold condom at base of penis when pulling out
- never use oil based lubricants like butter, vaseline, mineral oil
- always use water based lubricants like K-Y jelly, muco, astroglide.
- always use a new condom for each act of intercourse; do not reuse.

3. Trainer discusses and demonstrates use of lubricants.

4. Trainer discusses the pros and cons of the dental dam debate.

pro: provides people with free choice to decide
con: cumbersome, little risk to warrant activity

NOTE: make sure that one side of the dental dam, which is exposed to the anus or genitals, is marked so that it is not mistakenly licked.

LOOK FOR REALITY – THE FEMALE CONDOM

Increasing numbers of people are reporting an allergy or sensitivity to latex especially latex gloves. A new polyurethrane (plastic) material is now being marketed for condoms and gloves. Although more expensive, it is one choice if you have allergies.

5. PREVENTION GAME - CONDOM CARDS (A TWO - PART EXERCISE)

PURPOSE:

This exercise will provide participants with concrete steps in negotiating and implementing condom use. It is a fun exercise to do with any group, especially teens, to reinforce correct condom use. It allows people to move around and get involved in discussion.

MATERIALS:

PART 1 - Prevention Game - Cards with the following steps on them:

1. Acknowledging sexuality;
2. Getting necessary information;
3. Talking to partner about sexuality;
4. Negotiating prevention of HIV, STIs & pregnancy;
5. Going public;
6. Obtaining protection

METHOD:

Distribute the six cards (one card per person) face down. Then have the group members go to the front of the room and put themselves in order for negotiating prevention. Ask for input from remaining participants.

POINTS FOR DISCUSSION (corresponds to numbering of the cards):

1. Acknowledge intent to be sexually active – sometimes difficult
2. Where to get information - clinics in area
3. Set limits for sexual activity – not everyone wants to progress at the same time
4. Both people need to take responsibility

5&6. Going public may be difficult when people are shy or embarrassed

7. How would 'Falling in Love' or 'Alcohol' affect the above

PART 2 - Condom Cards: Cards with the following steps on them:

1. Tear package open
2. Sexual arousal
3. Pinch end of condom
4. Apply lubricant
5. Leave room at tip
6. Unroll onto erect penis
7. Sexual intercourse
8. Ejaculation/orgasm
9. Hold condom at base of penis
10. Pull out
11. Remove Condom
12. Dispose of condom keeping semen inside
13. Praise partner for using condom

METHOD:

Distribute the 14 cards (one card per person) face down. Then have the group members go to the front of the room and discuss the sequence of condom use. When they agree on the sequence – line up for the rest of the participants. Ask for input from remaining participants.

POINTS FOR DISCUSSION:

1-3. Keep extra condoms on hand
1-3. Check expiry date
4. Pull foreskin back if not circumcised
5. Use water base lubrication
6. Leave room for semen
7. Availability of different sizes of condoms
8-9. Does ejaculation and orgasm occur at same time?
10-12. Hold condom in place during withdrawal to prevent it coming off
13. Dispose of condom in the garbage rather than the toilet.
14. Reinforce effective behaviour

Discuss alternatives to latex if either partner has allergy - plastic condoms now available, or doubling up with animal skin condoms (see Appendix)

Source: Adapted from the article by Fisher & Fisher "Understanding and Promoting HIV/AIDS Preventive Behaviour: A Conceptual Model and HIV/AIDS Education Tools", The Canadian Journal of Healthy Sexuality Vol.4(3), 1992.

RESOURCES

CANADIAN GUIDELINES FOR SEXUAL HEALTH AND EDUCATION. Produced by Health Canada. Available at Ministry of Supply and Services Canada, 1994. CAT H39-300/1994E. ISBN 0-662-22362-4.

Sieccan Journal (These journals are available at various resource centres). The entire journal library is available at the East York Health Unit, 850 Coxwell Avenue, Toronto @ (416) 723-6026).

Annual Guelph Sexuality Conference and Training Institute on Sexuality. For more details contact The Department of Family Studies, Office of Continuing Studies, at the University of Guelph. Guelph, Ontario, Canada NIG 2W1. Fax: 519-767-1114

SECTION 5:

HOMOPHOBIA

Homophobia is defined as the irrational fear of lesbians and gays or prejudice against them. Unfortunately, these negative attitudes are often translated into discriminatory social practices, oppression, violence and hatred. Because HIV/AIDS first affected the gay population in North America, people's perceptions of homosexuality have an impact on HIV/AIDS education in many ways. Not only do these attitudes affect the way one teaches about HIV/AIDS, but a study in London, San Francisco and New York City, demonstrated that anti-gay attitudes interfered with people's ability to acquire knowledge about HIV/AIDS

There are four levels of homophobia:

1. **Personal Homophobia** is prejudice based on a personal belief that lesbian, gay and bisexual people are immoral and sick or that they are inferior to heterosexuals. These feelings range in intensity from fear, discomfort and disgust, to hatred.

2. **Interpersonal Homophobia** occurs when homophobia is expressed between people. This hatred may be expressed through name-calling, telling jokes, verbal or physical harassment or through other acts of discrimination. Though many gay people have been assaulted or killed on the basis of their sexual orientation, the majority of these acts occur in non-violent and more commonplace ways. For example, friends may become uninterested and co-workers may become distant when they find out that someone is homosexual.

3. **Institutional Homophobia** is perpetuated when an institution or an organization discriminates against people on the basis of their sexual orientation. This is demonstrated when agencies engage in illegal firing practices or do not provide equal services for gay or lesbian people. This may also be present in governments that do not protect the rights of all individuals.

4. **Cultural Homophobia** refers to social standards and norms, which dictate that being heterosexual is better or more moral than being lesbian or gay. These standards may not be written down but are supported by the media and expectations placed on one another. For example, most parents will expect their children to eventually marry a person of the opposite sex.

Some lesbians, gays and bisexuals **internalize homophobia** leading to intense self-hatred. They may feel their same-sex emotional and physical attraction is inferior to heterosexuality. These negative thoughts and feelings often result as a consequence of continual exposure to sources which promote homophobia. One result is that some people carefully conceal their sexual orientation; others try desperately to deny or change their orientation; and some have tried or have succeeded in committing suicide.

HETEROSEXISM

Institutional and cultural homophobia, are in fact, what we refer to as heterosexism. Heterosexism is the institutionalization of power, in a way that affords economic, social and legal advantage to heterosexuals. It stems from the belief that the only normal, healthy way for two people to express themselves sexually is with members of the opposite sex. Heterosexism also assumes that everyone is heterosexual.

Just like racism and sexism, discrimination on the basis of sexual orientation is another form of oppression within our society. In our Train the Trainer program we offer a gay-positive approach. We use terms such as partner to refer to a couple instead of wife, husband, girlfriend or boyfriend.

It is important to recognize that sexuality exists as a continuum ranging from those who only have same sex experiences; those who may have relationships with both sexes (referred to as bisexual); to those who have exclusive relationships with members of the opposite sex. According to studies done by Kinsey, 37% of men have had a same sex experience to orgasm. Also, he found that 50% of men have had same-sex fantasies. This study also claimed that 1 in 10 white American males had been primarily homosexual for at least three years between the ages of 16 and 65.

Many people who have same sex experiences do not see themselves as gay and therefore do not see themselves at risk for getting HIV. That is why it is important in sessions to refer to sexual behaviours, not sexual groups when discussing HIV transmission. It is better to talk about "Men who have sex with men" and "Women who have sex with women" rather than referring to risks for gays or lesbian.

Source: adapted from The Campaign to End Homophobia - PO Box 819, Cambridge Massachusetts - 02139 (617) 868-8280

ATTITUDES TOWARDS HOMOSEXUALITY

The Riddle Scale is a model used to understand people's responses towards homosexuality. The scale includes four positive levels and four negative levels of attitudes towards gays and lesbian people.

Negative Levels of Attitudes:

The four negative attitudes all contain elements of dominance rather than equality.

1. **Repulsion:** Gay people are sick, crazy, immoral and sinful, which justifies changing or eliminating them.

2. **Pity:** Gay men and lesbians are somehow born that way and should be pitied. The goal is to help these poor individuals to be as "normal as possible"

3. **Tolerance:** Homosexuality is just a phase of development that many people go through and that most people "grow out of". Thus, gays and lesbians must be protected and treated like children.

4. **Acceptance:** Heterosexuals need to make accommodations for gay or lesbian sexual identity. The attitude does not acknowledge that another's identity is of the same value and importance as one's own. For example, "I don't even think of you as gay; you are just a person"

Positive Levels of Attitudes

1. **Support:** Gay men and lesbians deserve legal and civil rights. Regardless of one's own comfort with homosexuality, people should treat others fairly.

2. **Admiration:** Being gay or lesbian in this society takes strength. This also includes openness to examining one's own homophobic attitudes.

3. **Appreciation:** Diversity in people is a good thing and gay men and lesbians are a part of that diversity. This attitude also includes the willingness to confront homophobia in oneself and in others.

4. **Nurture:** Gay men and women are indispensable in our society. This includes viewing them with a genuine affection and acting as an advocate for them.

EXERCISES

1. IDENTIFICATION

0ne helpful exercise is to have participants in your group identify:

- at what level are most of the people you educate?
- at what level are you right now?
- at what level would you like to be?
- at what level is the organization that you work for?

2. WORD ASSOCIATION – Homophobia Porcupine

PURPOSE:
To look at homophobic name-calling and stereotypes and how homophobia affects gay, lesbian, bisexual and transgendered/transsexual youth and those who are assumed to be one of the above:

MATERIALS:

- Flipchart
- Marker Pens

> **NOTE TO TRAINER:** It is important to clearly explain the purpose of this exercise so that gay and lesbian participants will feel supported.

METHOD:

1. Draw a large circle on the board and label it lesbian, gay and bisexual.

2. Ask the group to brainstorm a list of names that might be used to describe someone who is gay, lesbian, bisexual or transgendered/transsexual. **Explain to the group that this is the only time in the workshop where they can say negative names openly.** Ask the group to brainstorm stereotypes about gay, lesbian, bisexual and tg/ts people as well. Write these around the circle.

You may need to prompt the group around the stereotypes by asking these questions about lesbians, gay men, bisexuals, and tg/ts people: What do they look like? What do they wear? How do they act? What jobs do they have?

3. Have the group look at the names and stereotypes. Ask how they think the person, who is saying these names, feels? Draw another circle around the names and stereotypes and record their responses.

> *You may need to give an example: A student is walking down the hall and sees another student. He starts calling the other student a fag, queer…etc and says some stereotypes about him. What is the name-caller feeling? What motivates someone to name-call and spread stereotypes?*

4. Have the group look back at the names and stereotypes again. Cross out the words lesbian, gay, bi and tg/ts in the middle and write **"Me"** in the centre. Ask the group to brainstorm a list of feelings they would have if they were faced with such discrimination. Draw another circle around the last list and start recording the group's responses.

Sometimes you may get participants saying "I'm not gay so I don't know how I would feel in that situation. Get them to think about a time when they may have been called a name for another reason. Have them think about how it feels to be put down and called a name.

7. Ask the group what someone might do if they are experiencing all this homophobia. How would someone act out or react to this? Create a list beside the porcupine and write down the group's ideas. Divide the list first into the more negative actions that might happen. This is where you can start to share some statistics about the experiences of lgbtg/ts youth.

It is important to get the group to look at the positive steps that gay, lesbian, bi and tg/ts youth have taken to respond to homophobia and the positive things about coming out. Write this list next to the previous one

Positive Steps:

- Find support/counselling
- Find a community
- Be honest with self
- Join a youth group
- Educate people
- Find more supportive friends
- Attend Pride Day

Debunking the Myths and Stereotypes

An important part of the porcupine activity is to go back to the stereotypes and names that came out of the first brainstorm. As a facilitator, you want to start to debunk some of these. Ask the group to look back at the names and stereotypes to see if there are any that have thinks in common. Generally, you will find that there are some key areas that may come up when doing this workshop. While you may not have time to go into a lot of detail, it is important to start to debunk these. You can continue to debunk them through your stories and during question time.

Gender: Gay men want to be women and lesbians want to be men
Participants sometimes confuse gender with sexual orientation. Sexual orientation is about who you are attracted to, and gender is what roles and characteristics society assigns to being a man or a women. Not everyone, who is lesbian, gay or bisexual, fits these gender roles or characteristics, but this does not mean they want to be the opposite gender. This is also true for some straight women and men. Straight people who don't fit these roles can also experience homophobia.

Homophobia & Sexism
Men learn from a very young age to devalue things that are related to being female. They learn from words like sissy, pansy and fairy that the next worst thing to being female in this society is being gay. Homophobia restricts the behaviour of all men, women, boys, and girls. Homophobia keeps all of us afraid that if we really express who we are we are at risk of being labelled a "fag" or "dyke" (or any of the other names in the porcupine). Many gay men and lesbians resist homophobia by trying to challenge the rules about how "real" men and "real" women should behave. This link is an important reason why transgendered and transsexual people are targeted. To cross gender lines or to change to the opposite gender goes against the way society (and power) is structured with respect to gender.

Sex: Being lesbian, gay, bisexual is all about sex
Talk to the group about what it means to be lesbian, bay, or bisexual. It is not just about sex. It is about who you have crushes on, who you fall in love with, who you go to the movies with, who you walk the dog with, who you share your life with, which community events you go to, which books you like to read. One small tool that you can use with the group is to show them how sometimes people see homosexual or bisexual. Write the words on the board like this:

Homo**sex**ual bi**sex**ual

Sex is only one part of being lesbian, gay or bisexual, just like it is one part of being heterosexual.

Anal Sex
Anal sex – many negative names that are used against gay men make reference to anal sex. The stereotype is that gay men, and only gay men, have anal sex. Inform the group that studies have shown that about 30% of gay men (about 1 out of 3) have anal sex and that straight people have as much anal sex (about 30%) as gay people.

Religion: Homosexuality is a sin
There are a lot of different religious views on homosexuality: from groups that consider homosexuality a sin to others who consider it a gift from god. While someone may be free to have a particular belief about homosexuality, discriminating against someone because of their sexual orientation is against human rights. Within most religions, there are people who are attracted to the same sex and some of them are trying to work within their religious communities to raise awareness of homophobia and gain more acceptance and understanding. There are also religions and churches that openly accept lesbian, gay, bisexual, transsexual and transgendered members (like Metropolitan Community Church, Unitarian Universalists).

Illness & Disease: All gay men have AIDS
While the gay community in North American has been most affected by AIDS, most gay men do not have HIV/AIDS. Around the world, most people with AIDS are straight and were infected through unprotected sex with opposite sex partners. Lack of access to information and safer sex tools has contributed to this. In Canada, 20% of all new cases of HIV infection are women and most of these women identify as straight. HIV infection is related to sexual activity, not to sexual orientation. Practicing safer sex, whether a person is gay, lesbian, bisexual or straight decreases the risk of being infected with HIV and other sexually transmitted infections.

Source: Adapted from Planned Parenthood in Toronto.

3. GUIDED FANTASY EXERCISE - (20 minutes)

PURPOSE:

A clip from Brian McNaught's video " **On Being Gay**" helps people to imagine what it would like to be homosexual and male in a heterosexual world.

MATERIALS:

- Video - "On Being Gay"
- VCR & TV
- Flipchart
- Marker pens

NOTE TO TRAINERS:
Some participants find the comparison between growing up gay and growing up black problematic. McNaught suggests that black youth are less isolated and better supported by their families, because they can relate to other blacks. In contrast gay youth are invisible to their families and do not have readily identifiable support systems. *As one AIDS educator says " you don't get thrown out of your house for being black, you do for being gay". But if you're gay and black double oppression is at play "* In debriefing this video be prepared for this issue to emerge. Understanding homophobia needn't preclude understanding what it's like to grow up in a racist society.

METHOD:

Show film clip (15 min)
Encourage people to share how they felt during the clip.

- as a child
- as a teenager
- as an adult
- what they learned about being homosexual, and
- what they learned about themselves

4. CHANGING HOMOPHOBIC ATTITUDES (30 minutes)

PURPOSE:

To illustrate that people are capable of changing homophobic attitudes.

MATERIALS:

- Paper and markers
- Chalk and Chalkboard

METHOD:

1. In a large group discuss the extent to which homophobia and heterosexism is present in ourselves (personal homophobia), between our families and friends (interpersonal homophobia) and in our institutions (institutionalized homophobia).

2. Break into small groups and think of three or four specific ways in which these types of homophobia can be reduced. For example, a person can reduce personal homophobia by reading books and articles on the subject. Interpersonal homophobia can be reduced by responding negatively to homophobic jokes and slurs instead of ignoring them. Institutionalized homophobia can be reduced by writing letters, which support legislation for equal rights and opportunities for all, regardless of sexual orientation.

3. Return to a large group and discuss what ideas have been generated.

COMMUNITY RESOURCES

Central Toronto Youth Services - Lesbian Gay and Bisexual Youth Program
(416) 924-2100.

519 Church Street Community Centre – 416 -392-6874

Toronto Board of Education Human Sexuality Program - counselling and support groups for gay, lesbian and bisexual students. Call the Student Support Services, 416-397-3749

Lesbian, Gay, and Bisexual Youth Line – 416-962-9688.

PFLAG Parents and Friends of Lesbians and Gays of Toronto: 416-406-6378

SECTION 6:

INJECTION DRUG USE

There should be increased emphasis on the development of comprehensive education and counselling within both HIV/AIDS prevention and addiction treatment services....service providers should be equipped to address safer sex and safer injecting practices, and also deal with sexuality, drug use and the health and medical complications of injection. (Myers et al., 1995)

INTRODUCTION

The potential link between HIV and injection drug use (IDU) is well known. The sharing of needles or needle paraphernalia has led to the spread of HIV in drug users and their sexual partners. However, educating injection drug users on the apparent risks of HIV infection has been difficult. This may be because in our society, people often assign a positive or negative value to drug use. While it may be more acceptable to be addicted to drugs like caffeine or alcohol, addiction to substances like heroin or cocaine is highly stigmatized. As a result, injection drug use is for many, a very private and personal practice, making it difficult for health educators to reach injection drug users through traditional health related programs or facilities. Currently, there are many needle exchange programs operating within North America, Europe and Australia which show that with the correct approach, IDU's decrease their risks of HIV and other blood borne infections as well as protecting their sexual partners from infection. The most recent data, relating to HIV trends in Canada (2003), indicate that the proportion of HIV rates have decreased for injection drug users.

Regardless of your target group, facilitators must be aware of issues surrounding injection drug use. This is a topic that has often been neglected because facilitators have been uncomfortable with injection drug use, and have made false assumptions about people who use drugs. Just like sexuality, homophobia and racism, it is important that facilitators examine and challenge their attitudes towards addiction and drug use.

NOTE TO TRAINERS: In this manual any reference to drugs includes legal and illegal drugs including performance enhancing drugs (steroids), narcotics (heroin, crack) as well as insulin or vitamin injections.

Ideally, HIV/AIDS education should include a section on Injection Drug Use, harm reduction strategies and safer needle use.

.

Toronto Public Health offers a workshop titled “Working with drug users from a Harm Reduction Perspective” which addresses safer drug use to prevent HIV and Hepatitis; personal and societal issues/policies around drug use; and strategies to reduce barriers to accessing equitable services. Please contact the AIDS and Sexual Health InfoLine for more details.

IMPORTANT POINTS REGARDING INJECTION DRUG USE:

- Sharing needles is high risk for transmitting HIV, Hepatitis B, C and other blood borne illnesses
- An important strategy to reduce the spread of HIV is to reduce the sharing of needles
- Some injectors frequently report that they share needles because unused needles are difficult to obtain or that sharing has become a ritualistic part of the drug culture, which is difficult to reverse
- Access to clean needles is an important component of HIV prevention

HARM REDUCTION STRATEGIES

Definition: Harm Reduction

Harm Reduction is a non-judgemental approach to an individual's level of risk. It encompasses the behaviour and the environment, and attempts to reduce the specific risks of an individual. The goal of harm reduction is not abstinence, although it doesn't preclude abstinence. Harm reduction takes an individual's personal circumstances into account. This is done by determining achievable goals that may or may not lead to abstinence. Consider the person who is injecting cocaine 20 times a day. A harm reduction strategy may be to suggest that cocaine be injected 5 times a day, and other methods explored such as snorting and/or smoking the drug. This is a risk reduction strategy.

Drug policy in North America has focused on reducing the prevalence of drug use from "just say no " campaigns to zero tolerance and abstinence- based treatment programs. Most HIV/AIDS activists are advocating for harm reduction in lieu of drug enforcement. Harm reduction is aimed at decreasing the negative consequences of drug use rather than eliminating drug use. Harm reduction establishes a hierarchy of goals, which although perhaps not ideal, are realistic, immediate and achievable.

Source: Riley, Diane. Canadian Centre on Substance Abuse

1. Needle exchanges are a form of harm reduction. Needle exchange acknowledges that the IDU's may be unwilling or unable to stop injecting and that intervention must occur to lower the risk of HIV infection.

2. Using bleach (household bleach such as Javex) to clean needles is an example of harm reduction. Access to sterile needles is preferable but not always possible.

3. Methadone maintenance may be part of a harm reduction strategy.
   Methadone:
   - is a synthetic opiate taken orally
   - has similar properties as heroin and morphine
   - keeps a heroin user stable and prevents withdrawal

SAFER NEEDLE INJECTION or USE

Using bleach or having access to sterile needles is not the ultimate goal in a harm reduction strategy. Drug users also need to learn how to inject safely:

In your discussion, include:

l) site selection - certain body parts are better and safer for injection than other body parts. For example, a general rule of thumb is to inject away from the centre of the body avoiding the neck, hands and feet. General education about specific sites for different drugs i.e., steroids are injected into the muscle, other drugs are injected into the vein and injection into the arteries is dangerous.

2) injection rotation - it's important to rotate sites so that tissues and veins have a chance to heal.

3) care of veins, tissues and skin - if veins tissue or skin are red, hot to touch or swollen you may have an infection which requires medical attention.

4) do not sharing spoons, cottons, filters, etc. - this drug paraphernalia may contain germs and/or blood which can transmit infections leading to blood poisoning or conditions such as Hepatitis and HIV.(See also Precautions in this manual)

Training Tip: Where does IDU fit into your session on AIDS Education? Although not every section in this manual can be covered in each session, it is especially important to cover these issues when educating staff from hospitals, addiction treatment facilities, group homes, correctional facilities and halfway houses. There are workshops available to assist those working with Injection Drug Users. Ask your facilitator or call the AIDS – Sexual Health Infoline – 416-392-2437 or 1-800-668-2437.

SECTION 7:

BEHAVIOUR CHANGE

It has now been almost two decades since most of us became aware of HIV and AIDS. With no reliable vaccine or effective cure in sight, the only way to limit the spread of this virus is to assess our risks and change complex behaviours. As anyone knows who has tried to change behaviour, from smoking cessation to dieting, it is complicated and difficult. To complicate matters even further, sexual behaviour change involves negotiation with another individual. Once a new behaviour has been established, attention must also be directed at maintaining the change.

Early on in efforts to curb the spread of HIV/AIDS, many educational efforts focused on simply supplying information. However, recent studies have shown us that although it is important for people to know how HIV is transmitted and the possible consequences of infection, information about AIDS is not enough. Despite high levels of knowledge, regular condom use, for example, is still disturbingly low.

Understanding Why People Engage in Risky Sexual Behaviours

It is important to understand the reasons why people still engage in dangerous sexual practices that expose them to HIV infection. Behavioural and social scientists have developed and tested theoretical models to try and help us understand why people act the way they do. A better understanding of how people make decisions allows us to develop programs and interventions to try and affect behaviour.

There are different models of behaviour change that can help direct educational efforts aimed at affecting personal behaviour. Many of these interventions centre on promoting the idea that a certain set of protective behaviours work, that they are the norm in our society, and that everyone is doing it.

Understanding the principles of behaviour change, is essential to all aspects of health promotion. As we untangle what prompts people to make changes, we can better promote behaviours such as applying sunscreen, taking part in breast cancer screenings, as well as safer sex and needle use.

Behavour Change Theory – Stages of Change/Transtheoretical Model

The Stages of Change model originated in psychotherapy and smoking cessation research. This conceptual model describes health behaviour change as a gradual, continuous and dynamic process. According to the model, people do not move directly from old to new behaviours, but progress through a sequence of five discrete stages:

Pre-contemplative: Individuals in this stage have no intentions to change their behaviours. They are unaware of risk, deny the adverse outcome that could happen to them. Or are aware of the risk but have made a decision not to change behaviour.

Contemplative: Persons in this stage have formed intentions to change, but have no specific plans to change in the near future.

Ready for Action: Persons in this stage have plans to change their behaviour in the immediate future and may have taken some initial actions.

Action: Persons in this stage have begun changing their behaviours, but the behaviour change is relatively recent.

Maintenance: Persons have maintained consistent behaviour change for an extended period of time, the newly acquired behaviour has become a part of their lives.

The pace of movement through these stages may vary greatly. For example, some individuals may remain in the contemplative stage for months. Also, once a person initiates a behaviour change, that person is vulnerable to relapse at any time, and therefore may cycle back through the stages repeatedly.

The model has implications for both public health interventions and evaluation. In terms of intervention, the concept suggests that prevention interventions should be targeted to the stage of behavour change individuals are in, because factors that facilitate movements between early stages, are different from factors that facilitate movements through later stages.

TTM Principles:

1. **Clients are in different stages of readiness to change.**

2. **Interventions need to be matched to stages.**

3. **Change occurs in steps over time.**

4. **Spiral movement through stages.**

5. **Relapse can occur at any stage and is part of the process of change.**

STAGES OF CHANGE IN WHICH PARTICULAR PROCESSES OF CHANGE ARE EMPHAZISED.

Pre contemplation	**Consciousness raising** **Dramatic relief** **Environmental Re-evaluation**
Contemplation	**Self-reevaluation**
Preparation	**Self-liberation**
Action/Maintenance	**Reinforcement management** **Helping relationships** **Counter-conditioning** **Stimulus control**

STAGES OF CHANGE – TRANS THEORETICAL MODEL- INTERVENTIONS

Process	Definitions and Interventions
Consciousness raising	Increasing information about self and problem; Observations, confrontations, interpretations
Self-reevaluation	Assessing how one feels and thinks about oneself with respect to a problem; value clarification, imagery
Self-liberation	Choosing and commitment to act or belief in ability to change: decision-making therapy, New Year's resolutions
Counter-conditioning	Substituting alternatives for problem behavious: relaxation, desensitization, assertion, positive self-statements
Stimulus control	Avoiding or countering stimuli that elicit problem behaviours; restructuring one's environment, avoiding high risk cues
Reinforced Management	Rewarding one's self or being rewarded by others for making changes: self reward, contingency contract
Helping relationships	Being open and trusting about problems with someone who cares, therapeutic alliance, social support, self-help group
Dramatic relief	Experiencing and expressing feelings about one's problems and solutions: psychodrama, role playing
Environmental Reevaluation	Assessing how one's problem affects physical environment: empathy training, documentaries
Social Liberation	Increasing alternatives for non-problem behaviours available in society: advocating for rights of the oppressed, empowering, policy interventions

1. Practice: Stages of Change – "Stage Yourself"

Purpose:
The following exercise can be done with a group to determine at what stage people are in regarding a "new public health concern".

Instructions:
Trainer pretends to be the Federal Health Minister and gives a new "public health message" to the participants regarding a newly recognized risk of brain cancer from watching television. They are to eliminate television from their home to prevent this.

> Participants are asked to stage themselves according to how they would react to that message. They are asked to get up and go to the stage they are in with regard to removing the television from the home. (Put up signs with the different stages illustrated.)

Facilitator:
Process groups with the following questions:

> **Why did you put yourself in this stage?**
> Write responses on newsprint – relate to concepts of perceived risk, intentions, self efficacy, family/relationship influences, norms, etc.
>
> **Ask the following questions of the group:**
>
> How important is TV in your life today?
> How much TV do you presently watch?
> Who do you typically watch with?
> How important is TV to your family members, friends?
> How would this impact on your children?
>
> **What would it take to move you to the next stage?**
>
> What are the cues that tempt you to watch?
> What value do you get from watching?
> Could you get those needs met elsewhere?
> What are the pros and cons of watching?
> What if your family members, friends object?

What does this mean for the clients you see in your work?
What does this mean for you as a counselor?
Why doesn't "telling" work?

Risk Assessment/Staging
When educators are able to understand their own risk behaviours, they are better able to understand others' and develop interventions to move from one stage to another.

Staging is based on present and future risk – and on the client's perception of their risk behavours.

STAGES OF CHANGE AS APPLIED TO SEXUAL BEHAVIOURS

Sexual Behavioral Targets

- Postponing or avoiding sexual activity
- Mutually monogamous with uninfected partner – both are tested for HIV/STIs.
- Consistent and correct use of condoms/safer sex

Precontemplative:
Individuals in this stage have no intentions to change their sexual behaviours. They are unaware of risk or feel that the risk does not apply to them. They see no need to change their sexual behaviours.

Contemplative:
People in this stage often acknowledge a need to change, but have so specific plans to change in the near future. They often view the consequences of the change as very risky or undesirable, and so are ambivalent about making any changes in their sexual behaviours. They can be described as responding with a "yes, but" when discussions of their behaviour change occur.

Ready for Action:
People in this stage have plans to change their sexual behaviours in the immediate near future and have taken some initial steps towards change.

Action:
People in this stage have made some changes in their sexual behaviours, but the change is relatively recent.

Maintenance:
These people have maintained consistent behaviour change for an extended period of time; the newly acquired behaviour has become a part of their lives.

Relapse:
Relapse can occur at any stage when a person in unable to maintain the behaviour change that they have attempted.

Staging is a tool to understanding behaviour change. When the stage is identified, an intervention to assist in moving to the next stage can be implemented. Staging is client centered. It is not a value judgement.

HOW DOES HARM REDUCTION FIT INTO THE STAGES OF CHANGE APPROACH?

1. The stages of change " behaviour targets" represent risk elimination for the client.

2. Clients who are Precontemplative and Contemplative for the target behaviours are NOT doing them and NOT ready to do them.

3. There are options to reduce their risk even though they are not ready to move to risk elimination.

4. These risk reduction options are part of a Harm Reduction approach.

5. Harm Reduction options should be offered to PC and C clients if they are not ready to move towards one of the risk elimination behaviour targets.

The above information on **stages of change** is to assist those providing HIV/AIDS Education with an understanding of what is needed to prevent HIV infection in clients who may not be ready for the target behaviours.

Adapted from Rochester STD/HIV Risk Reduction Training Center, Monroe County, Department of Health, University of Rochester "Behavioral Counselling for STD/HIV Risk Reduction" March 1997

OTHER BEHAVIOUR CHANGE MODELS

INDIVIDUAL CENTRED MODELS

The **Health Belief Model** (Maiman & Becker, 1974) was one of the first models that attempted to identify factors, which affect behaviour. This model states that in order for people to change their behaviour, they must be made aware of the following things:

1. They are at risk for contracting the disease (e.g. Everyone is at risk for contracting HIV).

2. The consequences from contracting the disease are severe (e.g. HIV can lead to death).

3. The costs of engaging in the desired behaviour (e.g. using condoms) outweighs the costs of not engaging in the appropriate behaviour (e.g. If I do not use condoms I may get HIV). In addition to creating positive attitudes towards condom use, it is necessary to change negative attitudes that may prevent people from learning about HIV and AIDS. For example, homophobia and the belief that AIDS is a condition that affects homosexual people, may prevent some individuals from obtaining the information necessary to change their behaviour.

Though this model was originally used widely, studies have shown that many other variables also affect behaviour. For this reason, this model has limited application.

The Theory of Reasoned Action (TRA), (Fishbein and Azjen, 1975) suggests that there are two factors which determine whether an individual will engage in a certain behaviour.

1. Attitudes - how does one perceive the behaviour? ie., condom use;

2. Subjective Norms - what are the opinions of friends, parents and significant others regarding the value of the behaviour?

Attitudes and subjective norms lead to intentions and this, is the most reliable predictor of actual behaviour change. That is, individuals who report high intentions to change their behaviour are most likely to actually change their behavior.

Table 1: Theory of Reasoned Action

According to this model, an individual's intentions can only be affected by modifying their personal attitudes toward condom use and influencing their perception of normative behavior. According to the TRA, people that have positive attitudes towards condoms and believe that people who are important to them also use condoms will have stronger intentions to use condoms and hence be more likely to use condoms.

However, this may not always be the case. For example, despite good intentions to use condoms, people often fail to do so because they may feel like they lack the skills to obtain or properly use condoms or they may feel uncomfortable or unable to convince their partners that condom use is necessary.

That is why Azjen (1991) revised the TRA to form a new model called **The Theory of Planned Behaviour (TPB)**. This new model is identical to TRA, except that it proposes that a person's intentions are also affected by their Perceived Behavioural Control (PBC). Perceived behavioural control refers to an individual's perception of the ease or difficulty of performing the behaviour of interest.

Other beliefs that affect planned behavior change include:

- ease or difficulty in expressing personal values and beliefs
- ability to go to a store to purchase condoms
- perception that one is able to properly use a condom
- perception that one is able to initiate discussion of safer sex
- ability to say "no" to unsafe sexual suggestions

Table 2: Theory of Planned Behaviour

Newer studies on condom use have shown that, in addition to a person's attitudes towards condoms and their normative beliefs, one's perceived behaviour control, significantly influences their intentions and hence their likelihood to use condoms.

A Note on Eroticizing Condom Use

Some people complain that stopping to put on condoms breaks the romantic intimacy between two people. Some programs have been very successful in getting people to use condoms by talking about ways in which condoms can be eroticized and be made a fun part of having sex. There are a wide variety of condoms available (coloured, flavoured, ribbed, etc.) that can enhance your sex life. Having a partner put on the condom is another way to integrate condoms into your sex life. Can you think of other ways?

SOCIALLY-DRIVEN INTERVENTIONS

In spite of attempts to change individual behaviours to fight against the spread of HIV/AIDS, some social scientists believe "individualistic models" by themselves may not be enough to produce significant behaviour changes. They feel that it is equally important to examine the social groups, networks and subcultures that have an influence on the behaviour of individuals and on groups. For example, in drug subcultures, the sharing of needles often occurs in groups called shooting galleries. Researchers believe that this high risk behaviour is not so much a reflection of the personal characteristics of the individuals participating in them. Rather, it is largely driven by the pressures and social norms, already established in these groups.

Therefore, the aim of socially-driven interventions is not to directly affect individuals by enrolling them in risk reduction programs, but rather, try to modify the social structures which perpetuate these high risk behaviours.

Influencing social structures
There are four major theories for how to change subcultures. These are:

l) diffusion models;
2) leadership-focused approaches;
3) the social movement theory; and
4) models of changing the social environment.

1. Diffusion Theory

The Diffusion Theory tries to understand how an innovation or idea (e.g. condom use) is adopted into a particular culture. This theory suggests several important steps, which must be followed if a concept is to be integrated into a group:

1) It is necessary to understand the subculture sufficiently well to be able to reasonably predict whether an innovation will be accepted.
2) It is necessary to devise an innovation that will be acceptable to this group.
3) It is necessary to monitor this group's reactions to the innovation.
4) On the basis of the monitoring, it may be necessary to alter the innovation itself, or the way that it is presented.

2. Leadership-Focused Approaches

This type of approach is an extension of the diffusion theory with the exception that it relies on pre-existing group leaders within a subculture to promote the innovation. Leadership-focused models have been applied in a number of areas of health intervention. These have included interventions around coronary health, injection drug use and unsafe sexual behaviour among gay men.

3. Social Movement Theory

Cultures also change as a result of social movements on the part of their members. Examples of social movements include the civil rights movement in the United States, and women's and gay rights movements in several countries. Usually these movements are initiated by motivated individuals and leaders within the groups. However, interventions may be a helpful way of supporting or stimulating these efforts. Social movement is unlike the diffusion or leadership-focused approaches in that in most cases, these movements directly challenge public authorities and policies.

One of the first things to do is investigate whether people within the target group have already begun to mobilize around HIV/AIDS. If mobilization efforts have not been successful, the obstacles that are hindering these efforts must be addressed. Specific techniques for public health interventions by social movement organizations, include the publishing of newsletters and leaflets that provide health information, as well as other articles, which may attract readers and supporters to the movement.

The best example of a public health social movement was the mobilization that occurred in the gay and lesbian community to fight AIDS. When the threat of AIDS surfaced, many social networks, community institutions (e.g. newspapers), organizations, informal and formal meeting spots already existed.

Thus in many cities, groups formed to pressure the medical and public health establishments to commit substantial money for AIDS support. Moreover, groups formed to establish hospices for the sick, provide legal services as well as news about possible medications that were becoming available. Other groups held workshops to develop peer – led support and the promotion of condom use within the gay community. The effect of this community mobilization caused the rates of HIV in many gay communities to decrease considerably.

4. Environmental Changes

Where environments predispose people to behave in certain ways, efforts to change these environments are an essential part of public health initiatives. These interventions attempt to change public policies or social structures that make change difficult. The HIV pandemic has raised many controversial policy issues, including the distribution of condoms in schools, the content of AIDS education in the classroom and needle exchange programs. Social structure issues are also important to the HIV issue. Studies have shown that racial stratification affects the extent to which people engage in injection drug use. Sexual stratification in the economy, politics and everyday life also means that women are less able to protect themselves by insisting on condom use. Moreover, sexual stratification and the stigmatization of homosexuality, prevents the targeting of men who have sex with men but still consider themselves to be heterosexual. Efforts to change social structures have to take into account the ways in which they are institutionalized and think of way to defeat or neutralize opponents of change.

CONCLUSION:

Much progress has been made in understanding just how complex is the subject of behaviour change. Theoretical health models that have focused on individuals have been important for producing desired health behaviours in some populations. However, the importance of socially driven interventions, policy, and structural changes cannot be neglected. An appreciation of these factors and an awareness of how these variables are related will maximize our efforts to prevent the further spread of HIV.

RESOURCES:

Azjen, I. (1991) The theory of planned behavior. Organizational Behavior and Human Decision Processes, 50, 179-211.

Fisbein, M., & Azjen, I. (1975). Belief, attitude, intention, and behaviour: An introduction to theory and research. Reading, MA: Addison-Wesley.

Maiman, L.A., & Becker, M.H. (1974). The health belief model: Origins and correlates in psychological theory. Health Education Monographs, 2, 336-353.

DiClemente, R.J. & Peterson J.L. (1994). Preventing AIDS; Theories of Behavioral Interventions. New York: Plenum Press.

Rogers, E.M. (1982) Diffusion of innovations. Third edition. New York: The Free Press.

Kelly, J.A., St. Lawrence, J.S. Diaz, Y.E., Stevenson, L.Y. Hauth, A.C., Brasfield, T.L., Kalichman, S.C., Smith, J.E., & Andrew, M.E. (1991). HIV risk reduction behaviour following intervention with key opinion leaders of population: An experimental analysis. American Journal of Public Health, 81, 168-171.

SECTION 8:

THE IMPACT OF HIV/AIDS ON SOCIETY

HIV/AIDS can affect all aspects of an individual's life. Living with HIV/AIDS often means coping with changes - psychological, physical, emotional, social and financial. A person's support system - family, friends and caregivers are also affected by these changes.

This section of the manual will increase your awareness of the immense challenges encountered by people with HIV and the implications for health care professionals. This section also includes exercises that you can use in designing your lesson on the impact of HIV infection.

> **NOTE TO TRAINER:** Assume that someone in your organization is HIV positive or is close to someone who has HIV/AIDS. It is important to be sensitive to this when you use these exercises. You may be discussing issues that someone is currently struggling with. You must also be prepared for the fact that someone may disclose personal information. Some strategies are included to help you deal with this.

SPEAKER OR VIDEOTAPE (45 min.-1 hour)

PURPOSE:
To give the learners an opportunity to enhance their understanding about challenges facing people with HIV/AIDS infection.

MATERIALS:

- VCR and TV (if showing a video)

NOTE TO TRAINER: The ideal approach is to invite a speaker from a recognized organization who is HIV positive. This experience helps break stereotypes individuals may have about people with HIV/AIDS. Be sensitive to the speaker's needs when you are booking. What time of day does he/she prefer? Is there a fee or is transportation required? Can you make a donation to the speaker's organization? The difficulty with inviting a speaker is that due to the unpredictability of this illness, people may not be able to guarantee that he/she will be well enough to attend the session. So always have a backup plan.

People in the group often have strong emotions towards People who have HIV or AIDS. It is the job of the trainer to:

1. Prepare the speaker
2. Intervene to support the speaker as necessary

Further, treat any speaker with consideration and respect. Offer refreshments and comfortable seating.

METHOD:

You may choose to show a video as an alternative or as a backup to a speaker.
Once you have shown the video or the speaker has presented and answered questions, have the group participate in small and then large group discussions.

SMALL GROUP DISCUSSION (15 min.)

1. What feelings did you experience?
2. What issues affected you the most?
3. What are your concerns about meeting the emotional needs of a person with HIV/AIDS that you care for/work with?
4. What are your concerns about meeting emotional needs, in caring for/working with people with HIV/AIDS?

LARGE GROUP DISCUSSION (20 min.)

Depending on your target group, focus your questions for discussion on the specific concerns of your group. For example, health care professionals may be concerned with caregiving.

1. Who do you think would benefit from this video/hearing a speaker? Facilitator can discuss other video options.

2. What might your goals be in using this video/inviting a speaker?

3. What methods could you use to help a group to explore their feelings about the video/speaker?

4. What strategies are available for your learners to help them in their work with HIV infected people?

STRATEGIES FOR DEALING WITH FEELINGS THAT EMERGE FROM DISCUSSIONS

As the group examines the impact of HIV/AIDS on society, people may express a variety of emotions:

- Helplessness
- Anger
- Frustration
- Fear
- Sadness

As the trainer, you should discuss the emotions that may be generated by a discussion of the impact of HIV/AIDS on society. Lead a group discussion on how to handle these feelings on an individual, interpersonal and societal level.

Also encourage the group to examine what they can do to help someone who is dealing with a chronic illness.

Check the resources in your community – The Blue Book is a Directory of Community Services in Toronto – Published by Community Information Toronto

Community Helpline: 211

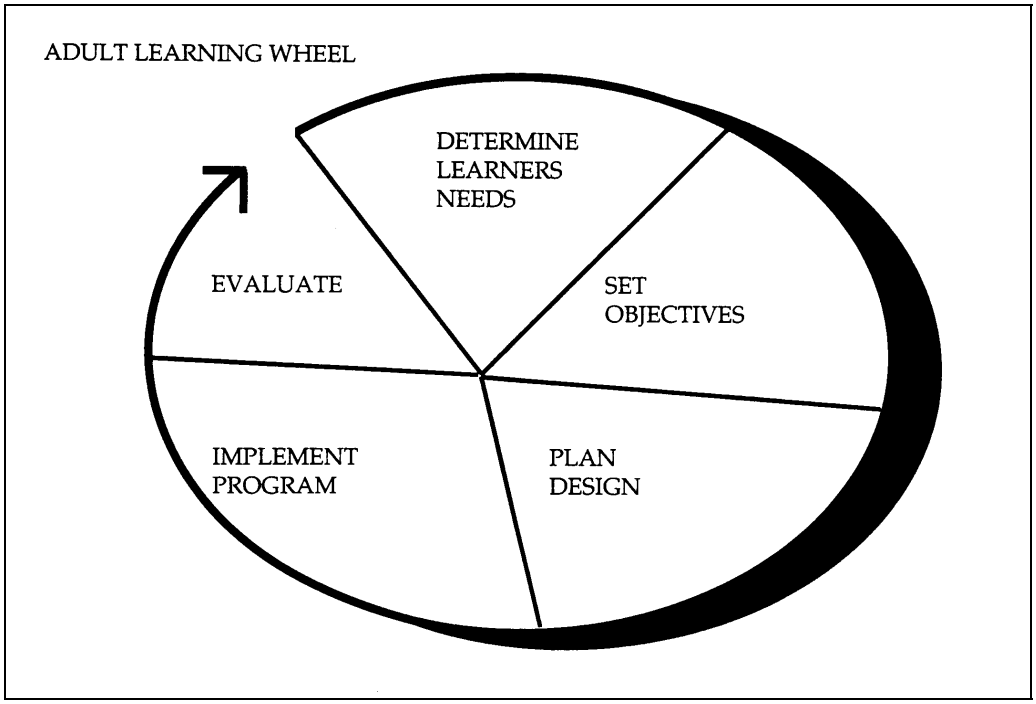
THE LIVING GUIDE – SERVICES FOR PEOPLE IN THE TORONTO AREA LIVING WITH HIV OR AIDS – THE AIDS COMMITTEE OF TORONTO – Call 416-340-2437

SECTION 9:
PLANNING HIV/AIDS EDUCATION PROGRAMS

This section is designed to help you plan an effective HIV/AIDS teaching session. It provides you with factors to consider and ways to incorporate principles of adult learning into your design.

This section also includes useful forms for developing an HIV/AIDS program; and forms for use in the program, and subsequent evaluations.,

When planning any program it is important to do the following:



I. Set Objectives

Be clear about the goals and objectives for the program. While you may discuss many aspects of HIV/AIDS during the session, if you are clear about your goals then you will be better able to guide the group.

Consider the Learners' Needs.

Just as you plan to teach the session with particular goals, the learners will also have specific needs and concerns that must be addressed. If these concerns are considered, the learners will feel that they have had their needs attended to and they will be more receptive to new information.

You can address the learners' needs in three ways:

1. Have participants complete a needs assessment prior to the program. Incorporate their responses when planning your session. (see Sample Needs Assessment) .

2. If the request for an education program came from a specific incident, find out as much as possible about this situation.

3. Question box.

II. Plan the Design and Implement the Program

When designing and implementing the program, utilize what is already known about adult learners:

Use a variety of teaching methods to appeal to the different learning styles.

- Adults come with a lot of past experience.
- Adults need to feel safe.
- Adults are nervous about being tested or evaluated.
- Adults prefer material that is relevant to their lives.

III. Evaluate the Program

Demystifying Evaluation

Why evaluate? Evaluate to predict and measure program results, and help determine why they occurred. If you know which teaching strategies or activities work well and which don't, you can gain important insights into improving your work.

Often people resist evaluation. Consider evaluation as one part of program planning that isn't tacked onto the end, rather considered throughout the cyclical process. Indeed, evaluation should be one of the first things you consider in program planning. When you determine your needs through a pretest or survey, this is evaluation. When you set your objectives and ask yourself if they are measurable, this is evaluation. When you alter your program based on feedback, this is evaluation. When you use the results of your program to argue for more training or education, this too is evaluation.

Although there are many barriers to conducting formal evaluation projects, you can use evaluation tools to assess and improve the work you do.

To improve future sessions and to give the learners the opportunity to give you feedback about the session, provide them with an evaluation form at the end of the session (see Sample Evaluation Form).

For a further discussion on types of evaluation, please see the Appendix.

EVALUATION

TRAIN THE TRAINER WORKSHOP

1. How did you hear of the workshop?

3. After attending the workshop I feel:

4. To teach others about HIV/AIDS I feel I need more guidance in the following areas:

5. Please rate the specific components of the workshop on a scale of 1-10: 1 = least valuable 10 = most valuable

   a) Ice Breaker and Warm Up
      1 5 10

   b) Basic HIV/AIDS information & discussion
      1 5 10

   c) Attitudes and Values – information & discussion
      1 5 10

   d) Human Sexuality information & discussion
      1 5 10

   e) Homophobia information & discussion
      1 5 10

   f) Microteach (preparation & presentation)
      1 5 10

   g) Behaviour Change information & discussion
      1 5 10

   h) PHA Speaker
      1 5 10

6. What I learned most and why:

7. What I found most difficult and why:

8. Three things I would like to tell the presenters:

TIPS FOR RESPONDING TO QUESTIONS

It is important that people who use this manual stay current on HIV/AIDS issues. Whenever questions arise for which you have no information or when new facts are reported in the media, information should be sought from an authoritative source such as the AIDS and Sexual Health InfoLine at (416) 392-2437. HIV/AIDS is very complex and misinformation can pose serious problems.

Before an educational session:

Scan the newspapers, TV and magazines to see what's new or in the news - inevitably someone will ask a question about the headline they read in the paper that morning. Be prepared to respond.

During an educational session:

- Allow time for the audience to collect their thoughts and overcome inertia.
- While waiting for questions, pose one yourself, or answer one that could be asked.
- Give credit to the questioner: "Your question brings up a good point" or "Good question."
- Keep your answers brief to allow more people to participate and maintain a lively pace.
- Do not put down the questioner. If you answered the question previously, elaborate on your answer or word it another way.
- Allow for some disagreement with points made in your talk. Do not engage in a debate with the questioner. Restate your answer and move on to the next question.
- Remain in control of the questions. Allow one question per person. Do not allow speechmaking. Interrupt the speaker if necessary and ask for the question.
- If a questioner is hostile, maintain a friendly attitude and try to rephrase the question so it is problem-oriented. The audience's sympathies will be with you as long as you do not become defensive.
- What do you do if someone is monopolizing the conversation? Thank the person for their input and state " we have to move on and give others an opportunity to speak." If the person persists say you would be pleased to continue this discussion at the break. If the person perseveres, ask the group if they want to continue along that topic or move on?

- If you do not know the answer, there are several options, depending on the nature of the question. Possibilities include:

  "We expect to have that information shortly. May I send it to you?"

  "I don't have that information. May I send it to you?"

  "That question has never come up before, but it is interesting. Does anyone have any thoughts about that?"

  "I don't know. Try calling AIDS and Sexual Health InfoLine at (416) 392-2437"

  Make a note of the questions that are asked. They will provide important feedback to your presentation.

Things you can do to prepare yourself for presentations are:

- get a co-worker or family member to ask you questions;
- find a current newspaper article, and see if you can explain its implications;
- sit in on colleague's session;
- do a dry run with some supportive peers and get their feedback.

USING PARTICIPATORY EXERCISES

INTRODUCING AN EXERCISE:

- Never lead an exercise cold. Always practice with a large group of peers to iron out any wrinkles and to avoid surprises. You may find a crucial piece was left out or the instructions are too confusing. Alternatively, you may feel uncomfortable facilitating a particular exercise. Find this out during a trial run and if necessary find one you're more comfortable with.

- Allow participants the option of participating or not - no one wants to feel coerced. Don't pressure people to tell how they feel.

- Tell participants that all responses to the exercise are confidential. People can relate the impact of the exercise without revealing anyone's identity. If you hand out paper, make sure it's all the same colour and size so people can remain unknown.

- Give crystal clear instructions. "This is what you'll do, this is where you'll go and this is how we'll debrief at the end". Some adult learners need to know the entire process before they can comfortably participate in a task.

PROCESSING:

- Participants may convene to small groups to discuss impact.
- Discuss responses with participants in the large group, focusing on strategies and what to do with the emotions.
- Acknowledge input by recording thoughts and feelings on flipcharts and discussing strategic possibilities.

DEBRIEFING

- Review the purpose of the exercise.
- Sum up people's experiences.
- Thank people for their participation.
- Discuss how the exercise can be used or modified in other situations.
- Whenever possible be flexible, confident and maintain a high energy level.

HOW TO INTRODUCE A VIDEO

- Check the equipment to make sure it works. Do you need an extension cord?

- Preview your video prior to an educational session. Jot down key points to highlight when introducing the video.

- Ask participants to jot down discussion points during the video.

- Update and clarify anything new or confusing. Be sure to provide the Canadian context (ie. stats, programs etc...).

- Ask open ended questions like "What did you think?"

- Elicit reactions both negative and positive - you may do this on paper if the group is shy.

- Experiment with video clips - this is a very effective way to make a point in a short period of time. Also it's rare to find a video that completely meets your needs - using clips is a good way to extract the best piece for your target group.

- After the session, make a note of how the video went and the response. Indicate what you would change next time, if anything.

DEALING WITH GROUP EMOTIONS

LAUGHTER

When you are teaching about sexuality, for example, you will often get a lot of laughter from the group.

Ridicule- A negative type of laughter that is not helpful and is derogatory. For instance: a joke about homosexuality or racial or ethnic minorities. It is important to state that these types of jokes are not acceptable during the session. Stress a non-judgemental approach in your educational sessions.

Anxiety- People may feel uncomfortable discussing something such as sexual body parts or sexual activities and may respond by laughing. This is healthy and positive. As you continue with the session people will become more comfortable.

Creative- A releasing type of laughter when people are coming up with new ideas. For example, this may occur when people are thinking of ways to increase condom use. This laughter can be invigorating and can stimulate great ideas.

ANGER

Anger is a common defense mechanism that may surface when we feel threatened. It can reduce anxiety and momentarily increase a feeling of power. Hostility is used to safeguard vulnerability.

HIV/AIDS education involves providing factual information, and challenges us to examine our feelings about sexuality and death.

Discussing these sensitive issues may make some group members feel powerless. Strongly rooted attitudes and values about sex may be challenged in an HIV/AIDS education session. Opening a group to vulnerable areas may make them feel discomfort, anxiety and possibly overt anger.

Five Ways to Recognize Hostility in Your Group: Learners may express hostility by:

I. Verbal Retaliation

- rudeness
- criticism
- insults
- sarcasm
- repetitive complaining
- put downs

2. Withdrawal

3. Passive-Aggressive Behaviour

- being late
- cancelled appointments

4. Body Expressions

- headaches

5. Projection

- anger directed to other issues

Reducing Anger...Decreasing Anxiety

- Attitude - be non-judgemental
- Reflection - useful verbal technique for defusing anger
- Validation - acknowledge group member's feelings
- Soft Voice - decreases anxiety

- Limit Setting - at the beginning of the session, clearly define:
  - guidelines/objectives
  - format
  - length of session

- Clarification - clarify feelings and reactions

- Self Disclosure - give examples of similar experiences and how you dealt with the problem

- Humour/Wit - when appropriate

From Pat Finnegan & Mary Anne MacRae, Mental Health Nurses, City of Toronto, Department of Public Health

DESPAIR

The impact of HIV/AIDS affects people differently. For some, grief and loss can be overwhelming. Others feel powerless by the enormous toll that HIV has had globally. It is helpful to have people focus on the small steps that they can take individually to make a difference.

WEARING THE RED RIBBON

This concept, designed by the New York City organization, Visual Aids, was first introduced at the l99l Tony Awards. The entertainment community, along with others, has embraced this symbol to remind all of us of the ongoing battle against AIDS.

But wearing a ribbon is simply not enough. So we ask each of you to consider how you can become involved in winning the battle...through time, talent, or financial resources.

"MICROTEACH" EXERCISE FOR TRAINERS

PURPOSE:

This exercise is designed to give participants an opportunity to experience teaching strategies grounded in adult learning principles; to practice presenting segments of the content relevant to HIV infection; and to practice giving and receiving feedback. In order to accomplish these goals, the micro-teach format was selected. We also want to have an opportunity to test teaching strategies unfamiliar to you and to establish a learning climate. Therefore the first couple of minutes of your presentation will be spent establishing a learning environment.

Additional goals for this exercise are to provide participants with an opportunity to:

- Implement principles of adult learning and group facilitation in conducting a presentation.
- Describe your climate setting strategy, which allowed for participant diversity and exploration of perceptions related to HIV infection.
- Demonstrate your role and responsibilities as the group facilitator during the presentation. Consider your interaction with problem learners; accurate responses to questions; comfort with subject matter; sensitivity to the group's emotions.
- Present value laden information in a clear and concise manner.

Each presentation will take 10 minutes. This does not include the time required to set up your presentation.

TIME: 1 hour for planning – 20 MINUTES FOR PRESENTION

METHOD:

List potential topics and target groups on the flipchart. Ask participants to select a topic and target of interest. Have individuals break into smaller groups of 4-5 participants.

The task for each group will be to:

1. Fill out the Microteach Format form

2. Prepare the presentation

3. Put your audience in role. For example, if your presentation is targeted to street youth, have the large group act as though they are street youth.

4. Clearly state your objectives.

5. Share your presentation with the large group.

> **NOTE TO TRAINER:** The rest of the group will be the audience and the evaluators.

The large group's task is to examine the interaction between the facilitator and the audience in role, as well as the process and the accuracy of the content. When commenting on a group's presentation, make sure that your feedback is constructive and takes into account the positive aspects of the work presented. See Presentation Feedback Form.

PRESENTATION FEEDBACK FORM

Write a word in each section of the grid below that expresses your feelings about (1) the presentation, (2) the organization of the presentation, (3) the speaker and (4) your learning experience:

Presentation.....	Presentation Organization...
Speakers.....	Learning Experience....

What did you find helpful?

What do you think could have been done better?

Remember the Cardinal rule of constructive feedback is to provide two positive comments for each critical comment.

FACILITATOR CHECK LIST

The following may be used to assess/evaluate your presentations, and your effectiveness as a facilitator.

Points 1-11 concern the question: What techniques did the facilitator utilize/not utilize to move the group toward objective?

The facilitator:

1. Helped move group toward objective.
2. Motivated group actions and activities.
3. Attended to group tasks i.e. building the group interaction.
4. When appropriate, initiated behaviours i.e. put forth ideas and questions, which assisted in increasing the group's understanding.
5. Questions followed a logical sequence i.e. simple to complex; concrete to abstract.
6. Kept the group activities on time.
7. Brought closure to the discussion: emotional and conceptual closure.
8. Gave clear directions to the group.
9. Utilized some mechanism to collect data i.e. flip chart, overhead.
10 Attended to process needs, i.e. bringing in the quiet member.
11. Made effective transitions.
    a. between ideas within the presentation
    b. between learner participation activities and instructor presentations

Points 12-15 concern the question: How did the facilitator include/not include participants in the discussion?

The facilitator:

12. During discussion remained neutral or acknowledged changing roles from facilitator to member facilitator.
13. Assessed the group's chemistry i.e. noted persons with influence, similarities and differences, demeanour, degree of support.
14. Kept the group involved in the discussion i.e. allowed individuals to state their points of view, express feelings, move towards a sense of resolution.

15. When appropriate, the trainer can successfully handle problematic behaviour by:

- confrontation
- seeking group assistance in addressing the behaviour
- using non-verbal behaviour
- reinforcing acceptable behaviour

For the purpose of this manual, problematic behaviours are those which interfere with the goals and the objectives of the workshop. For example, due to religious or cultural beliefs, some people may object to the sexually explicit content of the workshop. However, to be effective, HIV/AIDS education must not be diluted to an extent that the information is unclear, but it cannot be so explicit that people can't hear the message due to extreme embarrassment, shock or discomfort.

Points l6-20 concern the question: How did the facilitator incorporate the adult learning principles into the presentation?

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

Points 22-30 concern the question: What presentation techniques/skills did the facilitator incorporate into the presentation?

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

Points 28-31 concern the question: How well did the facilitator address the information related to HIV/AIDS?

28. Provided accurate content related to the HIV infection process.
29. Addressed the requested content.
30. Adequately addressed questions and concerns raised by the audience.
31. Had adequate data to support the presentation.

- Adapted from the Xerox Corporation Facilitator Checklist.

TRAIN THE TRAINER MICROTEACH FORM

- **Overview/set-up** **5 mins.**
- **Teaching segment (timed)** **10 mins.**
- **Discussion** **10 mins.**

TOPIC _____

NEEDS ASSESSMENT _____

List 3 objectives: i) _____

ii) _____

iii)_____

Design/Implication Discussion

Evaluation Ideas

Presenters (List names)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

HIV/AIDS WORKSHOP CHECKLIST

WORKSHOP: _____

DATE: _____

	DATE COMPLETED	NOT NEEDED	COMMENTS
Room Reserved			
Needs Assessments Sent Out			
Needs Assessments Returned			
Speaker Arranged			
Handouts Printed			
Packages Compiled			
Agenda Prepared			
Name Tags			
Flipchart Stand & Paper			
Markers, Tape			
Refreshments			

SAMPLE NEEDS ASSESSMENT
HIV/AIDS EDUCATION SESSION

Please answer the following questions so we can try to plan an HIV/AIDS educational program geared to your needs.

1. What area do you work in and what do you do?

2. How has HIV/AIDS had an impact on your work or personal life?
   Please be specific if you can.

3. What HIV/AIDS education have you had to date? (informal or formal)

4. Three things I want to get out of this HIV/AIDS education session are...

5. The worst thing that could happen in this session is...

Comments:

SAMPLE EVALUATION
HIV/AIDS EDUCATION SESSION

1. After this session I feel I know how to protect myself from the HIV/AIDS virus.

   _____ strongly agree
   _____ agree
   _____ disagree
   _____ strongly disagree

2. What I liked most about this session was...

3. What I like least about this session was...

4. I would like more information about...

5. One thing I would like to tell the presenter is...

SECTION 10:
CANADA'S GROWING DIVERSITY

Canada's racial and ethnic makeup is continually changing.
According to the most recent Canadian consensus:

- over one million Canadians reported being of Aboriginal ancestry
- in 1998, there were 1.6 million people of visible minorities in Canada
- Ontario is home to almost half of the total population of people who identify themselves as visible minorities

Canada is becoming an increasingly diverse, multi-racial, multicultural and multilingual country. To be effective HIV/AIDS educators, we must respond effectively to the growing diversity of people in our communities and plan our educational outreach accordingly.

PROGRAM BIAS ASSESSMENT

We need to ensure that HIV/AIDS education services are accessible and appropriate for racial and ethnic minorities. Each program should be thoroughly assessed for cultural biases and mainstream cultural norms that may exclude minorities. The following are some key concepts to help you accomplish this assessment process:

- Ask yourself whether your educational materials such as posters, brochures and videos are culturally diverse and are available in an understandable language that is sensitive to the values of your audience.

- Analyze the mainstream values and assumptions that are inherent in your program, BUT OTHERS MAY FIND CHALLENGING.

- Determine whether the program is being offered at a time or a location that excludes racial or ethnic minorities?

- As an educator, try to familiarize yourself with the terms, values, traditions and belief systems of your targeted community. Be sensitive to the religious beliefs, traditions and attitudes of your audience. Consult with various resources in the development of your presentation, including cultural and racial community organizations.

- You may also need to ask yourself "Is there someone from the racial/cultural group I am addressing who might be more suitable as the educator than me, or who could be an additional presenter"?

INTERCULTURAL COMMUNICATION

As an HIV/AIDS educator you need to be an effective intercultural communicator. The following are some key points for effective intercultural communication:

1. **Be empathetic**. Put yourself in someone else's position. If a participant says he or she is afraid of someone with HIV/AIDS, express your understanding of the fear of the disease, but deal with the misunderstanding of the routes of transmission.

2. **Be non-judgemental**. Encourage people to express their concerns, including attitudes towards homosexuality. Some people may not be accepting of homosexual behaviour. This does not mean that you cannot challenge values or ideas that people have. Just use a positive approach and ask why the participant feels this way. Follow his or her logic and try to get the individual to examine his/her value. Relate gay oppression to the prejudice experienced by ethno-racial minorities.

3. **Avoid cultural stereotyping**. Every individual combines the general characteristics and tendencies of their culture with their own perceptions, values, attitudes, stereotypes and prejudices. Do not over generalize. Although there is a tendency for Chinese culture traditionally to be conservative around the discussion of sex, this does not mean you cannot have a condom demonstration. Let participants decide by their reaction.

4. **Encourage participation**. Intercultural communication requires a two way flow of communication. Avoid having your participants play a passive role by asking open-ended questions. Invite people to state their concerns about HIV/AIDS?

5. **Listen to others.** Let people define their needs and in response, find ways to handle their concerns. Paraphrase and reflect on the ideas and suggestions that your participants have brought up. If your are discussing basic HIV/AIDS information, but participants are more concerned about how someone with HIV/AIDS feels, follow their lead.

6. **Be flexible**. Each educational session is unique. Be ready to deal effectively with different ideas and situations. For example, the response of your participants may help you to decide the explicitness of your discussion around sex.

7. **Personalize your knowledge and perceptions**. When you talk about your own feelings, ideas and experiences, people will identify. This will help them to identify and express their own concerns. For example, "I too was afraid until I learned about how to protect myself from HIV infection".

PICKING THE RIGHT WORDS

The terms you choose to use in reference to race and ethnicity can have very powerful effects.

Appropriate terminology, is viewed by some people, as an important indicator of respect for, and belief in, the dignity and worth of individuals and groups. Even unintentional slights are noticed and may be interpreted as an indication of insensitivity, disrespect or even hostility towards those not in the mainstream.

Some of the more important preferred terms are listed in the box below. Note that not all members of the groups involved will necessarily be offended by the non-recommended words, nor will all agree with those words that are recommended. Nevertheless, this list does reflect current "best practice" and none of the listed terminology should offend.

USE	INSTEAD OF...
• people of colour • Black people, Afro-Canadians • Asians • South Asians • Aboriginal people, Inuit people First Nations • Jewish people, Jews • ethnic or cultural minorities • mainstream	• non-whites, coloured • coloured, Negroes • Orientals • East Indians • Indians, natives, Eskimo • Hebrews, Israelis • multicultural people, ethnics • normal

Confused? Don't panic. With a little thought and increased familiarity with the community you are serving, the language issue becomes a little more manageable. Some of the basic principles are easy:

Don't be afraid to ask co-workers, clients or social contacts how they want to be addressed. This is the surest way to learn what term or phrase is appropriate.

Use inclusive language ("us", "Canadians" and avoid words or labels which exclude people ("them", "those people").

Choose non-technical terms ("Asians") over clinical or quasi-scientific terms, which may be obsolete ("Mongoloid race").

Learn and employ polite or inoffensive terms preferred by the listener.

- Use words, which identify group similarities, ("people of colour") as opposed to those, which are based on differences ("non-whites").
- Avoid paternalistic phrases ("our Chinese community") and round-about terms ("of the Jewish persuasion")
- Avoid demeaning language ("Paki", "Pollack") and always use neutral terms, which respect dignity ("Pakastanian", "of Polish heritage").

HANDLING CONFLICTS AND MISUNDERSTANDINGS

Despite all the preparatory work you have done, the wide variety of unique experiences that each individual brings to a session creates the potential for misunderstandings and even conflict.

When inter-group conflicts arise, be prepared to distinguish between what is simply a misunderstanding and what is prejudicial. Misunderstandings are clarified by providing individuals with insights that broaden their awareness. This is very different from prejudice that is often malicious and unfounded. Challenge prejudices by stimulating some discussion about the issue within the group. An alternate approach is to provide individuals with scenarios that help depict different points of view.

Misunderstandings whether they are based on linguistic, racial or cultural differences are also common and can be damaging. For example, a male staff member may take the hand of an Asian woman with the intent of showing his concern for her comfort or well being. In some communities however, touching strangers (even handshakes) is considered an unacceptable liberty. This is a case of a cultural misunderstanding.

Always interact with your participants in a fashion that is comfortable to them. Listen and watch closely for non-verbal indicators of stress, discomfort or confusion. If you feel that you have made someone feel uncomfortable, acknowledge it by providing an appropriate apology.

HIV AND OTHER OPPRESSION: BEYOND HOMOPHOBIA

The discrimination felt by people living with HIV/AIDS goes beyond homophobia and heterosexism. Other pervasive forms of oppression like racism, sexism, ableism, classism, etc. have impact upon people infected and affected by this disease.

It is important for people to be able to name the multiple sources of their oppression in order for them to make sense of their world. Oppression occurs when one group believes that an idea, person or their group is superior to another. It is the result of discrimination. Discrimination is defined as:

> the denial of equal treatment, civil liberties, and opportunity - the unequal treatment of people or groups usually resulting in subordination and deprivation of political, social and economic rights with respect to education, accommodation, health care, employment, and access to goods, services and facilities. Discrimination may occur on the basis of race, nationality, gender (ed: sexual orientation), religion, political affiliation, ethnicity, age, marital or family status, physical development or mental handicap.
>
> Toronto Mayor's Committee on Community and Race Relations, 1994, Race Relations: Myths and Facts, p. 17

HIV/AIDS educators need to acknowledge that we can and do oppress others. We need to reflect upon our own attitudes and values towards those in our community who are poor, differently abled, women, lesbian, gay, bisexual, prostitutes, drug users, youth of a differing racial or ethnic group, and those with different religious beliefs. We all have work to do in eradicating those attitudes and values that discriminate and disempower many members of our community.

These oppressive attitudes and values influence our response to HIV/AIDS. For example, if we hold a negative attitude towards a specific group of people, we may elect to spend less money on HIV/AIDS education and support services for that group. Another example is the way in which certain groups are mistakenly blamed for bringing HIV to our community. This destructive misconception of "risk group" as opposed to "risk behaviour" is harmful in at least two ways. It disempowers the oppressed group, and creates a risk environment for HIV within this group. It encourages a false sense of security in the oppressor who believes that they are not at risk for HIV because they do not belong to a risk group.

HIV/AIDS educators must struggle to eliminate such attitudes and values that facilitate the unjust and false blaming and ostracizing of those who are infected with HIV. It is difficult to confront our prejudices because it means that we must accept the fact that we oppress others.

"The Tree of Oppression" is one exercise that many HIV/AIDS educators have found useful for personal growth, and as a learning tool for various audiences.

THE TREE OF OPPRESSION

The purpose of this exercise is to help people make links between various kinds of oppression. In this exercise, it is assumed that all oppression shares the following characteristics:

1. They are all part of the overall structure of domination at the personal, societal and institutional levels.

2. People use stereotypes of the oppressed group to justify continuing the oppression.

3. There is a cycle of socialization about this oppression. Whether we are a member of an oppressed group or not, we are socialized to accept the existing beliefs about that group.

4. Oppression continues because of our cooperation in its continuation; by not paying attention, confronting it or considering it important.

By understanding the similarities between the different types of oppression, people may be able to reflect upon personal situations of discrimination and empathize with other types of oppression that they have not experienced.

How to use this model:

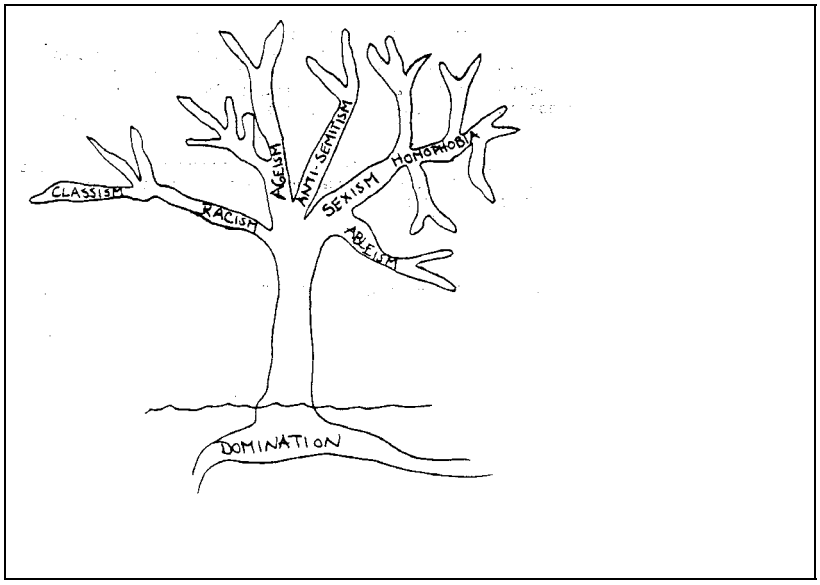
Draw a tree with a trunk, branches and roots. With the help of participants, label the parts of the tree as follows:

Branches =	the different types of discrimination/oppression that people experience eg. heterosexism, sexism, classism, racism, etc
Roots =	power and domination
Soil =	fear and ignorance
Fruit =	pain and violence

The different oppressions are distinct, as reflected by their positions on different branches, yet they are fed by the same soil, share common roots, and result in similar outcomes. This model may not be ideal. It has been criticized for being too simplistic, for neglecting the many important ways in which the oppressions are distinct. For example, gays and lesbians do not experience oppression in the same way that racial minorities do. A person experiencing discrimination because of their skin colour can always find support from their friends or family who share the experience. This is not the case for a gay man or lesbian because they may be invisible, or because their friends and family do not share their experience.

It is not the intent of this model to encourage debate about which oppression is worse than another. The image of a tree was chosen to discourage oppression from being represented in a hierarchical manner. The tree is an attempt to visually model a very complex and interdependent concept. It is an attempt to represent oppression as equal yet diverse, having common ground and specificity.

Once planted in a person's consciousness, it is difficult to uproot the tree of oppression. It becomes a powerful and lingering image for further reflection on both the conscious and unconscious levels.



The Tree of Oppression was developed by Jonathen Hanft 8 1990. May be used without permission.

TIP: Another way to integrate the isms surrounding HIV/AIDS education is to have a panel of presenters who can analyze the first hand effects of race, gender, age, sexual orientations etc... on their experience of living with HIV or working on issues HIV issues.

RESOURCES

HIV/AIDS, Words and Meanings. HIV/AIDS Committee of Toronto, 1990.

The Black Woman's Health Book - Speaking Ourselves. White, C. Evelyn, Editor, Seattle; Seal Press, 1990.

Community-Based Programs for a Multicultural Society: A Guidebook for Service Providers. Planned Parenthood, Manitoba, Winnipeg, 1993.

Community Action Pack. Health and Welfare Canada, Community Health Division, Ottawa.

Creating a Cultural Dialogue: HIV/AIDS Education in the Multicultural Community. St. Stephen's Community House, Toronto, 1990.

Aboriginal HIV/AIDS Resource Directory. National HIV/AIDS Clearinghouse, Washington, D.C.

HIV/AIDS: Sharing our Cultural Experiences and Strategies. HIV/AIDS Cultural Network, Toronto.

Responding to Diversity: A Manual for Working on HIV/AIDS Issues with Racially and Ethnically Diverse Communities. Canadian Public Health Association, 1993.

SECTION 11

APPENDIX I: COMMON QUESTIONS AND ANSWERS

The following section is a basic primer on HIV/AIDS. It is written in a simple, clear, non-technical fashion that is easy to read and understand. HIV/AIDS is a difficult enough subject to digest without the added complexity of medical and scientific jargon.

When people begin to do HIV/AIDS education, they often feel that they must know all about the virus, treatment, symptoms and drug protocols. **However, you don't need to be a medical expert to do basic HIV/AIDS education.** Rather, it is important to know the resources that are available to answer questions and to be able to refer people to these sources appropriately. Your understanding of this condition can be improved by speaking to health care professionals, telephoning information hotlines or visiting libraries and resource centres.

When first teaching people about HIV/AIDS, you need to provide basic and essential information. The following HIV/AIDS primer includes enough detail to translate into a teaching session.

HIV/AIDS has been one of the most closely monitored conditions in history. Our understanding of this illness has improved significantly since the beginning of the HIV/AIDS pandemic in the early 1980s. Despite extensive education campaigns, the same questions tend to be asked over and over again. Here are some questions and answers that have been prepared to help you address some of these concerns.

What is HIV/AIDS?

HIV is the virus that is believed to cause AIDS. Once inside blood, HIV weakens the immune system, the body's natural protection against disease. Eventually, over time, the body becomes susceptible to diseases and opportunistic infections, that healthy and uninfected individuals are able to fight off. An opportunistic infection is defined as a serious infection, which takes advantage of the "opportunity" presented by a weakened immune system. Such infections can cause death. AIDS is the advanced stage of HIV Infection.

What does HIV stand for?

HIV is an acronym that stands for Human Immunodeficiency Virus. It is carried in the blood, semen, vaginal fluids and breast milk of HIV infected persons.

H = Human: HIV is a disease that infects humans.
I = Immuno: refers to the immune system.
V = Virus: a small organism, similar to a germ.

AIDS is an acronym that stands for Acquired Immune Deficiency Syndrome.

Acquired - HIV can only be transmitted via specific activities when one person is already HIV positive.

Immune - This virus attacks or breaks down a person's immune system, which is the body's ability to protect itself.

Deficiency - Means weakness - this virus causes a weakened immune system. The portion of the system that is most affected by the HIV virus are T-cells in the blood.

Syndrome - refers to a group of signs and symptoms that are the result of opportunistic infections. These infections depend largely on individual and societal circumstances. There are many opportunistic infections and clinical conditions which indicate the diagnoses of AIDS.

WHAT IS THE DIFFERENCE BETWEEN HIV AND AIDS?

Though many people use these terms interchangeably, HIV and AIDS mean two different things. HIV refers to the virus which weakness the immune system. AIDS refers to the condition when opportunistic infections have developed within the body.

HOW CAN I GET HIV?
HIV is not easy to contract. For this to occur, HIV from an infected person must enter another's bloodstream. This has been shown to happen in specific ways:

Sexual Intercourse - The virus spreads by having unprotected sexual intercourse (vaginal, anal and oral) with a person who is infected with HIV.

Sharing Needles -The virus can be spread by sharing needles, syringes and other body piercing instruments i.e,. tattoo needles, acupuncture equipment

Vertical Transmission/Pregnancy - An infected mother can pass the virus to her baby during pregnancy or through the birth process. Some babies have been infected through breast milk. Women are encouraged to be tested for HIV during pregnancy. AZT and other medications taken by a pregnant woman during her pregnancy significantly lower the risk of HIV passing to the fetus.

Blood transfusions - There is absolutely no risk in donating blood since sterile needles are used only once and discarded. Before November of 1985, however, blood was not screened for HIV. This meant that some people receiving transfusions became infected with HIV this way. Now all blood products used for transfusions are tested for the presence of HIV. Hence, there is presently very little risk in blood transfusions transmitting HIV.

The virus can also be spread through organ donations and/or artificial insemination. While North American donors are now tested, this was not always the case. If you think you may be at risk from a previous donor, contact your doctor, nurse, HIV/AIDS organization or AIDS & Sexual Health Infoline.

HOW DON'T I GET INFECTED?

HIV IS **NOT** SPREAD THROUGH CASUAL CONTACT at home or in the workplace. Casual contact is defined as activities such as shaking hands, sharing utensils, food, tools, pools, hot tubs, bathrooms or even hugging or dry kissing. No one has become infected, by being in the same room, working in the same office, or riding on the same bus with a person with HIV/AIDS. HIV cannot be spread by mosquitoes or lice or through the air like a cold or the flu. You must exchange blood, semen or vaginal fluids with an HIV infected person in order to become infected.

Fortunately HIV is a difficult virus to get. People with HIV/AIDS deserve and need to be held and touched. It is important that unfounded fears do not keep people separated from their loved ones at a time when being close is so important.

Where did HIV/AIDS come from?

We really don't know. There are many theories about the origin of this virus, but no one knows for sure. One theory is of biological warfare - HIV was developed in a laboratory to rid the world of undesirable people. Another theory is that HIV has always been around. However, since our environment has changed so much due to deforestation and flooding, we have disturbed the natural checks and balances, thus exposing new viruses to the whole world. Another claim is that HIV was spread by green monkeys in Africa. There is evidence that monkeys were injected with potential cures for malaria in the mid century and African prisoners were then used to test these cures.

Is it safe to receive a blood transfusion?

All blood for transfusions in Canada has been screened for the presence of HIV and other blood borne diseases since November 1985. In addition to other safety measures some hospitals are contacting individuals who received blood before this time. No one can guarantee that the blood supply is 100% safe, but the risk of receiving contaminated blood is minuscule. Our system is one of the safest in the world. There is absolutely no risk in donating blood since a new needle is used for every donor.

Is HIV/AIDS a homosexual condition?

No. In most countries, HIV is spread almost exclusively by unprotected sexual intercourse between men and women. This mode of transmission is growing in Canada. Although it is true that HIV/AIDS first affected the gay community in North America, the spread of the disease has nothing to with who you are. It has to do with what you do.

What are the symptoms of HIV/AIDS?

There is no one symptom of HIV/AIDS. Symptoms depend on which opportunistic infection that is in the body. These opportunistic infections depend on gender, race and age and the health care available. Common symptoms of a weakening immune system are: unexplained weight loss, extreme fatigue, diarrhoea, swollen glands, night sweats and headaches. In addition, women may experience menstrual irregularities, increased vaginal yeast infections and abnormal PAP smears.

These are symptoms of many diseases and are not necessarily specific to HIV/AIDS. If you have engaged in an unsafe activity that may have exposed you to HIV and you are experiencing some of these conditions, get tested for HIV.

Will everyone who has HIV progress to AIDS?

Some scientists believe that eventually everyone who is HIV positive will develop AIDS. Others have noted that 6-10% of individuals, who have been positive for ten years, have yet to show any symptoms. These people are considered to be long-term survivors. An important message for people who are HIV positive may be to modify lifestyle habits like eating, drinking, smoking and exercise, which affect the immune system. Early diagnosis and treatment are very important. In fact, advances in treatment have substantially reduced the threat of PCP (a type of fungal pneumonia)

which once claimed the lives of many people with HIV/AIDS. The longer you are in good health, the greater your chances are for receiving treatments or cures that may become available.

If a woman is HIV positive, what are the risks to her baby?

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

When would I know if my baby is infected?

The virus can only be passed to the fetus if the mother is HIV Positive. It takes a while to find out if a baby has the virus. Samples of the baby's blood will be tested for HIV using a PCR test at birth, one month and two months times. A negative test means the baby does not have HIV.

How risky is oral sex?

No sexual contact involving an exchange of body fluids appears to be completely safe if one partner is infected. Oral sex is considered to be a low risk sexual activity. The person who takes pre-ejaculate (pre-cum), ejaculate (semen or cum) or vaginal fluid into the mouth, is at risk for infection if there is inflammation or infection in the mucous membrane of the mouth. There are a few documented cases of men being infected this way, but the vast majority of people have been infected by unsafe vaginal or anal sex. You can decrease the risk of becoming HIV positive by wearing a condom for oral sex on a man or placing a latex barrier (dental dam) over the vulva of a woman. A latex barrier can be made, by cutting along the shaft of a condom. These barriers not only decrease your chances of getting HIV, but, will decrease your exposure to other sexually transmitted infections.

How do I get tested for HIV?

You can get tested at your family doctor's office or clinic. HIV positive results must be reported to the local public health office. Statistics are kept to determine the age, sex and risk factors of people who become infected. An HIV test involves taking a sample of blood. Pre and Post counselling must be offered to everyone requesting testing. Test results are given in person, so you must return to the clinic for this information. To find out the location of your nearest clinic, contact the AIDS & Sexual Health Info-line at 416-392-2437.

Anonymous testing uses a number or a code on your lab slip instead of your name. Only you will know your test result, or even that you were tested. Anonymous testing is only available at selected health clinics. Anonymous tests are not done by family physicians.

Confidential testing means your test result will appear in your medical record. Only you and your physician will know this information. In rare instances legal authority could be used to access your medical record.

What can I do if I test HIV Positive?

A health care provider who is knowledgeable about HIV can monitor your health and help you decide what treatments are best for you. Your health care provider can also discuss with you how important it is to protect yourself from infection with other strains of HIV or other sexually transmitted infections. The Community AIDS Treatment Information Exchange (CATIE) provides information and resources to help people living with HIV/AIDS who wish to manage their own health care in partnership with their care providers. To contact CATIE by telephone – 1-800-263-1638 or 416-944-1916; by fax 416-928-2185 by e-mail info@catie.ca on the Web www.catie.ca.

PRECAUTIONS

This section discusses ways in which you can protect yourself from HIV infection. To avoid becoming HIV positive, you need to know about safe needle injection procedures, latex barriers for safer sex and guidelines for precautions where exposure to HIV is likely.

Safe Needle Injection

You can get the HIV virus by having HIV infected blood enter your body. If you inject drugs or other substances into your body, use a new needle each time you inject. Never share your needles with someone else. Call the AIDS & Sexual Health Info-line at (416) 392-2437 to see if there is a needle exchange program in your community.

Remember that HIV may also be spread if ear-piercing, tattooing, acupuncture or electrolysis equipment hasn't been cleaned properly. Sharing razor blades and toothbrushes may also be sources for HIV transmission if trace amounts of blood are present.

Safer Sex

Everyone should know about safer sex, even if they are not sexually active. You cannot tell if your sexual partners are HIV positive by just looking at them. Because many people are embarrassed to admit their sexual or drug history or are completely unaware of their HIV status, always practice safer sex.

Safer sex means, not doing anything that would let HIV enter your body.

This means avoiding contact with your partner's blood, semen (pre-cum), ejaculate (cum) or vaginal fluid. If you have cuts or wounds on your body, it is a good idea to keep them covered with a bandage. If you are having intercourse, use condoms and water-based lubricants.

The condom you choose will depend upon your own personal preference as well as how you will be using the condom. Though there are many types of condoms, only latex condoms are effective in preventing the spread of HIV. Natural skin condoms protect against pregnancy but permit the passage of the HIV virus and therefore do not provide adequate protection. Condoms are also available in many colours, shapes and textures. Water-based lubrication added to the condom will decrease friction and tearing. Lubricants that are oil-based (i.e. vaseline, hand lotion, baby oil) causes latex to break down very quickly and leads to condoms breaking during intercourse. Also, avoid spermicidal lubricants (contain nonoxynol-9) for intercourse because this chemical may irritate the vaginal and anal mucous membrane tissue.

Condoms also lower the risk of HIV transmission if you are kissing, licking or sucking a man's penis since HIV is present in ejaculation and pre-ejaculation (the clear drop of fluid that comes out of a man's penis before ejaculation). Oral sex on a penis without a condom is particularly dangerous if you have bleeding gums or ulcers in your mouth. Some people prefer using unlubricated or flavoured condoms when performing oral sex on a man.

Polyurethane condoms are now available and have some advantages:

- **made thinner so sensation is better**
- **fits more loosely which is preferable to some men**
- **material is stronger and less likely to tear or break down in heat and cold**

- **an alternative for people who have a latex allergy**
- **the female condom provides women with an option if males are reluctant to use condoms**
- **Laboratory tests demonstrate that plastic is an effective barrier from germs and sperm, but it costs much more than latex.**

Universal Precautions For First Aid

HIV in blood or other fluids cannot penetrate intact skin. You can only become infected if these fluids are passed through breaks in the skin. Since we are not always aware of the condition of our skin, the Canadian Centre for Disease Control recommends the following recommendations as protection against all blood borne diseases. Though many institutions have already developed their own policies, the following information is particularly important for hospital workers, emergency care professionals and research lab technicians where the handling of HIV containing materials may be required.

Consider the blood and body fluids of all persons to be infectious. Take precautions to prevent exposure to blood or body fluids.

1. Protect your hands with impermeable, disposable gloves. These may be vinyl or latex (there are fewer allergies/sensitivities when using vinyl). Use these when blood contact is inevitable - rendering first aid, cleaning up blood spills or when blood contact is probable - breaking up fights.

2. Any spills/contamination of blood or body fluids should be wiped up with disposable toweling to remove the bulk of organic matter. The area should then be cleaned with soap and water and then disinfected with a household disinfectant or a diluted bleach and water solution (one part bleach and nine parts water made up fresh each day).

3. After gloves are removed, hands must be washed with soap and water.

4. Take special care to prevent yourself from becoming punctured by possible contaminated sharp objects like glass or needles.

APPENDIX III

HIV TRANSMISSION: GUIDELINES FOR ASSESSING RISK

Principles of HIV Transmission:

The routes of HIV transmission are well established:

- Specific types of sexual activity;
- Sharing used, needles or syringes and other procedures that involve piercing of the skin
- Mother-to-child transmission, in the uterus, during childbirth or through breast-feeding; and
- Receiving transfusions of infected blood or blood products, transplanted organs, or donated sperm (for insemination).

In each of these routes, certain conditions must exist in order for HIV transmission to occur. These conditions are:

1. **There must be a source of infection.**
   Since there is no means of guessing whether a person is infected or not, it is appropriate to consider the presence of HIV in certain body fluids, such as blood, semen, vaginal fluid or breast milk, as the potential source of infection.

2. **There must be a means of transmission.**
   Someone must engage in a sexual or injecting activity that can allow HIV transmission to occur. Maternal transmission of HIV from an HIV-positive woman to the fetus in the uterus, during delivery or by breast-feeding during infancy is also possible.

3. **There must be a host susceptible to infection.**
   Everybody is considered to be a host susceptible to infection.

4. **There must be an appropriate route of entry to the target cells of the body.**
   In order for HIV infection to occur, infected blood, semen, vaginal fluid or breast milk must reach the HIV susceptible cells in the blood, usually through a break in the skin, absorption through mucous membranes or through some disruption to the mucosa. Mucosa are the moist surfaces of the body which line most of the body cavities and hollow internal organs such as the mouth, nose, eyelids, rectum, vagina and urethra.

5. **There must be a sufficient level of virus delivered to establish infection**. Semen, vaginal fluid, blood, and breast milk are of most concern in HIV transmission. Although HIV has also been isolated in urine, saliva & tears, it is highly unlikely that it will be present in sufficient concentrations for transmission to occur. HIV has been isolated in pre-ejaculatory fluid (pre-cum). Though the concentration of HIV in pre-cum is likely to be low, it cannot be discounted as a potential source of transmission.

HIV TRANSMISSION: A MODEL FOR ASSESSING RISK

The levels of risk of various activities are organized into four categories, based on the potential for transmission of HIV and the documented evidence that transmission has actually occurred. These categories of HIV transmission are: no risk; negligible risk; low risk; high risk.

HIGH RISK

All of the practices listed in this category present a potential for HIV transmission because they involve an exchange of body fluids such as semen, vaginal fluid, blood and breast milk. In addition, a significant number of scientific studies have repeatedly associated the activities with HIV infection. Even when the exact mechanism of transmission is not completely clear, the results of such studies conclude that activities in this category are high risk.

Potential for transmission: yes
Evidence of transmission: yes

Examples: Insertive or receptive penile-anal or penile-vaginal intercourse without a condom, sharing needles or syringes, receptive insertion of shared sex toys.

LOW RISK

All the practices listed in this category present a potential for HIV transmission because they involve an exchange of body fluids such as semen, vaginal fluid, blood and breast milk. There are also a few reports of infection attributed to these activities (usually through individual case studies or anecdotal conditions)

Potential for transmission: yes
Evidence of transmission: yes (under certain conditions)

Examples: Receptive fellatio without barrier (oral sex on penis), insertive cunnilingus (putting mouth and/or tongue inside vagina) without barrier, insertive or receptive penile-anal or penile-vaginal intercourse with barrier, injection of a substance using a used needle and syringe which has been cleaned.

NEGLIGIBLE RISK

All of the practices listed in this category present a potential for HIV transmission because they involve an exchange of body fluids such as semen, vaginal fluid, blood and breast milk. However, the amounts, conditions and method of exchange are such that the efficiency of HIV transmission appears to be greatly diminished. There are no confirmed reports of infection from these activities.

Potential for transmission: yes
Evidence of transmission: none

Examples: insertive or receptive fellatio/cunnilingus with barrier, anilingus, digital-anal intercourse.

NO RISK

To our knowledge, none of the practices in this group has ever been demonstrated to lead to HIV infection. There is no potential for transmission since none of the basic conditions for viral transmission is present.

Potential for transmission: none
Evidence of transmission: none

Examples: Kissing, solo masturbation, being masturbated by partner (without using semen/vaginal fluids as lubricant), using unshared sex toys, urination, ejaculation or defecation on unbroken skin, massage, touch, caressing, dirty-talk, body rubbing, injection of a substance using a new needle and syringe.

Source: HIV Transmission – Guidelines for Assessing Risk – A Resource for educators, counsellors and health care professionals, Third Edition (January, 1999)
Canadian AIDS Society/Health Canada

613-230-3580 (Tel) or 613-563-4998 (Fax)

Condoms

Latex or polyurethane condoms are an effective barrier and one of the most important tools in preventing HIV transmission. Female condoms are now also available.

Condoms must meet design, length and width requirements as well as specific tests for water leakage, bursting volume and bursting pressure described in regulations by the Health Protection Branch of Health Canada. Complaints or concerns about a particular product can be reported to the medical Devices Hotline at 1-800-267-9675

If condoms are used properly, they have been shown to substantially reduce risk. However, condoms may sometimes fail, usually because they are not used properly and consistently.

When using condoms, use these guidelines;

- Always use before the expiry date on the package
- Store in a cool dry place – exposure to heat or direct sunlight can break down latex
- Try several brands to find the most comfortable

The Female Condom
It is a sheath that lines the vagina, with two flexible plastic rings at either end. It is made from polyurethane and is considerably more expensive that the latex male condom. It offers the welcome potential of giving women the chance of more control over their own protection.

APPENDIX V

THE LECTURE

THE LECTURE: Adding new life to an old companion

PROBLEM: Boring lectures

Most adult students expect to be lectured to. They come with notepads and pens and are prepared to sit through, or attend, what are often boring lectures. Many instructors also dread the boring-lecture-monster and wish there was a way to prevent it from rearing its ugly head.

Some time ago, an experiment was conducted in California. A college course was taught by regular professors and by professional actors, who had been carefully briefed in the subject matter. The students did not know about this experiment. At the end of the term the examination results were compared and the overwhelming evidence was (you guessed it), those instructed by actors had acquired more information (i.e. learned better than those taught by the subject experts. Do we need to take acting lessons?

A lecture is best used when:

- We are concerned mainly with giving information.
- The information is not readily available to the learners in another form.
- The material presented is needed for short-term retention only
- We introduce a subject or give oral directions that will lead to the use of other techniques involving the student more actively.

A lecture is best not used when:

- The material is complex, abstract or very detailed.
- We are dealing with learning that involves the attitudes and feelings of our learners.¦ The information must be available in its fullest form for long-term retention.
- We are working with a group of learners whose level of educational experience is minimal.¦ The material presented has to be integrated by the students with the previous learning or back-home experiences and situations.

TIME REQUIRED:

Unless an instructor is very entertaining, the subject matter most compelling and the audience superbly committed, research suggests that a lecture should last no long than 30 minutes.

PHYSICAL SETTING:

All students should be able to have a full view of the lecturer at all times.

STEP-BY STEP PROCEDURES:

1. Do not present too many points. Six major points are probably enough for half an hour.

2. Present summaries both at the beginning and the end.

3. Pause occasionally to give listeners a chance to catch up.

4. Explain when questions should be asked: any time, at the end, at a certain interval.

5. Use visual aids to support your points – If using overheads – only major points should be on the overhead.

6. The speed of speaking and the choice of vocabulary must be geared to the level of your audience.

7. Using elaborate visual aid gadgets does not change the essentially one-way communication nature of the lecture.

VARIATIONS:

A short lecture of not more than 10 minutes is called a Lecturette. A formerly long and somewhat boring lecture can be broken up into several lecturettes allowing you to incorporate other techniques (more below). A lecturette requires discipline and organization from the speaker, but tends to put fewer people to sleep.

When I first started using these I put a cooking timer on my table in full view, set a 10 minutes. The students knew why and I knew why. At least every ten minutes the focus was on me ... and the timer.

A longish lecture can also be broken up by a brief question-and-answer period. This is sometimes called a Lecture-Forum. It provides some activity for the learners by giving them an opportunity to examine a portion of the lecture in more detail before more information is presented. You have to be alert to avoid being led astray. Rather than asking: "Are there any questions?" you might start with "How could you apply the three points I have discussed in your work situations?"

Or, "What additional information could I give you to help you understand this important step in the process?" As soon as you are satisfied that the group is "with you", proceed.

NOTES:

Most of us have a large amount of information to "get across" to our learners. Also, we are not comfortable with many techniques other than lecturing. The point is not to abolish lectures but to make them more meaningful and to involve the learners. Our own level of excitement caused by being freed from a chore will further add to the enjoyment.

Two important facts to remember are:

1. Lecture in its strictest form requires some activity from the instructor but considerable passivity of the learners.

2. As adults age, there is no change in their ability to learn, but there is slowing down in their rate of learning.

Therefore try to:

1. Mix your activities in such a way that the student is alternately passive (sit, hear, see) and active (problem-solve, write, construct, discuss, move, walk, speak, operate equipment).

2. Introduce your topic by specifying what will presented, how long it will take, and how you are going to proceed with it. This helps learners anticipate events, prepare for change in pace/technique and assign their energies accordingly.

3. Present new material in a logical sequence, step-by-step, relating it to familiar and known material (such as readings, previous discussions, students' own experience).

4. Allow more time for complex material and repeat key points.

5. Consider giving handouts either before or after presentation.

6. Use one of many techniques to keep listeners/watch interested in what you are saying:

    - Change Place: move around, speak from the back of the room, the front of the left or right of the room. I have been known to stand on top of a table to make a point.

    - Use Gestures: hand, head and body movements can serve as supporters (and distracters!) of verbal output.

    - Concentrate Attention: "Now listen to this...", "Look over here..."

    - Change Style of Interaction: use questions, student-student interactions, buzz-groups, demonstrations, problem-solving, tasks, discussions.

    - Use Silence: for reflection, question formulation, concentration.

    - Change Tone of Voice: loud-mellow, fast-slow, happy-sad, technical-personal.

7. Experiment!

Giving up lecturing is perhaps a threat to many instructors. What will they do instead? Will they lose control? Will the students learn? If a snappy handout can take the place of my lecture, does that mean I am redundant?

I found that by switching to other teaching techniques, I became less tied to my lecture notes and my spot in front of the class. I gradually discovered that I had more time and energy to spend on helping my student learn. Instead of saying "Oops, there goes the time, quickly two more points and then I'll see you next week"; I became more available to my students to assist them in determining what they wanted to learn, how my course material could relate to their own situation and to help them determine how well they had done in the course.

Caution: Experiment with any new ideas only at a pace that is comfortable to you. Allow your students to share the responsibility for the success of the course without threatening yourself - or upsetting their role expectation as learners.

* Source: Taken from "Teaching Others" a course given by Mary Graham and Barbara Williams, City of Toronto, Management Services Division.

APPENDIX VI
EVALUATION

DEMYSTIFYING EVALUATION

Why evaluate? Evaluate to predict program results, measure results and help determine why they occurred. If you know what teaching strategy or activity worked well and which ones failed you can gain important insights into improving your work.

Often people resist evaluation. Consider evaluation as one part of program planning that isn't tacked onto to the end but rather considered throughout the cyclical process. Indeed, evaluation should be one of the first things you consider in program planning. When you determine your needs through a pretest or survey this is evaluation. When you set your objectives and ask yourself if they are measurable, this is evaluation. When you alter your program based on feedback, this is evaluation. When you use the results of your program to argue for more training or education this too is evaluation. Although there are many barriers to conducting formal evaluation projects, one can use evaluation tools to assess and improve the work you do. Four types of evaluation are discussed:

1. FORMATIVE

This takes place before implementation and is designed to assess the strengths and weaknesses of existing materials, programs etc. before the full effort proceeds. Pre-testing and needs assessments are covered in this type of evaluation.

2. PROCESS

Process evaluation includes monitoring daily tasks and assessing program activities. When you complete summary forms or satisfaction questionnaires at the end of a workshop, this is a type of process evaluation. What procedures and tasks are involved in implementing your program? What administrative and organizational aspects are involved in the program? How does your planning group work? What resources do you have or need? Were the tools and strategies you used for your workshop appropriate? As you plan and implement your program, were you expectations met? When you think about the image your program has, this too is process evaluation.

3. OUTCOME:

This is descriptive data on your project, program or resource.

What are the short- term results of your project? How many inquiries resulted, how many people were reached, how much material was distributed? Outcome evaluation also includes knowledge and attitude change, intentions of the target group, short-term behavior change; i.e., purchasing condoms and policy changes.

4. IMPACT

This is the most comprehensive, expensive and rigorous type of evaluation as it measures the effectiveness of the program. It focuses on long term results. Information yielded from impact evaluation includes long term maintenance of desired behavior and changes in mortality and morbidity.

For more information on evaluation see: Wong-Rieger, Durhane and Lindee, David " A Hands on Guide to Planning and Evaluation, How to Plan and Evaluate Programs in Community Based Organizations. Canadian Hemophilia Society. ISBN 0-920967-04-3.